



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

CERTIFIED MAIL: 7012 1010 0002 0836 1840

March 11, 2014

Samuel R. Long, Administrator
Riverview Rehabilitation
3550 West Americana Terrace
Boise, ID 83706-4728

Provider #: 135139

Dear Mr. Long:

On **February 26, 2014**, a Complaint Investigation survey was conducted at Riverview Rehabilitation 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 actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, 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 24, 2014**. Failure to submit an acceptable PoC by **March 24, 2014**, may result in the imposition of civil monetary penalties by **April 14, 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 **April 2, 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 **April 2, 2014**. A change in the seriousness of the deficiencies on **April 2, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 2, 2014** includes the following:

Denial of payment for new admissions effective **May 26, 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 26, 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 26, 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 24, 2014**. If your request for informal dispute resolution is received after **March 24, 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: 03/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/26/2014
NAME OF PROVIDER OR SUPPLIER RIVERVIEW REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 WEST AMERICANA TERRACE BOISE, ID 83706	
(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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during a complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator, and Sherri Case, LSW, QMRP.</p> <p>The survey team entered the facility on 2/25/14 and exited the facility on 2/26/14.</p> <p>Survey Definitions: BG = Blood glucose DON = Director of Nursing Services ED = Executive Director MAR = Medication Administration Record NL = Nurse Liaison</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Riverview Rehabilitation does not admit that the deficiencies listed on HCFA 2567 exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies".</p>	
F 309 SS=G	<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> <p>This REQUIREMENT is not met as evidenced by: Based on a complaint from the public, staff interview, record review, and policy review, it was determined the facility failed to ensure staff clarified confusing admission orders for insulin per sliding scale (ss) and consistently implemented interventions and/or rechecked the BG levels after an intervention was implemented</p>	F 309	<p>F 309 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #4 discharged from the facility. Resident #1's sliding scale insulin orders were clarified.</p>	3/14/14

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MAR 14 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 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.

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F 309	Continued From page 1 when residents' BG levels were low. The facility's policy and standing orders contained conflicting information regarding hypoglycemia. This was true for 2 of 3 sample residents (#s 1 & 4) reviewed for diabetes management and had the potential to affect any resident who was at risk for low BGs. Resident #4 was harmed the resident was harmed when the resident experienced a seizure related, in part, to hypoglycemia (BG less than 70) after the facility failed to clarify two very different orders for insulin administration per sliding scale. Sliding scale insulin was administered when the resident's BG was 60. The resident received scheduled insulin then declined breakfast and the BG dropped again and was not rechecked after an intervention. The failure also created the potential for more than minimal harm when interventions were not consistently implemented and BGs rechecked when Resident #1's BG was low. Findings included: The American Diabetes Association (ADA), at http://www.diabetes.org states, in part, "Hypoglycemia is...characterized by abnormally low blood glucose...usually less than 70 mg/dl...per deciliter [mg/dL]...may also be referred to as an insulin reaction when the level of glucose in the blood is too low (at or below 70 mg/dL)...symptoms...include hunger, nervousness, shakiness, perspiration, dizziness or light-headedness, sleepiness, and confusion. If left untreated, hypoglycemia may lead to unconsciousness. Hypoglycemia is treated by consuming a carbohydrate-rich food such as a glucose tablet or juice. It may also be treated with an injection of glucagon if the person is unconscious or unable to swallow...The only sure way to know whether you are experiencing hypoglycemia is to check your blood	F 309	<ol style="list-style-type: none"> Care plans for diabetics on sliding scale insulin medications were implemented for Resident #1. Licensed Nurses will document on resident #1 every shift that they have assessed resident for BG levels and if needed interventions, rechecking BG levels, and notification of physician. Nurses will document their continued assessment of resident #1's physical condition to reflect changes in condition. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;</p> <ol style="list-style-type: none"> All residents on sliding scale insulin were reviewed and orders clarified to remove conflicting information. Care plans of diabetic resident's on sliding scale insulin medications will be reviewed to assure they are in place. The facilities policy and standing orders were clarified to remove conflicting information 	

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F 309	<p>Continued From page 2</p> <p>glucose...Severe hypoglycemia has the potential to cause accidents, injuries, coma sleep-like state...Treatment Consume 15-20 grams of glucose or simple carbohydrates Recheck your blood glucose after 15 minutes If hypoglycemia continues, repeat. Once blood glucose returns to normal, eat a small snack if your next planned meal or snack is more than an hour or two away...Glucagon If left untreated, hypoglycemia may lead to a seizure or unconsciousness (passing out, a coma)...Injectable glucagon kits are used as a medication to treat someone with diabetes that has become unconscious from a severe insulin reaction..."</p> <p>1. Resident #4 was admitted to the facility 1/21/14 with multiple diagnoses which included dementia and diabetes mellitus. The resident was transferred via ambulance to a local emergency department on 1/23/14.</p> <p>The resident's Interagency/Interfacility Physician Orders from the referring hospital to the facility, dated 1/21/14, included: * "Medications: see: ADMRO (Admission/Discharge Medication Reconciliation Orders) [and] MTF (Medication Transfer Form)..." * "Additional Physician Orders: See ADMRO [and] MTF..." * The ADMRO, dated 1/15/14 - included orders for Lantus insulin 24 units sub-Q (per subcutaneous injection) daily in the morning and, "Special Instructions: In morning prior to brkfst [breakfast] insulin lispro (Humalog) Subcutaneous [Resume] Yes" and "[I]nsulin lispro (Humalog) Subcutaneous Before Meals [last dose] 1/14/2014...[Resume] Yes " and "Blood Sugar [glucose] Range... 51 to 60 give 1 [unit],</p>	F 309	<p>and in accordance with the American Diabetes Association.</p> <p>3. Documentation in the medical record of three residents per week for 4 weeks then 2 times a month for 1 month will be reviewed by DNS or designee for residents who are on sliding scale insulin to assure daily documentation of assessment has been completed by licensed nurse according to policy. (Starting 3/24/14)</p> <p>What measures will be put into place or what systemic changes you will ensure that the deficient practice does not recur; Licensed Nurses will be re-educated on the following: 1) Changes to policy and standing orders. Alerts were added to EMAR for BG levels below 70 for licensed nurses charting. 2) Implementation of a Diabetic Care Plan for those residents on sliding scale insulin. 3) Implementation of daily assessment and documentation for residents who have had a</p>	

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F 309	Continued From page 3 61 to 79 give 2 [units], 80 to 150 give 2, 151 to 200 give 3, 201 to 250 give 5, 251 to 300 give 6, 301 to 351 give 7, 351 to 400 give 8..." In handwriting next to the ss orders was, "***No insulin is given after dinner insulin if given" and "***Do not give [with] Novolog. May switch back to Humalog if pt desires***" * The MTF, dated 1/21/14, included orders for Lantus insulin 24 units sub-Q daily; and, "Insulin Aspart Flexpen (Novolog Flexpen)" per the following sliding scale: "0 total unit [from] 1 [to] 80, 0 total unit[s] [from] 81 [to] 150, 4 total unit[s] [from] 151 [to] 200, 6 total unit[s] [from] 201 [to] 250, 8 total unit[s] [from] 251 [to] 300, 10 total unit[s] [from] 301 [to] 350, 12 total unit[s] [from] 351 [to] 999. Notify MD if: BG [less than] 70...Chart total dose given. Scale is 0 units prandial plus custom correction protocol. Do not adm[ister] if pt. [patient] is NPO [nothing by mouth]. Hold dose and inform MD..." and, "Insulin Aspart Flexpen (Novolog Flexpen)... 2 units [from] 251 to 300, 4 units [from] 301 [to] 350, 6 units [from] 351 [to] 999. Notify MD if: BG [less than] 70...Chart total dose given, check BG at [3:00 a.m.] and follow bedtime correction if needed..." In handwriting next to the ss orders was, "Do not give with humalog [sic]" and "May switch back to Humalog if patient [and] family desires." NOTE: The Interagency/Interfacility Physician	F 309	low BG level. Documentation to include interventions, recheck of BG, and physician notification until condition has resolved. Areas of concern will be addressed immediately and discussed at CQI (Quality Improvement) meeting monthly and PRN. Completion Date: March 24, 2014	

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F 309	<p>Continued From page 4</p> <p>Orders from the hospital to the facility contained 2 very different orders for insulin per sliding scale.</p> <p>The resident's facility orders called an "Order Summary Report" included:</p> <ul style="list-style-type: none"> * "HumaLOG Solution (Insulin Lispro (Human)) Inject as per sliding scale if [BG]: 51-60 = 1 [unit of insulin]; 61-150 = 2 [units]; 151-200 = 3; 201-250 = 5; 251-300 = 6; 301-350 = 7; 351-400 = 8; 401+ call md [physician], subcutaneously before meals for Diabetes." These orders were dated 1/21/14; * Lantus insulin 24 units sub-Q one time a day, dated 1/21/14; * "Glucagon...Kit 1 milligram [mg] Inject 1 dose subcutaneously as needed for hypoglycemia. Give one dose for inability to arouse and s/sx [signs/symptoms] of hypoglycemia with bg less than 50. Patient should arouse in 15 minutes. Call MD after administration." It was dated 1/23/14; and, * Glucose Gel 40% [percent]...Give 1 dose by mouth as needed for hypoglycemia Give 1 dose orally PRN [as needed] for BG less than 50 not resolvable by food." It was dated 1/31/14. <p>The resident's January 2014 MAR documented, in part:</p> <ul style="list-style-type: none"> * Lantus insulin administered at 6:30 a.m. on 1/22 and 1/23; * BG to be checked at 7:00 a.m., 10:00 a.m., and 4:00 p.m.; * 1/22 at 7 a.m. BG = 60 and Humalog insulin 1 unit administered; 	F 309		
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F 309	<p>Continued From page 5</p> <ul style="list-style-type: none"> * 1/23 at 10:00 a.m. BG = 50 with "See Progress Note" noted; * The area to document Glucagon Kit on 1/23 was blank; and * The area to document Glucose Gel on 1/23 was blank. <p>The resident's Progress Notes (PN) documentation included:</p> <ul style="list-style-type: none"> * 1/22 at 7:48 a.m. - "...eMAR- [electronic medication administration record]...Note Text: not indicated per bg [BG] parameters BG 60." NOTE: This entry indicated the ss insulin was not administered despite the eMAR documentation that Humalog insulin 1 unit was administered when the resident's BG was 60 at 7:00 a.m. on 1/22. Please refer to F 514 for details regarding the medical record accuracy issue. NOTE: There were no other entries about the low BG on 1/22. * 1/23 at 9:23 a.m. - "...eMAR- ...Note Text: Patients [sic] BG 50. Orange juice and a snack given. Will continue to monitor." NOTE: There was no documentation regarding the resident's level of consciousness at the time, what the "snack" consisted of, if the resident consumed the juice and/or snack, how much was consumed, or that the BG was rechecked afterward. There were no other entries until 3:08 p.m. * 1/23 at 3:08 p.m. - "Note Text: Staff notified nursing at [1:15 p.m.] that patient was having a seizure...Upon assessment was having abnormal extremity movements, with eyes rolled back...Duration of seizure was less than one minute. Vital signs immediately after seizure stable aside from o2 [oxygen] saturation was 83-85% on RA [room air]. Pupils pinpoint and fixed immediately after seizure. BG immediately 	F 309			

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F 309	<p>Continued From page 6</p> <p>after seizure 111...called MD...send patient to hospital...Emergency responders called...Transport staff left at [2:45 p.m.] with patient..."</p> <p>A complainant stated that on 1/23/14, sometime between 9:30 a.m. and 10:00 a.m., the resident, who was a Type I insulin-dependent diabetic, was in "diabetic shock" and "so out of it" the resident was unable to chew a peanut butter sandwich staff were trying to feed to the resident. A family member asked a staff person to get the resident some juice or some glucose. Staff left the room but did not return. The family member then found a glucose tablet among his/her things, crushed it and gave it to the resident and after that the resident started to come around. Two staff who assisted the resident to the bathroom were informed that a glucose tablet had been given to the resident because no staff returned with anything to alleviate the low blood sugar.</p> <p>The resident's Meal Intake records contained no documented evidence the resident ate any food before the brunch meal (at 10:00 a.m.) on 1/23/14. The records documented the resident consumed 76-100 % of the brunch meal and 76-100 % of the dinner meal (4:00 p.m.) on 1/23/14. However, the resident was not in the facility after 2:45 p.m. on 1/23/14. (Refer to F 514 for the details regarding the medical record accuracy issues.)</p> <p>NOTE: On 1/23/14, the resident received Lantus insulin 24 units at 6:30 a.m. but did not eat anything until about 10:00 a.m., 3 1/2 hours, after the insulin was administered.</p> <p>On 2/26/14 at 9:00 a.m., the DON referred the</p>	F 309			

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F 309	<p>Continued From page 7</p> <p>surveyor to the NL for questions regarding Resident #4. The NL was asked what medication was "not indicated" on 1/22/14 at 7:00 a.m. when the resident's BG was 60 and ss insulin was administered per the eMAR. The NL said he thought the ss insulin was not given though it was documented on the eMAR. The NL stated, "It's dependent on the nurse to write the follow up note if there's a low BG. If they [nurses] noted it, it would be in the nurses' notes [also called progress notes]."</p> <p>On 2/26/14 at 10:30 a.m., the DON was asked to provide the facility's policy regarding hypoglycemia.</p> <p>Also on 2/26/14 at 10:30 a.m., the NL was asked about the 2 different Interagency/Interfacility Physician Orders for the resident's sliding scale insulin. The NL picked up the 1/15/14 ADMRO and stated, "These are the orders I used." When shown the 1/21/14 MTR sliding scale orders, the NL indicated he was not aware of them. The NL acknowledged the MTR orders were the most current sliding scale orders. He stated, "There was a lot to clarify with these orders. I remember talking to the [spouse] and I thought I wrote a note. I've looked extensively and I can't tell you why the note wasn't made. I used the wrong sliding scale orders."</p> <p>On 2/26/14 at about 1:00 p.m., the DON provided the resident's 1/23/14 emergency department and acute care hospital stay records, as well as the facility's Diabetic Blood Glucose Monitoring policy, and the facility's Standing Orders.</p> <p>The emergency department records, dated 1/23/14, and acute care records included:</p>	F 309		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/26/2014
NAME OF PROVIDER OR SUPPLIER RIVERVIEW REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 WEST AMERICANA TERRACE BOISE, ID 83706		
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F 309	<p>Continued From page 8</p> <ul style="list-style-type: none"> * Diagnoses which included seizure; * H&P (history and physical) which documented, in part, "Seizure. Suspected by course - potential contributors in hyponatremia (low sodium level) and hypoglycemia; and, * Discharge Summary, dated 1/30/14, which documented, in part, "Encephalopathy: Etiology is probably multifactorial...There is potential that the patient might have mild seizure secondary to hypoglycemia and hyponatremia..." <p>The facility's Diabetic Blood Glucose Monitoring policy documented, in part: "... 7...blood glucose will be monitored ac and hs [before meals and at bedtime] or per physicians' order... 10. If patient [sic] blood glucose level is less than 60mg/dl administer 120 ml [milliliters] of fruit juice or 2 glucose tablets may repeat every 15 minutes until blood glucose is above 60mg/dl. 11. Repeat blood glucose every 15 minutes until blood glucose is above 60mg/dl... 13. Notify physician if blood glucose level does not stabilize after 2 doses or 30 minutes. 14. Notify physician when patient stabilizes. 15. Document incident in patient chart."</p> <p>The facility's Standing Orders documented, in part: "...12. May provide oral glucose for BG [less than] 70 not resolved by providing food 13. May provide Glucagon kit (1 mg) IM [per intramuscular injection] for unrouseable patient with BG [less than] 70 and symptoms of hypoglycemia. Client should rouse within 15 minutes. Call MD after administration."</p> <p>On 2/26/14 at 3:00 p.m., the ED and DON were informed their policy did not meet the ADA recommendations for hypoglycemia and that the policy and the Standing Orders for treatment of hypoglycemia instructed interventions at different</p>	F 309			

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F 309	<p>Continued From page 9</p> <p>BG levels. The DNS stated, "All patients admitted to the facility have these standing orders." The DNS and ED both acknowledged that the policy and the Standing Orders were different. The ED indicated the policy and the Standing Orders would be updated to reflect the ADA recommendations for hypoglycemia.</p> <p>The resident was harmed by a seizure, caused in part by hypoglycemia, when the facility failed to clarify which of 2 very different admission sliding scale insulin orders were to be used, administered ss insulin when the resident's BG was 60 on 1/22, and did not recheck the resident's BG after an intervention for a BG of 50 on 1/23.</p> <p>On 2/26/14 at 4:30 p.m. the Administrator and the DON were informed of the issues. No other information or documentation was received from the facility which resolved the issues.</p> <p>2. Resident #1 was admitted to the facility on 2/10/14 with diagnoses which included diabetes, knee joint replacement and hypertension.</p> <p>The resident's February 2014 MAR documented the resident's BG level was to be taken at 7:00 a.m., 10:00 a.m., 4:00 p.m. and 8:00 p.m. The MAR documented the following low BG levels:</p> <p>* 2/12/14 - at 4:00 p.m. the BG was 63.</p> <p>NOTE: The resident's 2/13/14 Progress Notes (PN) did not document the BG was rechecked or any interventions were provided regarding the low BG.</p> <p>* 2/17/14 - at 10:0 a.m. BG was 66.</p>	F 309			

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F 309	Continued From page 10 The PN for 2/17/14 at 10:05 a.m. documented "insulin held per patient & nurse d/t (due to) BG being 66. Patient eating breakfast and orange juice." The PN documented at 12:05 p.m. the insulin was not given "this a.m." due to the BG of 66, but the PN did not provide evidence that nursing staff rechecked the resident's BG. *2/24/14- at 4:00 p.m. the BG was 68. The only PN on 2/24/14 regarding BG levels documented at 11:27 a.m. (prior to BG of 68 at 4:00 p.m.) "no signs of hyper/hypoglycemia." The PN notes for 2/24/14 did not document the low BG at 4:00 p.m., if the BG had been rechecked or if interventions were provided. On 2/26/14 at 9:00 a.m. the NL stated the low BGs should have been rechecked and documented in the PN. The NL also stated interventions to address the low BGs sugars should have been documented in the PN. On 2/26/14 at 4:30 p.m. the Administrator and the 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	F 514	F514 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;		

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F 514	<p>Continued From page 11</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure resident clinical records were accurate. This was true for 1 of 4 sample residents (#4). The deficient practice created the potential for more than minimal harm if medical decisions for residents were based on inaccurate information. Findings included:</p> <p>Resident #4 was admitted to the facility 1/21/14 with multiple diagnoses which included dementia and diabetes mellitus.</p> <p>Review of the resident's clinical record revealed the following documentation: * January 2014 - MAR - Humalog insulin 1 unit administered 1/22 at 7 a.m.; - Progress Note on 1/22 at 7:48 a.m. - "...eMAR [Electronic Medication Administration Record]...Note Text: not indicated per bg [blood glucose, or BG] parameters BG 60." NOTE: This indicated the insulin was not administered despite the eMAR documentation that Humalog insulin 1 unit was administered.</p> <p>*Progress Note on 1/23 at 3:08 p.m. - "Note Text: ...Emergency responders called...Transport staff left at [2:45 p.m.] with patient..." - Meal intake records - consumed 76-100 % of the dinner meal (scheduled at 4:00 p.m.) on 1/23.</p>	F 514	<p>Resident #4 discharged from the facility. Licensed Nurse and CNA's were re-educated regarding accurate documentation and in having discharged residents status changed in the EMAR.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken; DNS or designee will audit 3 resident records who have been out of the facility or discharged weekly for 1 month and then bi-weekly for 1 month (Starting 3/24/14) – areas of concern will be addressed immediately.</p> <p>What measures will be put into place or what systemic changes you will ensure that the deficient practice does not recur; Licensed Nurses will be re-educated regarding: 1) Proper documentation on residents including times where</p>		

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F 514	<p>Continued From page 12</p> <ul style="list-style-type: none"> - Indwelling Urinary Catheter for urinary retention - staff initials and time noted once after 2:45 p.m. on 1/23 and once on 1/24. - Output from Foley catheter (a type of indwelling urinary catheter) - same as Indwelling Urinary Catheter above. - Bed Mobility - included 4 entries after 2:45 p.m. on 1/23 and 5 entries on 1/24. <p>NOTE: The resident was not in the facility after 2:45 p.m. on 1/23 and not at all on 1/24.</p> <p>On 2/26/14 at 10:30 a.m., the NL was asked about the conflicting documentation regarding the Humalog insulin on 1/22 at 7 a.m. The NL acknowledged that the MAR and the Progress Note documentation was contradictory. He said he thought the insulin probably was not given even though it was documented as administered in the MAR.</p> <p>On 2/26/14 at 11:30 a.m., DON and Certified Dietary Manager were asked about meal intake documentation. Both of them said the documentation would have been for the dinner meal at 4:00 p.m. on 2/23/14. The DON stated, "[The resident] was not here at that time."</p> <p>On 2/26/14 at 4:10 p.m., the NL was asked about the other aforementioned documentation after 2:45 p.m. on 1/23 and 1/24/14. The NL said it was possible the computer cued staff to continue to document because the resident's name had not yet been removed from the system. He stated, "It shows they [staff] charted, not what they charted."</p> <p>On 2/26/14 at 4:30 p.m., the ED and DON were informed of the documentation issue. No other information was received from the facility which resolved the issue.</p>	F 514	<p>resident is out of the facility or discharged.</p> <p>2) How to have the status of a discharged resident changed.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur; DNS or designee will audit 3 resident records who have been out of the facility or discharged weekly for 1 month and then bi-weekly for 1 month – areas of concern will be addressed immediately and discussed at QI (Quality Improvement) meeting monthly and PRN.</p> <p><i>COMPLETION DATE: MARCH 24, 2014 FOR CONVERSATION WITH ADMINISTRATOR ON 4/4/14 AT 10:05 AM</i></p>	

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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001665	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2014
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <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 a complaint investigation of your facility.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator, and Sherri Case, LSW, QMRP.</p>	C 000	<p style="text-align: right;">RECEIVED MAR 14 2014 FACILITY STANDARDS</p> <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Riverview Rehabilitation does not admit that the deficiencies listed on HCFA 2567 exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies".</p> <p>C 784 02.200.03.b Please refer to F 309 Completion Date: March 24, 2014</p> <p>C 881 02.203.02 Please refer to F 514 Completion Date: March 24, 2014</p>	
C 784	<p>02.200.03,b Resident Needs Identified</p> <p>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:</p> <p>This Rule is not met as evidenced by: Please refer to F 309 as it related to the management of residents' low blood glucose levels.</p>	C 784		
C 881	<p>02.203.02 INDIVIDUAL MEDICAL RECORD</p> <p>02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following:</p> <p>This Rule is not met as evidenced by: Please refer to F 514 as it related to medical record accuracy.</p>	C 881		

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



TITLE

Administrator

(X6) DATE

3/14/14

Bureau of Facility Standards

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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 11, 2014

Samuel R. Long, Administrator
Riverview Rehabilitation
3550 West Americana Terrace
Boise, ID 83706-4728

Provider #: 135139

Dear Mr. Long:

On **February 26, 2014**, a Complaint Investigation survey was conducted at Riverview Rehabilitation. Linda Kelly, R.N. and Sherri Case, L.S.W., Q.M.R.P. conducted the complaint investigation.

The following documentation was reviewed:

- The facility's "Diabetic Blood Glucose Monitoring" policy;
- The facility's "Standing Orders";
- Facility's medical records, including Interagency/Interfacility orders from the referring hospital and facility's orders, medication administration record and meal intake records for the identified resident;
- Emergency department records dated January 23, 2014, and hospital records dated January 23 through 30, 2014, for the identified resident;
- Facility's medical records regarding diabetes management for two of three additional residents and regarding transfer orders and facility's orders for three of the three additional residents;
- The facility's lists of "House Stock" and "Emergency Kit" medications;
- Menus for the week of February 23 through March 1, 2014;
- Facility's reports regarding incidents and accidents for November 1, 2013 through February 25, 2014;
- Facility's transfer/discharge lists for November 1, 2013 through February 25, 2014; and,
- Facility's census and roster/sample matrix for February 25, 2014.

The following was observed:

- The "Siesta Snack" on the 100 hall; and,
- The dinner meal in the dining room and on the 100 hall.

The following staff was interviewed:

- The Executive Director (ED);
- The Director of Nurses' (DoN);
- The Nurse Liaison (NL);
- One Licensed Practical Nurse (LPN);
- Three Certified Nurse Aides (CNAs);
- Certified Dietary Manager (CDM); and,
- Registered Dietitian.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006357

ALLEGATION #1:

The complainant stated an identified resident has been a Type I insulin-dependent diabetic for over 50 years and on the morning of January 23, 2014, sometime between 9:30 and 10:00 a.m., the resident was in "diabetic shock." Staff tried to feed the resident a peanut butter sandwich; however, the resident was "so out of it" the resident could not chew. A family member asked the staff present to get some juice or some glucose. The staff left the room but did not return. The family member found a glucose tablet in the complainants things, crushed it and gave it to the resident. After a few minutes, the resident "started coming around" and asked for the bathroom. The two attendants who assisted the resident to the bathroom were informed that a glucose tablet had been given to the resident because staff did not return with anything to alleviate the low blood sugar. Once in the bathroom, the resident had a seizure, the attendants alerted the nurse, an ambulance was called and the resident was taken to the hospital. This was around 11:00 a.m. and at that time; the resident's blood glucose was 99. The complainant found out later that the resident requested not to have breakfast and was given the morning dose of insulin anyway.

FINDINGS:

The identified resident's records contained documentation that the resident was harmed when the resident experienced seizure activity related in part to hypoglycemia (blood glucose, or BG, less than 70) after the facility failed to clarify two very different orders for insulin administration per

Samuel R. Long, Administrator

March 11, 2014

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sliding scale. Sliding scale insulin was administered when the resident's BG was 60; the resident received scheduled insulin then declined breakfast and the BG dropped to 50 and then not rechecked after intervention.

The facility was cited a F309 at the level of harm for this failed practice. The facility was also cited at F514 at the potential for harm level regarding inaccurate documentation.

CONCLUSIONS:

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

ALLEGATION #2:

The complainant stated the identified resident was supposed to be on a low potassium diet but was regularly served potatoes, bananas and orange juice, even though the dietary staff was provided a list of foods to avoid. The facility was under the impression the resident had Type II diabetes, not Type I.

On January 23, 2014, the resident was admitted to a local hospital with pneumonia, dehydration, elevated potassium and decreased sodium levels, an eye infection and edema in the legs. The elevated potassium level may have been related to the diet served. The facility did not recognize the resident had developed pneumonia and become dehydrated.

FINDINGS:

Review of the hospital's records prior to the identified resident's admission to the facility and facility's records revealed that the documented diagnoses included DM (diabetes mellitus) and DM Type II. There was no indication in any of these records that the resident had Type I insulin-dependent diabetes.

The Interagency/Interfacility Physician's Orders (from the referring hospital to the facility) included two diet orders. One was an ADA (American Diabetes Association) 45-gram carbohydrate breakfast and 60-gram lunch and dinner diet. The other was "Diabetic diet (high) protein, (high) fiber." Upon admit, the facility obtained a verbal order to clarify the diet. The provider ordered a controlled carbohydrate (CCHO) diet with regular texture. There was no evidence that a low potassium diet was ever ordered for the identified resident. Based on an interview with the CDM, the resident was asleep when attempts were made to obtain the resident's food preferences and no information was received from the resident's spouse.

The facility's records documented that the resident was dyspneic (had difficulty breathing) with activity and decreased lung sounds at the right lateral and posterior base but were clear otherwise

Samuel R. Long, Administrator
March 11, 2014
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on the day of admission; and, that the resident received Lasix (diuretic medication) daily for hypertension. By the next day, a physician's assistant documented clear lungs sounds and one to two plus pitting edema in both lower extremities, which the spouse "reports this is (resident's) norm." There was no documented evidence to indicate the resident was dehydrated or had pneumonia during the resident's two-day stay in the facility. In addition, there was no documentation about an eye infection in either the facility's or the emergency department's records. The facility's records noted seizure activity on January 23, 2014, after which the resident was transported via ambulance to a local emergency department. The emergency department's records for the same day noted the following diagnoses: bacterial pneumonia, hyperkalemia (elevated potassium level), renal insufficiency and seizure, and that the resident was admitted to the hospital for continued care.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

LKK/dmj