



IDAHO DEPARTMENT OF
HEALTH & WELFARE

G.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
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PHONE 208-334-6626
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CERTIFIED MAIL: 7012 1010 0002 0836 1864

February 26, 2014

Stephen Farnsworth, Administrator
Pocatello Care & Rehabilitation Center
527 Memorial Drive
Pocatello, ID 83201-4063

Provider #: 135011

Dear Mr. Farnsworth:

On **February 11, 2014**, a Complaint Investigation survey was conducted at Pocatello Care & Rehabilitation Center by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag 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 both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in

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the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 11, 2014**. Failure to submit an acceptable PoC by **March 11, 2014**, may result in the imposition of civil monetary penalties by **March 31, 2014**.

The components of a Plan of Correction, as required by CMS include:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title, who will do the monitoring. It is important that the individual doing the monitoring have the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for "random" audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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 both the federal survey report, Form

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CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **March 18, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **March 18, 2014**. A change in the seriousness of the deficiencies on **March 18, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 18, 2014** includes the following:

Denial of payment for new admissions effective **May 11, 2014**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 11, 2014**, 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, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS

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Regional Office or the State Medicaid Agency beginning on **February 11, 2014** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **March 11, 2014**. If your request for informal dispute resolution is received after **March 11, 2014**, 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, please contact us at (208) 334-6626.

Sincerely,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj
Enclosures

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

PRINTED: 02/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/11/2014
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201	
(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 complaint investigation survey of your facility. The surveyors conducting the survey were: Arnold Rosling, RN/QMRP and Sherri Case, LSW/QMRP. The survey team entered the facility on Monday, February 10, and exited the facility on Tuesday, February 11, 2014. Survey Definitions: ADON = Assistant Director of Nursing Services CNA = Certified Nurse Aide DON = Director Nursing Services LN = Licensed Nurse MDS = Minimum Data Set assessment MAR = Medication Administration Record UTI = Urinary Tract Infection	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge	F 157		

RECEIVED
MAR 06 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **3/4/14**

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 157	<p>Continued From page 1</p> <p>the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the facility failed to notify residents' physicians timely when blood glucose (BG) levels were out of range for 2 of 5 sample residents (#1 & 2). Additionally, the facility failed to notify a family member when the resident was admitted to the hospital. This was true for 1 of 5 sample residents (#3). This had the potential for affect treatment decisions related to residents' needs. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 10/30/08 and readmitted on 1/30/14. The resident had diagnoses which included depression, anxiety and diabetes.</p> <p>The most recent quarterly MDS assessment, dated 11/28/13, documented the resident: - was cognitively intact, - had 0 incidents of delusions, hallucinations or</p>	F 157			

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F 157	<p>Continued From page 2 behaviors,</p> <ul style="list-style-type: none"> - had an indwelling catheter, - required extensive assistance of 2 staff for transfers, bed mobility and dressing. <p>A report from the local hospital, with an admit date of 1/28/14, documented the resident's laboratory results included a blood glucose (BG) level of 690 (American diabetes identifies fasting blood sugar of 70-130 and after a meal a BG of less than 180). The report also documented the resident received an antibiotic for a UTI, and insulin for the high BG. The assessment section of the hospital report documented possible bladder or urethral trauma as evidenced by bloody urine and possible infection.</p> <p>Resident #3's Progress Notes (PN) documented in a late entry dated 1/28/14 at 9:26 a.m. that the resident had been sent to the hospital. The entry documented the resident had pulled out her catheter, had lost some blood and her laboratory results were abnormal. The PN did not document a family member had been notified.</p> <p>On 2/11/14 at 8:20 a.m. the DON was asked for the incident report for when the resident went to the hospital on 1/28/14. The DON stated an incident report had not been completed.</p> <p>On 2/11/14 at 9:05 a.m. the DON was asked where family notification of significant events for a resident would be located. The DON stated it would be documented in the PN or on an incident report. The DON was informed the resident's PN did not include documentation the family had been notified.</p> <p>2. Resident #2 was admitted to the facility on</p>	F 157		

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F 157	<p>Continued From page 3 3/21/11, and readmitted on 5/11/11, with diagnoses which included diabetes and a UTI.</p> <p>The resident's 1/14 and 2/14 MAR documented the resident's physician was to be called "If BG less than or equal to 70 or greater than or equal to 400."</p> <p>*The resident's 1/12/14 MAR documented a BG of 70.</p> <p>The resident's PN did not contain an entry on 1/12/14 that the physician had been notified.</p> <p>* The resident's 2/4/14 MAR documented a BG of 61 and a BG of 70 on 2/9/14.</p> <p>The resident's PN for 2/4/14 and 2/9/14 did not document the physician had been notified.</p> <p>On 2/11/14 at 4:35 p.m. the Administrator and DON were informed of the above concerns. The facility provided no further information.</p> <p>3. Resident #1 was admitted to the facility on 10/7/10 with diagnoses of diabetes mellitus.</p> <p>The Lab, on 10/19/13, reported to the facility the resident had a "critical" value BG of 671 mg/dl. The resident's physician was contacted and ordered the resident to receive 5 units insulin subcutaneous.</p> <p>The resident received the insulin at 12 noon on 10/19/13. At 1:05 p.m. the nurse retested the resident's BG with a glucometer and got a reading of "high." This was an indication the resident's BG glucose was still greater then 400 mg/dl.</p>	F 157		
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F 157	Continued From page 4	F 157			
F 225 SS=D	<p>The resident's medical record did not document the nurse notified the physician of the resident's 1:05 p.m. high BG reading.</p> <p>The Administrator and DON were notified of the failure to notify the physician on 2/11/14 at 4:45 p.m. No further information was provided.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p>	F 225			

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F 225	<p>Continued From page 5</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to investigate an injury of unknown origin to rule out abuse or neglect for 1 of 5 sample residents (#3), whose catheter was pulled out when inflated on two separate occasions. Findings include:</p> <p>Resident #3 was admitted to the facility on 10/30/08 and readmitted on 1/30/14. The resident had diagnoses which included depression, anxiety and diabetes.</p> <p>The resident's most recent quarterly MDS assessment, dated 11/28/13 documented the resident:</p> <ul style="list-style-type: none"> - was cognitively intact, - had 0 incidents of delusions, hallucinations or behaviors, - had an indwelling catheter, - required extensive assistance of 2 staff for transfers, bed mobility and dressing. <p>During an observation on 2/10/14 at 2:35 p.m. the resident stated that about 2 weeks prior she had eaten about 5 candy bars and had a "bad reaction." The resident stated she had been so confused she had pulled out her catheter.</p>	F 225		

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F 225	Continued From page 6 The resident's Progress Notes (PN) documented the following: *1/23/14 at 6:18 p.m. -"Pt (patient) was pulling at catheter. Nurse educated PT not to pull at catheter. Pt stated I haven't pulled on it." *1/24/14 at 10:59 p.m. -"Continues ABX (antibiotic) for UTI (urinary tract infection). No itching, swelling ... No blood noted in depends (adult brief) or urine... C/O (complains) pain in peri area and states she is voiding around cath." *1/26/14 at 2:23 a.m. -"Resident continues on (antibiotic)...no blood in urine or attend." *1/27/14 at 4:48 a.m. -"... continues on Cipro (antibiotic) for UTI ...urine has some blood in cath r/t (related to) resident pulling on catheter educated resident not to pull on cath; resident stated 'I never do that.'" The PN documented at 4:50 p.m. that the resident requested more pain medication but was informed the medication was not due until 6:00 p.m. Additionally, the PN documented the physician was called and stated the patient was already on bladder spasm medication and increased the pain medication. *1/28/14 at 9:26 a.m. (late entry) -"...ADON was notified of transfer to hospital....When paramedics arrived explained to them about her pulling out her catheter and that she had lost some blood earlier and was still having some bleeding. Also that her labs were abnormal and sent packet with them and that she was having difficulty staying awake and having much lethargy."	F 225			

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F 225	<p>Continued From page 7</p> <p>*1/28/14 at 12:49 p.m. -"Pt given increased pain meds at 9:30 a.m. At noon the pt appears sedated, asleep with food in her hands. When aroused by this nurse the pt had a difficult time making eye contact and repeated, "I'm awake..."</p> <p>*1/28/14 at 2:38 p.m. - "At 2:00 p.m. CNA called and stated that (Resident name) was bleeding. Assessed and noted that her foley catheter was out and had bleeding on her sheet and in her attends. Continues to have some bleeding mixed with urine...Bulb was still attached to foley catheter." The physician was called and instructed the nurse to leave the catheter out.</p> <p>A report from the local hospital, with an admit date of 1/28/14, (no time noted) documented the resident's laboratory results included a blood glucose (BG) level of 690. The report also documented the resident received an antibiotic for a UTI, and insulin for the high BG. The assessment section of the hospital report documented possible bladder or urethral trauma as evidenced by bloody urine and possible infection.</p> <p>On 2/11/14 at 8:20 a.m. the DON was asked if the incident on 1/28/14 had been investigated. The DON stated the incident had not been investigated as the resident had been taken to the hospital. When informed the resident stated she had eaten a large amount of candy the DON stated the resident had no access to candy and did not believe the statement was true. The surveyor stated without an investigation there was no evidence the resident had not been able to access the candy.</p> <p>The resident's PN documented the catheter was</p>	F 225			

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F 225	Continued From page 8 pulled out a 2nd time on 2/5/14. *2/5/14 at 11:49 p.m. - PN document "...staff noted blood clots and urine in depends with bowel movement. Also noted blood up side, and on rt (right) lower side of gown and on Rt hand. Res denied pulling on cath but staff thinks she was....at 11:00 p.m. ...found foley cath completely out with 10 cc balloon inflated with blood clots wrapped around cath with blood and urine in depends." *2/6/14 notes at 10:20 p.m. document the resident went to the urologist and the catheter was to be left out for 2 weeks so the "bladder can heal." On 2/11/14 at 8:20 a.m. the DON was asked if there was an incident report or investigation regarding the 2nd incident on 2/5/14. The DON stated she was not aware of the 2nd incident. Later that day the DON stated the ADON was aware of the 2nd incident. On 2/11/14 at 4:35 p.m. the Administrator and the DON were informed of the above concern. Without an investigation the facility could not determine if the resident had pulled the catheter out, if she had eaten an excessive amount of candy or if staff had been neglectful in providing care for the resident.	F 225			
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, mental, and psychosocial well-being, in	F 309			

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

PRINTED: 02/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/11/2014
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NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201
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(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
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F 309	<p>Continued From page 9 accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and policy and procedure (P&P) review, it was determined the facility failed to ensure low blood glucose (BG) levels were rechecked and appropriate interventions implemented for 1 of 5 sampled residents (#2). Failure to recheck BG levels or implement interventions placed the resident at risk for complications related to diabetes. Findings included:</p> <p>Resident #2 was admitted to the facility on 3/21/11, and readmitted on 5/11/11, with diagnoses which included diabetes and a UTI.</p> <p>The resident's January 2014 and February 2014 MAR documented the resident's physician was to be called, "If BG less than or equal to 70 or greater than or equal to 400."</p> <p>Note: The American Diabetic Association's (ADA) Standards of Medical Care in Diabetes, January 2010, defines hypoglycemia as a glucose level less than 70. The ADA recommends 15-20g of glucose in the treatment of hypoglycemia. The ADA also recommends checking blood glucose levels 15 minutes after treatment. If the blood glucose level showed continued hypoglycemia, the treatment and blood glucose rechecks should be repeated until the blood glucose level was normal."</p> <p>The facility's P&P for Diabetic Protocol</p>	F 309		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/11/2014
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F 309	<p>Continued From page 10</p> <p>documented that if the resident's glucose level was 0-70 and the resident was able to swallow, to give 4 oz of fruit juice, 8 oz of 2% milk or 1 pouch of glucose gel, if available, combined with a sandwich or other snack containing protein. The P&P also directed staff to notify the supervisor and recheck the blood sugars in 15 minutes.</p> <p>The resident's 1/12/14 MAR documented a BG of 70.</p> <p>The resident's PN and MAR did not contain an entry on 1/12/14 that the physician or supervisor had been notified, the BG level had been rechecked in 15 minutes, or that the resident had received a snack for the low BG.</p> <p>The resident's 2/4/14 MAR documented a BG of 61 and a BG of 70 on 2/9/14.</p> <p>The resident's PN for 2/4/14 documented at 12:30 the resident received apple juice, root beer, tea and honey and "advised him to eat his lunch." At 1:45 p.m. (1 hour and 15 minutes later) the BG was rechecked and was 68. The resident had not eaten his lunch, was given a sandwich and the BG was to be checked at 2:30 p.m. (45 minutes). There was no documentation in the PN the BG was rechecked at 2:30 p.m.</p> <p>The resident's PN for 2/9/14 had no information regarding the BG of 70.</p> <p>The P&P was not followed as the BG's were not rechecked in 15 minutes and the supervisor was not notified. Additionally the MAR documented the physician was to be notified which, was not done.</p>	F 309		

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F 309	Continued From page 11 On 2/11/14 at 9:10 a.m. the DON stated the interventions for the low BG's and the BG rechecks should be in the PN. On 2/11/14 at 4:35 p.m., the Administrator and DON were informed of the above concerns. The facility provided no further information.	F 309			
F 514 SS=D	483.75(l)(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 record review and policy review, the facility failed to ensure the medical record of 1 of 5 (# 5) sampled residents documented services provided by the licensed staff. There was a potential for harm due to the resident had a low blood glucose (BG) level and it could not be determined what was done to ensure the resident was not harmed as a result of the reading. Findings include: Resident #5 was admitted to the facility 10/9/13	F 514			

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F 514	<p>Continued From page 12 with diagnoses of diabetes without complications type II and non-essential hypertension.</p> <p>Facility policy, dated 2009, NCLN-4 "Diabetic Protocol" documented a process the facility was to complete when the resident's blood glucose was less then 70 mg/dl [milligrams per deciliter]. The policy documented the staff was to, "call the physician..."</p> <p>On 10/23/13 at 2:01 p.m. the facility received Resident #5's laboratory results. The testing reported the resident had a BG of 67 mg/dl.</p> <p>The Laboratory report had a notation from a nurse stating that the physician was called, but the note failed to document the time the physician was contacted. In addition, the LN failed to document what the nursing staff and/or the physician ordered/did for the resident because of the low value.</p> <p>The administrator and DON were informed of the findings on 2/11/14 at 4:45 p.m. No further information was provided.</p>	F 514			

RECEIVED
MAR 18 2014
FACILITY STANDARDS

F-157 D

1. In-service provided to LN's on 2-25-14 on policy for notifying legal representative or interested family member/physician with a change of condition or discharge from facility. In-service provided to LN's on policy for Blood Glucose monitoring and when to notify physician.
2. All patients that have a significant change have the potential to be affected.
3. LN's will report any significant change, as defined by facility policy and regulation, in a timely manner to physician and legal representative. Medical records will review progress notes daily to identify significant changes to ensure notification was documented.
4. DNS or RN designee will audit progress note review from medical records for continuity and accuracy. 2 x weekly for one month, then 1 x weekly for one month. DNS or RN designee will audit MARs to ensure Blood Glucose out of parameters per policy was reported to physician and documented. All audits to begin 3/10/14
5. Date of Compliance 3/17/14.

F-225 D

1. Resident #3 was sent to the hospital for treatment.
2. Any resident experiencing an injury with unknown origin have the potential to be affected.
3. All staff re-trained on criteria for initiating an investigation for injuries of unknown origin.
4. DNS or RN designee will audit progress note review from medical records to identify injury of unknown origin, also for continuity and accuracy. 2 x weekly for one month, then 1 x weekly for one month. All audits to begin 3/10/2014.

5. Date of Compliance 3/17/2014

F-309 D

1. In-serviced LN's on the facility policy on managing the Blood Glucose readings that are out of parameters and documentation on follow up for Blood Glucose readings.
2. All patients with insulin dependent diabetes have the potential to be affected.
3. LN's will follow facility policy on monitoring Blood Glucose and documenting the follow up for Blood Glucose readings that are out of parameters, ongoing. LN's will review Blood Glucose at change of shift to ensure all follow up was completed.
4. Medical records will audit MARs for Blood Glucose parameters to ensure that proper follow up was completed. 5 x weekly x one month, then 2x weekly for one month, then weekly x 1 month. All audits to begin 3/10/2014.
5. Date of Compliance 3/17/2014

F-514 D

1. In-serviced LN's on the facility policy on managing the Blood Glucose readings that are out of parameters and documentation on follow up for Blood Glucose readings.
2. All patients with insulin dependent diabetes have the potential to be affected.
3. LN's will follow facility policy on monitoring Blood Glucose and documenting the follow up for Blood Glucose readings that are out of parameters, ongoing.
4. Medical records will audit MARs for Blood Glucose parameters to ensure that proper follow up was completed. 5 x weekly x one month, then 2x weekly for one month, then weekly x 1 month. All audits to begin 3/10/2014.
5. Date of Compliance 3/17/2014

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/11/2014
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NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201
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(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) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiency was cited during a complaint survey for your facility. The surveyors conducting the survey were: Arnold Rosling, RN, QMRP, Team Coordinator Sherri Case, LSW, QMRP	C 000		
C 155	02.100.08 NOTIFICATION OF CHGE PTNT/RSDNT STATUS 08. Notification of Change in Patient/Resident Status. There shall be written policies and procedures relating to notification of next of kin, or sponsor, in the event of a significant change in a patient's/resident's status. This Rule is not met as evidenced by: Please see F157 as it pertains to family notification.	C 155	<p>RECEIVED</p> <p>MAR 06 2014</p> <p>FACILITY STANDARDS</p>	
C 175	02.100.12,f Immediate Investigation of Incident/Injury f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Refer to F 225 as it related to investigation of possible neglect.	C 175		

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

TITLE
Executive Director

(X6) DATE

3/4/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/11/2014
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C 784	Continued From page 1	C 784		
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Refer to F 309 as it relates to care to meet the needs of the resident.	C 784		
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Please refer to F309 as it relates to contacting the physician and implementing interventions for low blood sugars.	C 788		

C-155

1. In-service provided to LN's on 2-25-14 on policy for notifying legal representative or interested family member/physician with a change of condition or discharge from facility. In-service provided to LN's on policy for Blood Glucose monitoring and when to notify physician.
2. All patients that have a significant change have the potential to be affected.
3. LN's will report any significant change, as defined by facility policy and regulation, in a timely manner to physician and legal representative. Medical records will review progress notes daily to identify significant changes to ensure notification was documented.
4. DNS or RN designee will audit progress note review from medical records for continuity and accuracy. 2 x weekly for one month, then 1 x weekly for one month. DNS or RN designee will audit MARs to ensure Blood Glucose out of parameters per policy was reported to physician and documented. All Audits to begin 3/10/2014.
5. Date of Compliance 3/17/14.

C-175 D

1. Resident #3 was sent to the hospital for treatment.
2. Any resident experiencing an injury with unknown origin have the potential to be affected.
3. All staff re-trained on criteria for initiating an investigation for injuries of unknown origin.
4. DNS or RN designee will audit progress note review from medical records to identify injury of unknown origin, also for continuity and accuracy. 2 x weekly for one month, then 1 x weekly for one month. All audits to begin 3/10/2014.

5. Date of Compliance 3/17/2014

C-784

1. In-serviced LN's on the facility policy on managing the Blood Glucose readings that are out of parameters and documentation on follow up for Blood Glucose readings.
2. All patients with insulin dependent diabetes have the potential to be affected.
3. LN's will follow facility policy on monitoring Blood Glucose and documenting the follow up for Blood Glucose readings that are out of parameters, ongoing. LN's will review Blood Glucose at change of shift to ensure all follow up was completed.
4. Medical records will audit MARs for Blood Glucose parameters to ensure that proper follow up was completed. 5 x weekly x one month, then 2x weekly for one month, then weekly x 1 month. All audits to begin 3/10/2014.
5. Date of Compliance 3/17/2014

C-788

1. In-serviced LN's on the facility policy on managing the Blood Glucose readings that are out of parameters and documentation on follow up for Blood Glucose readings.
2. All patients with insulin dependent diabetes have the potential to be affected.
3. LN's will follow facility policy on monitoring Blood Glucose and documenting the follow up for Blood Glucose readings that are out of parameters, ongoing.
4. Medical records will audit MARs for Blood Glucose parameters to ensure that proper follow up was completed. 5 x weekly x one month, then 2x weekly for one month, then weekly x 1 month. All audits to begin 3/10/2014.
5. Date of Compliance 3/17/2014



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

March 12, 2014

Stephen Farnsworth, Administrator
Pocatello Care & Rehabilitation Center
527 Memorial Drive
Pocatello, ID 83201-4063

Provider #: 135011

Dear Mr. Farnsworth:

On **February 11, 2014**, a Complaint Investigation survey was conducted at Pocatello Care & Rehabilitation Center. Arnold Rosling, R.N., Q.M.R.P., and Sherri Case, L.S.W., Q.M.R.P., conducted the complaint investigation.

The medical records of five residents, including that of the identified resident, were reviewed and facility staff were interviewed. Neither of the identified resident's physicians were available for interview at the time of the investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006348

ALLEGATION #1:

The complainant/reporting party (RP) said an identified resident's diabetes was not managed appropriately.

FINDINGS:

The identified resident was followed by a Physician of choice and a Resident Physician. Most of the resident's medical care and documentation was by the Resident Physician. There was not much oversight found to show the identified resident's Physician of choice was following the resident. Review of the laboratory reports and an interview with a clinical pathologist that

Stephen Farnsworth, Administrator
March 12, 2014
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reviewed the resident's laboratory values indicated there was some concern over the way the resident's diabetes was managed. The resident's A1C percentage markers showed a steady increase along with the resident blood glucose (BG) levels. The Resident Physician made notes that the identified resident's diabetes not in control on the September 12, 2013, and October 18, 2013, visits but only made a change in oral hyperglycemic medication on the October 18, 2013, visit. The resident's laboratory BG levels on August 9, 2013, was 302 milligrams per deciliter and on September 12, 2013, was 226 milligrams per deciliter. The reference range for BG values were 74 - 100 milligrams per deciliter. The A1C laboratory test percentage on June 10, 2013 was 6.4%, on September 13, 2013 was 7.9% and on October 18, 2013 was 11.3%. The laboratory reference range for A1C was 3.9 to 5.7 %.

The National Diabetes Information Clearinghouse (NDIC), NIH Publication No. 11-7816, dated September 2011, documented a resident with an A1C greater than 6.5% is considered a diabetic. The NDIC publication further documented that an A1C of 8% showed the resident had an average Glucose level of 183 milligrams per deciliter. The publication further documented, "Studies have shown that people with diabetes can reduce the risk of diabetes complications by keeping A1C levels below 7%." (Note: the resident's was 7.9% in September 2013.)

These laboratory values were significant enough that the resident physician should have further investigated the etiology of the steadily increasing A1C and glucose values. The resident's medical record did not contain information the Resident Physician did any further investigation regarding this issue. However, there was no deficient practice on the facility's part as they kept the physician informed of the resident's condition and followed the physician's plan of care for the resident.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The RP stated that on October 19, 2013, the identified resident's BG levels were very high. The MD was notified and ordered the resident be sent to the local hospital's Emergency Room (ER). Due to the resident's "Do Not Resuscitate (DNR)" status, the facility called for non-emergent transport. While waiting for non-emergent transport, the resident expired.

FINDINGS:

The licensed nurse (LN) who worked the afternoon of October 19, 2013, was interviewed on February 11, 2014. The LN nurse stated that the resident had a DNR order but was having

Stephen Farnsworth, Administrator
March 12, 2014
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clinical indications that indicated the need for a higher level of care. The LN contacted the Resident Physician who she had been in communication with over the resident's deteriorating condition. The Resident Physician questioned the nurse if the resident was a DNR. She indicated the resident was DNR and informed him of what the resident had on the Idaho Physician Orders for Scope of Treatment. Specifically, "Comfort Measures....These measures are to be used where patient lives, do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location." He then told her to transport the resident to the emergency room but to do it as a non-emergent transport.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The RP said the facility failed to notify the guardian of significant changes in the identified resident's condition.

FINDINGS:

The resident Medical record indicated the resident's clinical condition deteriorated over a span of about four hours. The guardian was not contacted because the nurse was busy with the resident. The nurse failed to notify the physician of an elevated BG level at 1:00 p.m. on October 19, 2013. This was a violation of the facility's policy and a deficiency was cited at F157 as a result.

CONCLUSION:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

The RP stated the facility failed to implement a physician's order to increase the identified resident's Metformin.

FINDINGS:

The Metformin, if it was ordered October 18, 2013, at 1501 (3:01 p.m.), which is when the Resident Physician documented he was in the facility, would not have been transcribed to the Medication Administration Record until later that evening and would not have been administered until the next morning. It could not be determined exactly when it was ordered.

Stephen Farnsworth, Administrator
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Page 4 of 4

The resident's medical record identified multiple issues related to dates, timing and what was done with the resident. The Resident Physician notes and orders had different times and dates when he was in the facility. It could not be accurately determined when the physician saw the resident in October 2013. The original records show different types of ink were used on the 17th and 18th documentation.

The issue was substantiated. The facility was out of compliance with F 514 Medical Records on October 19, 2014, due to deficient practice found at a follow-up survey to the annual recertification survey. Because this occurred prior to that survey, no deficiency was written as a result of this investigation.

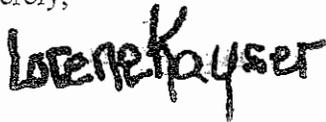
CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The signature is written in a cursive, slightly slanted style.

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LK/lj