



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
Boise, ID 83720-0009
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CERTIFIED MAIL: 7012 1010 0002 0836 1857

March 3, 2014

Steve Gannon, Administrator
Safe Haven Care Center of Pocatello
1200 Hospital Way
Pocatello, ID 83201-2708

Provider #: 135071

Dear Mr. Gannon:

On **February 14, 2014**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **December 11, 2013**. However, based on our on-site follow-up revisit conducted **February 14, 2014**, we found that your facility is not in substantial compliance with the following participation requirements:

- F155 -- S/S: D -- 42 CFR §483.10(b)(4) -- **Right to Refuse; Formulate Advance Directives**
- F166 -- S/S: D -- 42 CFR §483.10(f)(2) -- **Right to Prompt Efforts to Resolve Grievances**
- F309 -- S/S: D -- 42 CFR §483.25 -- **Provide Care/Services for Highest Well Being**
- F441 -- S/S: D -- 42 CFR §483.65 -- **Infection Control, Prevent Spread, Linens**
- F456 -- S/S: D -- 42 CFR §483.70(c)(2) -- **Essential Equipment, Safe Operating Condition**
- F492 -- S/S: D -- 42 CFR §483.75(b) -- **Comply with Federal/State/Local Laws/Prof Std**

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. **Please provide ONLY ONE completion date for each federal and state tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance.** After each deficiency has been answered and dated, the

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administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your copy of the Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 17, 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

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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 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*.

As noted in the letter of **October 28, 2013**, as a result of our finding that your facility is not in substantial compliance we are recommending to the Centers for Medicare & Medicaid Services (CMS) that the following remedy, already imposed, be continued:

Denial of payment for new admissions [42 CFR §488.417(a)]

We must also recommended to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 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.

STATE ACTIONS effective with the date of this letter (**February 28, 2014**): none

If you believe the 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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>

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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 17, 2014**. If your request for informal dispute resolution is received after **March 17, 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 on-site follow-up revisit survey. If you have any questions or concerns, please contact this office at (208) 334-6626.

Sincerely,

A handwritten signature in cursive script that reads "Loretta Todd".

LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj
Enclosures

MAR 20 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING FACILITY STANDARDS B. WING	(X3) DATE SURVEY COMPLETED R-C 02/14/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 onsite followup recertification and complaint investigation survey that was conducted at your facility February 12 -14, 2014. The surveyors conducting the survey were: Shari Case, LSW, QMRP, Team Coordinator Arnold Rosling, RN BSN, QMRP Survey Definitions: ADON - Assistant Director of Nursing Services CNA - Certified Nursing Assistant DNS/DON - Director of Nursing Services LN - Licensed Nurse PRN - As needed SSD - Social Service Director F 155 483.10(b)(4) RIGHT TO REFUSE; FORMULATE SS=D ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	{F 000}	Preparation and execution of this Plan of Correction (PoC) is not an admission of guilt nor does the provider agree with the conclusions set forth in the Statement of Deficiencies rendered by the Bureau. The Plan of Correction is prepared and executed simply as a requirement of federal and state law. We maintain that the alleged deficiencies do not individually, or collectively, jeopardize the health and safety of our residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of skilled nursing facilities, and this document, in its entirety, constitutes this providers claim of compliance. Completion dates are provided for the procedural procession purposes to comply with the state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in compliance with the requirements of participation or that corrective actions was necessary. Resident Specific 1 of 9 sampled residents (#27) was affected. Resident #27 was informed of the risks and benefits of his medication, a policy was written that addressed refusal of medication and medical necessity, resident #27 was assessed by the physician and a new order was obtained, staff was educated regarding new order and policy, resident #27 care plan was updated to reflect changes. Other Residents Any residents having the medical necessity to conceal medications in food or fluid had the potential to be affected. Facility Systems Policy and procedure has been written to address residents medical necessity and risk of complications outweighing residents right to refuse. Physician assessment and order received to address all medications and medical necessity specific to resident #27.	2/25/2014

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

TITLE

(X6) DATE

[Signature]

ADMINISTRATOR

3/14/14

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.

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

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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
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F 155	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a resident's right to refuse treatment was maintained. This was true for 1 of 9 (# 27) sampled residents. There was a potential for psychological harm when a resident wants to refuse treatment and was not allowed the opportunity. Findings include: Resident #27 was admitted to the facility, on 5/8/13, with diagnoses of disturbance of conduct, encephalomalacia, seizure disorder, history of traumatic brain injury and borderline intellectual functioning. The resident's care plan, dated 5/8/13, documented, "Risk for injuries/complications (seizure) as related to seizure disorder." The care plan did not have anything in it about hiding the residents' seizure medication in food. On 2/13/14 at 11:44 a.m. LN #1 was observed to put Ativan and Neurontin in a glass of juice that was served to the resident during the noon meal. LN#1 was interviewed at 1:50 p.m. about the observation and stated she thought all his medications could be hidden in food because "he refused them" most of the time and had seizures. Review of the physicians' recapitulation orders for February 2014 documented the Ativan, Zyprexa Zydys and Phenobarbital liquid may be hidden in food or fluids. The neurontin did not have a	F 155	F 155 continued... Facility Systems Resident #27 seizure care plan was updated to include ability to conceal seizure medication in food or fluids due to facility policy concerning medical necessity outweighing resident right to refuse. Inservice to all license nursing staff regarding the need to ensure residents receiving medications concealed in food or fluid follows the facility's policy and procedure of residents medical necessity and risk of complications outweighing residents right to refuse. Monitoring An audit will be performed by DNS / designee weekly X4 weeks then every other week X4 weeks then monthly X3 months to ensure any residents with the need for medication concealment in food or fluid follows the facility's policy and procedure regarding such.	

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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201
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F 155	Continued From page 2 physicians' order to hide it in food or fluids. On 2/13/14 at 3:10 p.m. the LSW was interviewed about policy and procedures the facility had for residents that refused their medications and were at risk for medical complications as a result. The LSW stated a process that was used but stated there was no policy or procedure. The interpretive guidance was discussed, the LSW had not seen the new information. The administrator and Assistant DON were informed on 2/14/14 at 11:00 a.m. No further information was provided.	F 155		
{F 166} SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on review of resident council meeting minutes and staff interview, the facility failed to promptly resolve grievances from the resident council. This had the potential to affect all residents in the facility including 8 of 8 (#s 1 - 8) sampled residents. Findings include: F 166 was cited at the recertification survey of 10/11/13 due to failure to resolve grievances by residents. The facility's Plan of Correction documented staff would be in serviced on resident's rights and audits would be completed to ensure resolutions were acceptable, however	{F 166}	F 166 Resident Specific 8 of 8 sampled residents (#s 1-8) were affected. 8 of 8 residents were informed of the new policy regarding snack times. Each night residents are offered snacks between 7pm and 9pm. Staff document daily the offering of snacks to those residents along with any refusals. Administrative staff is performing random audits to ensure compliance. Other Residents Any resident that have an HS snack had the potential to be affected. Facility Systems The facility has created a form to log all HS snack passes on a daily basis to ensure snacks are offered to all residents in a timely manner and that are awake. Inservice provided to all staff regarding documentation and providing HS snacks to all residents in a timely manner that are awake. Monitoring An audit will be performed by Social Services Director / designee monthly X6 months to ensure all prior resident council concerns have been addressed promptly and will be reported back at the next resident council.	2/25/2014

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{F 166}	<p>Continued From page 3</p> <p>the facility failed to resolve verbal grievances by the resident council.</p> <p>*Resident Council Meeting minutes dated 12/19/13 documented "Old Business" was reviewed, however, the minutes did not identify the issues reviewed.</p> <p>On 2/14/14 at 8:45 a.m. the Social Worker stated the residents had stated at the 12/19/13 meeting that evening snacks were delivered too late for them to eat.</p> <p>A "Resident Council Follow-Up" form dated 12/20/13 identified that on 12/19/13 a concern of "Evening snacks are coming too late, used to come at 7:30, now seeing them at 8:30-9. Sometimes they don't come at all." The form had a section which stated the concern was to be responded to within one week of receipt of the form. Hand written on the form was "The evening snacks are taken to the nurses station by 7:00 p.m."</p> <p>*Resident Council Meeting minutes dated 1/16/14 documented in the "Old Business" section "Kitchen concerns."</p> <p>The facility provided 2 Resident Council Follow-Up forms dated 1/16/14.</p> <p>The first form, dated 1/16/14, documented "Snacks at night don't always get passed out." The response section documented staff were reminded at the "All staff meeting" that all snacks must be passed and the nurses were notified to "ensure it gets done."</p> <p>The 2nd form dated 1/16/14 documented "Drinks</p>	{F 166}	<p>F166 continued...</p> <p>Monitoring continued...</p> <p>An audit will be performed by DNS / designee weekly X4 weeks then every other week X4 weeks then monthly X3 months to ensure HS snacks are being passed in a timely manner and offered to all residents that are awake.</p>	

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135071		B. WING _____		R-C 02/14/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
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{F 166}	<p>Continued From page 4</p> <p>coming in late at the evening shift. And snacks are coming out late." The response section documented "Kitchen prepares the snacks and drink carts. The snacks are taken to the nurses station by 7:30 p.m. The drink carts are picked up by the CNAs."</p> <p>*The Resident Council Meeting minutes dated 2/13/14 documented in the "Old Business" section, "Snacks and drink cart reviewed..."</p> <p>On 2/13/14 at approximately 3:00 p.m. the Social Worker was asked about the council meeting held earlier. The Social Worker stated resident's had again stated at the meeting snacks were still an issue. The Social Worker stated she was in the process of developing a plan to address the time the snack cart was at the nurses station. The surveyor asked if the issue was the time the snacks were delivered from the kitchen or if the CNA's failed to deliver them in a timely manner. The Social Worker stated she would check into the concern.</p> <p>On 2/14/14 at 10:50 a.m. the administrator and the Assistant DON were informed of the above concerns. The facility provided no further information.</p>	{F 166}		
{F 309} SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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>	{F 309}	<p>F 309</p> <p>Resident Specific 2 of 9 sampled residents (#9 & 24) were affected. Resident #24 Nystatin order was not carried over from the December MAR to the January MAR. Resident #24 was evaluated at time of error and was found to not need to be restarted. Resident #24 is assessed weekly due to ongoing skin issues. Resident #24's bed had soaker pad removed and chux pad put in place. Staff was educated in regards to our Turn Q mattress policy. Administrative staff are doing random audits to ensure compliance.</p>	2/25/2014

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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
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{F 309}	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation staff interview and record review, the facility failed to ensure physician orders were followed so residents can achieve their highest practicable physical well being, specifically medication orders and TED (thromboembolism-deterrent) hose administration. This was true for 2 of 9 (#9 & 24) sampled residents. Failing to administer medications and treatments ordered by the physician may potentially harm residents that need them to treat medical conditions. Findings include: F 309 was cited at the recertification survey of 10/11/13 due to failure to provide treatment for an ulcer, implement care plans (physician orders) and ensure communication for dialysis with the dialysis provider.	{F 309}	F 309 continued... Resident Specific continued... Resident #9 was assessed at the time of survey to assure that ted hose were in place while resident #9 was up as per order. Nursing staff documenting daily when ted hose are on and when they are off. Nursing administration are doing random audits to ensure compliance. Other Residents Any residents with orders for ted hose or on a turn Q mattress had the potential to be affected. All residents with new medication orders had the potential to be affected. Facility Systems Nurses will document daily resident Ted-Hose placement on in AM and off at HS in the MAR. Inservice performed to all nursing staff regarding all medications must be documented appropriately and moved to the new MAR at the beginning of the new month. Inservice performed to all staff regarding disposable chux pads must be used on beds with turn-Q mattresses. Re-education performed to all staff regarding the use and necessity of ted hose. Monitoring An audit will be performed by DNS / designee monthly X6 months by the 3rd of the month to ensure all orders have been carried over to the next months MAR. An audit will be performed by DNS / designee daily X2 weeks then weekly x2 weeks then every other week X4 weeks then monthly X3 months to ensure all turn Q mattresses have a disposable chux pad instead of a soaker pad. An audit will be performed by DNS / designee weekly X4 weeks then every other week X4 weeks then monthly X3 months to ensure ted hose are in place on those residents with ted hose orders.		
	1. Resident #24 was admitted to the facility on 7/27/12 with diagnoses of Alzheimer's disease, dementia with behavior disturbance, bipolar disorder manic with psychotic features and depressive disorder. The resident's medical record was reviewed. The resident's December 2013 nursing notes documented the resident had a red perineal area. The physician was contacted on 12/29/13 at 9:30 p.m. and ordered, "Nystatin Powder to Peri-area and scrotum BID [two times a day] for 7 days or until resolved." The order was transcribed to the resident's December 2013 MAR. The resident's January 2013 MAR did not have the medication on it. Review of the nurses notes revealed a lack of documentation the resident received the full 7				

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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201
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{F 309}	<p>Continued From page 6</p> <p>day dose of the Nystatin. The resident only received 2 and 1/2 days of the medication.</p> <p>The resident's peri-area on a 2/3/14 Skin Assessment Form documented, "Peri Area excoriated [with] white exudate [and] foul odor. Smells yeasty...." The physician on 2/3/14 at 0300 (3:00 a.m.) ordered, "Nystatin Powder to groin [and] scrotum after cleaning and drying [three times a day] x 10 days due to excoriation...."</p> <p>On 2/13/14 at 8:30 a.m. resident cares were observed being done with Resident #24. The resident was on a "Turn q Mattress" for skin issues. The Turn q Mattress was ordered by the physician on 10/7/13 in an order that stated, "Turn q Mattress to bed for skin integrity/pressure reduction." The mattress was a special type that turned the resident and distributed the resident's weight to prevent skin breakdown. During the observation of cares, it was observed there was a thick soaker pad and incontinence brief between the resident and the bed which decreased the pressure-relieving effectiveness of the mattress. On 2/13/14 at 8:35 a.m. the Assistant DON was interviewed and affirmed the effectiveness of the mattress was compromised by the thick soaker pad. She further indicated the resident was on Hospice and they would provide the thin "blue pads" if needed to control incontinence.</p> <p>The Administrator and Assistant DON were notified on 2/14/14 at 11:00 a.m. No further information was provided.</p> <p>2. Resident #9 was admitted to the facility with diagnoses that included edema and dementia.</p>	{F 309}		
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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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}	Continued From page 7 Resident #9's 2/14 Physician Order Report (recapitulation orders) included the resident was to have TED hose on "in AM and off at HS [Hour of sleep]." During observations on 2/12/14 at 4:05 p.m. the resident was observed seated in a recliner with shoes and dark colored ankle socks on. The resident was not wearing TED hose. On 2/14/14 at 11:00 a.m. the Administrator and the Assistant DON were informed of the concern. The facility provided no further information.	{F 309}		
{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. (b) Preventing Spread of Infection (1) When the infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	{F 441}	F 441 Resident Specific 9 of 9 sampled residents were affected. Linen for all 9 of 9 residents is handled properly according to regulation. Hand washing is performed properly when providing care for all 9 residents. Other Residents Most residents in the facility had the potential to be affected. Facility Systems Re-education was provided to all staff regarding hand hygiene including return demonstration by staff. One on one counseling provided to staff members that were observed not following facility protocol for hand hygiene during survey. Inservice provided to all staff regarding proper handling and storage of clean linens and lift slings. Monitoring An audit will be performed by DNS / designee daily X2 weeks then week X2 weeks then every other week X4 weeks then monthly X3 months observing random direct care staff to ensure that the facility's hand hygiene policy is followed. Variances will be corrected at the time of observation.	2/25/2014

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

PRINTED: 03/03/2014
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/14/2014
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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201
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{F 441}	Continued From page 8 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that infection control practices were maintained in the facility, specifically CNAs were observed not washing their hands and clean linen was found on the floor during a tour of the facility. This had the potential to affect most residents in the facility including 9 of 9 (#s 1, 2, 8, 9, 23, 24, 25, 26 and 27) sampled residents. There was a potential for harm with failed infection control practices by introducing disease causing organisms to the residents. Findings include: 1. On 2/13/14 at 8:10 a.m. CNA #2 and CNA #3 were observed getting Resident #24 up for breakfast. Resident #24 was incontinent of urine and needed his incontinence brief changed and peri-care done. The CNAs completed cleaning him up and both removed their gloves before applying the new brief. CNA#3 stayed with the resident and CNA#2 retrieved gloves for both of them. CNA #3 stated, "We need sanitizer in	{F 441}	F441 continued... Monitoring continued... An audit will be performed by DNS / designee weekly X4 weeks then every other week X4 weeks then monthly X3 months to ensure linens are handled properly.	
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{F 441}	Continued From page 9 here." and CNA#2 stated, "You know we need to sanitize before we put these on." (Note: referring to the gloves.) Both then proceeded to put gloves on without sanitizing their hands. Then the CNAs completed getting the resident dressed and transferred him into his wheelchair. The Administrator and Assistant DON were informed on 2/14/14 at 11:00 a.m. no further information was provided. 2. During a tour of the environment on 4/12/13 at 1:50 p.m. a Hoyer Lift sling and a sheet were observed to be on the floor in a storage closet. At that time LN #4 was shown the items on the floor. LN #4 stated the items should not be on the floor and had staff remove them to be washed. The Administrator and the ADON were informed of the concern on 2/14/14 at 11:00 a.m. The facility provided no further information.	{F 441}		
{F 456} SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the essential equipment in the kitchen was in good operating condition. This had the potential to affect most residents in the facility including 9 of 9 (#s 1, 2, 8, 9, 23, 24, 25, 26 and 27) sampled residents. There was a	{F 456}	F 456 Resident Specific 9 of 9 sampled residents were affected. Dishwasher chemicals are checked for accuracy and documented with each use of the dish machine. Other Residents Most of the resident in the facility had the potential to be affected. Facility Systems Dietary tray cart was repaired and functional on 2/13/2014. Tubing on the sanitation pump for the dishwasher was replaced. Sanitation pump is working correctly. Additional pump has been ordered to replace current pump if it fails to work properly.	2/25/2014

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{F 456}	<p>Continued From page 10</p> <p>potential for foodborne illness if the dishwasher did not sanitize dishes. Findings include:</p> <p>1. On 2/13/14 at 11:10 a.m. the three compartment food cart was observed to have one door that was hanging partially off its hinge. The door could not be closed and sealed to keep the food warm. The kitchen staff were observed to serve up resident trays and put them in the other two compartments. At 11:32 a.m. all the trays were served up, one tray was left over and because the door was broken the tray for Resident #27 had to be put on top of the cart for transport to the dining room. The dietary manager was interviewed at 11:32 a.m. and stated the maintenance person could no longer get parts for it, so it was not repaired.</p> <p>2. On 2/13/14 at 11:10 a.m. the dishwasher was found to have a Styrofoam cup with a yellow substance and a plastic spoon in it setting on top of the chemical mixer. The dietary manager was questioned about the substance. She indicated it was bleach. The dishwasher rinse cycle was a chemical rinse not a temperature rinse but the automatic sanitizer dispenser was not working. As a result the person who was washing dishes had to put a spoonful of bleach in each load to ensure dishes were sanitized properly.</p> <p>On 2/13/14 at 1:40 p.m. the dietary aide was observed doing dishes. The mechanical sanitizer was not working. The dietary aide was observed putting bleach in each rinse cycle. The aide was requested to check to see if the rinse water reached proper sanitizer level. The test strip showed the rinse water was within appropriate levels of sanitation.</p>	{F 456}	<p>F 456 continued...</p> <p>Facility Systems</p> <p>Inservice of dietary manager regarding proper and timely reporting of maintenance issues and needed equipment repairs.</p> <p>Inservice of all staff regarding proper and timely reporting of any maintenance issues or equipment concerns.</p> <p>Monitoring</p> <p>An audit will be performed by the dietary manager weekly X4 weeks then every other week X4 weeks then monthly X3 months to ensure kitchen equipment is functioning properly.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/14/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
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{F 456}	Continued From page 11 On 2/14/14 at 11:00 a.m. the dietary manager during interview indicated the machine had not worked properly since "before Christmas." There was no way to make sure that every rinse cycle received the proper amount of sanitizer solution. No further information was provided.	{F 456}			
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to be in compliance with the state of Idaho administrative rules (IDAPA) for administration of medications in a nursing home and the professional standards that apply to the facility. Specifically, administration of medications by non licensed personnel is not permitted in Idaho. The State of Idaho Nursing home regulations specify: "IDAPA 16.03.02.200. 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; b. The patient/resident is identified prior to administering the medication; c. Medications are	F 492	F 492 Resident Specific 2 or 9 residents sampled (#s 24 & 27) were affected. Other Residents All residents with prescribed medications had the potential to be affected. Facility Systems Medication error reports were completed and investigated with physician notification on 2/13/2014 on residents #24 and #27. Disciplinary action / counseling completed for the 2 nurses identified as not following proper protocol for medication administration. Inservice provided to all staff regarding facility policy on administration of medication by licensed personnel only. Monitoring An audit will be performed by DNS / designee weekly X4 weeks then every other week X4 weeks then monthly X3 months to ensure all medications are passed by licensed staff only.	2/25/2014	

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F 492	<p>Continued From page 12</p> <p>administered as soon as possible after preparation; d. Medications are administered only if properly identified; e. Medications are administered by the person preparing the medication for delivery to the patient (exception: Unit dose); f. Patients/residents are observed for reactions to medications and if a reaction occurs, it is immediately reported to the charge nurse and attending physician; g. Each patient's/resident's medication is properly recorded on his individual medication record by the person administering the medication. The record shall include: i. Method of administration; ii. Name and dosage of the medication; iii. Date and time of administration; iv. Site of injections; v. Name or initial (which has elsewhere been identified) of person administering the medication;"</p> <p>IDAPA 16.03.02.201.02 Care of General Medications. The care and handling of medications shall be conducted in the following manner.</p> <p>c. No person other than licensed nursing personnel and physicians shall administer medications. This does not include execution of duties of inhalation therapists as ordered by the attending physician.</p> <p>e. Prescription medication shall be administered only to the patient whose name appears on the prescription legend.</p> <p>CNAs were observed administering medications to residents. This affected 2 of 9 (#s 24 & 27) sampled residents. There is a potential for harm when non-licensed personnel administer medications and do not have the training to perform the task. Findings include:</p> <p>1. Resident #24 was a male resident admitted to</p>	F 492		
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F 492	<p>Continued From page 13</p> <p>the facility with multiple diagnoses including Alzheimer's disease.</p> <p>On 2/13/14 at 8:10 a.m. CNA#2 and CNA#3 were observed to provide peri-care to Resident #24. The resident had a red excoriated peri-area. CNA#3 was observed to apply a powder to the peri-area.</p> <p>The bottle of powder was inspected and it contained "Nystatin Topical Powder, 100,000 us units per gram." The bottle contained 60 grams of powder. The instructions for application of the medication documented, "Apply Topically twice a day underneath right breast for 10 days and as needed for redness." The name on the the bottle was not for Resident #24 but for Resident #28.</p> <p>CNA #3 was asked about the medication and stated the LN gave her the medication and told her to administer it to the resident.</p>	F 492			
	<p>On 2/13/14 at 8:35 a.m. the Assistant DON (ADON) was informed of the violation in IDAPA rules and the aide administering medications. The ADON indicated an incident report would be completed.</p> <p>2. Resident #27 was admitted to the facility with multiple diagnoses including seizure disorder and history of traumatic brain injury.</p> <p>On 2/13/14 at 11:44 a.m. a CNA was observed removing the resident's lunch tray from the top of the food cart. As the aide was going toward the resident's room LN#1 stopped the aide and put crushed medications of Ativan and Neurontin powder in the resident's juice. The aide proceeded to the resident's room and delivered</p>				

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F.492	Continued From page 14 the tray and medications. On 2/13/14 at 1:50 p.m. LN#1 was interviewed and indicated the resident's medications were hidden in his food. On 2/13/14 at 4:30 p.m. the ADON was interviewed. She indicated an incident report would be completed and the LN should have administered the medication not the CNA.	F.492			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001620	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/14/2014
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{C 000}	16.03.02 INITIAL COMMENTS	{C 000}		
	<p>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.</p> <p>The following deficiencies were cited during the onsite followup recertification and complaint investigation survey that was conducted at your facility February 12-14, 2014.</p> <p>The surveyors conducting the survey were: Sherri Case, LSW, QMRP, Team Coordinator Arnold Rosling, RN, BSN, QMRP</p>		<p>RECEIVED</p> <p>MAR 17 2014</p> <p>FACILITY STANDARDS</p>	
{C 121}	<p>02.100,03,c,v Encouraged/Assisted to Exercise Rights</p> <p>v. Is encouraged and assisted, throughout his period of stay, to exercise his rights as a patient/resident and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;</p> <p>This Rule is not met as evidenced by: Please refer to F166 as it relates to the facility resolving grievances.</p>	{C 121}	<p>C 121</p> <p>Please refer to response to F 166.</p>	2/25/2014
{C 252}	<p>02.106,07 MAINTENANCE OF EQUIPMENT</p> <p>07. Maintenance of Equipment. The facility shall establish routine test, check and maintenance procedures for all equipment.</p>	{C 252}	<p>C 252</p> <p>Please refer to response to F 456.</p>	2/25/2014

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **3/14/14**

Bureau of Facility Standards

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{C 252}	Continued From page 1 This Rule is not met as evidenced by: Please refer to F-456 as it relates to maintenance of patient care equipment.	{C 252}		
{C 644}	02.150,01,a,i Handwashing Techniques a. Methods of maintaining sanitary conditions in the facility such as: i. Handwashing techniques. This Rule is not met as evidenced by: Please refer to F 441 as it relates to handwashing.	{C 644}	C 644 Please refer to response to F 441.	2/25/2014
{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 784 Please refer to response to F 309.	2/25/2014



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
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FILE COPY

March 5, 2014

Steve Gannon, Administrator
Safe Haven Care Center of Pocatello
1200 Hospital Way
Pocatello, ID 83201-2708

Provider #: 135071

Dear Mr. Gannon:

On **February 14, 2014**, a Complaint Investigation survey was conducted at Safe Haven Care Center of Pocatello. Arnold Rosling, R.N., Q.M.R.P., and Sherri Case, L.S.W., Q.M.R.P., conducted the complaint investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006299

ALLEGATION #1:

The resident's Power of Attorney was not notified of his air hunger discomfort on December 8, 2013.

FINDINGS:

The resident's medical record was reviewed, nursing staff were interviewed and the facility's process for oxygen use was evaluated.

The resident was admitted to the facility November 27, 2013, and had diagnoses of hypertensive cardiovascular disease with congestive heart failure, pulmonary hypertension,

depressive disorder, anxiety disorder and diabetes mellitus type II insulin dependent.

From the day the resident was admitted to the facility, the resident was on oxygen due to air hunger. The physician's orders documented the resident was to have, "Oxygen two to five liters per minute continuous to keep saturation greater than 90%." The documentation of the resident's oxygen use showed the resident fluctuated between 86% to 95% and the liter flow ranged from two to four liters.

The medical record nursing notes and hospice notes documented that the resident had a lot of anxiety and pain. The resident was in the facility for nine days and had ten medication changes related to anxiety and pain. The changes were to increase either the pain or anxiety medications. The resident was on hospice. The medical record documented the hospice nurse and the facility's nursing staff were in contact with the physician to facilitate the changes in medications in order to get the resident comfortable.

The L.P.N. and R.N. that cared for the resident were interviewed about the sequence of events the morning of December 8, 2013. The L.P.N. was interviewed on February 14, 2014, at 9:35 a.m. and provided the following information. The L.P.N. indicated he came to work between 5:30 and 5:40 a.m. He checked on the resident and the resident was sitting on the edge of the bed complaining of pain. The L.P.N. went to the medication cart and prepared the resident's morning medications, these were Valium, Norco, and he had him push the morphine pump button. He administered the medications to the resident shortly after 6:00 a.m. Then the L.P.N. went back to his morning duties. At 6:45 a.m. the aides working with the resident got him up in the wheelchair and brought him to where the L.P.N. was working. The resident was having some problems with anxiety. The resident's anxiety was manifested by continually saying "Help me, help me." The LPN brought the resident to the office of the charge nurse and requested assistance. The resident's pulse oxygen saturation was at 89%.

The R.N. charge nurse was interviewed on February 14, 2014, at 9:20 a.m. and provided the following information. The L.P.N. brought the resident to the nursing office sometime around 6:50 a.m. The resident was having a lot of anxiety, which was causing the resident to have respiratory distress. The resident had a portable oxygen tank with a nasal cannula on. The oxygen saturation was at 89%, which was low and needed to be raised. The resident was having a problem getting oxygen because he was breathing through his mouth. His respiratory rate was 36 per minute. The R.N. changed the cannula to a mask. The R.N. stated he did not put the strap over the resident's head but held it next to his nose and mouth and talked with him to get him to calm down. The resident's rate decreased to 30 breaths per minute and the resident appeared to become more comfortable. The R.N.

Steve Gannon, Administrator

March 5, 2014

Page 3 of 4

stepped back into the office and came back out less than a minute later and the resident had expired. The resident had Advance Directives for "Do Not Resuscitate" so he was taken back to his room and put back to bed by the aides. His vitals were checked when he was back in bed and they were not present. The Hospice R.N. was called at 7:00 a.m. The family was not notified, the hospice agency was to do the notification so a chaplain or social service could be available if there was a need.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The medical record has obvious late entries made after concerned parties raised questions to the facility. The record states the resident was anxious at 9:45 p.m. and expired at 6:55 a.m. It states the oxygen was increased to 6 liters per mask. The complainant questions whether this could be accurate as the resident was on an oxygen concentrator, and those can only go up to 5 liters per minute.

FINDINGS:

The medical record showed the resident was anxious most of the time and the medications had been increased frequently to address the issue. The resident's physician last changed his anxiety medication on December 6, 2013. The change was to increase his Valium to 5 milligrams every four hours. The resident was also on Haldol 5 milligrams three times a day. All these medications were to help with his anxiety.

The December 7, 2013, 2145/(9:45 p.m.), nursing note in question was one of many notes by nursing documenting the resident's anxiety state. The resident received the ordered Haldol, Valium and Trazodone medications for his anxiety. The nurse further documented the resident rested after he received the medications.

The resident's oxygen orders were to be two to five liters per minute to keep his saturation levels greater than 90%. According to staff interviews, the morning the resident expired, the R.N. increased the oxygen to six liters per minute to try to increase the resident's comfort and bring his saturation level up to greater than 90%. The resident was on portable oxygen at that time, not a concentrator. While there was no order for oxygen at 6 liters, it was clearly done to try to increase the resident's comfort. Though technically incorrect, investigators determined it did not warrant a citation.

Steve Gannon, Administrator
March 5, 2014
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CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



LORETTA TODD, R.N., Supervisor
Long Term Care

LT/lj