



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 83720-0008
PHONE 208-334-6626
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CERTIFIED MAIL: 7012 1010 0002 0836 1765

March 28, 2014

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

Provider #: 135133

Dear Mr. Shull:

On **March 14, 2014**, a Recertification and State Licensure survey was conducted at Idaho State Veterans Home - Lewiston by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies 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.) **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.

Kenneth Shull, Administrator
March 28, 2014
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After each deficiency has been answered and dated, the administrator should sign both the 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 Plan of Correction (PoC) for the deficiencies must be submitted by **April 10, 2014**. Failure to submit an acceptable PoC by **April 10, 2014**, may result in the imposition of civil monetary penalties by **April 30, 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 does 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 (X5).

Kenneth Shull, Administrator
March 28, 2014
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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 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*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 14, 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 Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (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. 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>

Kenneth Shull, Administrator
March 28, 2014
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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 **April 10, 2014**. If your request for informal dispute resolution is received after **April 10, 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, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj
Enclosures

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

PRINTED: 03/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/14/2014
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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 821 21ST AVENUE LEWISTON, ID 83501
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(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 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual Federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Arnold Rosling RN, BSN, QMRP Team Coordinator Brad Perry LSW Susan Gollobit RN Jana Duncan RN, MSN</p> <p>The survey team entered the facility on Monday March 10, 2014 and exited the facility on Friday March 14, 2014.</p> <p>Survey Definitions:</p> <p>ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide DON/DNS = Director of Nursing EMR = Electronic Medical Record IDT = Interdisciplinary Team LN = Licensed Nurse MDS = Minimum Data Set assessment SW = Social Worker</p>	F 000		
F 156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be</p>	F 156	<p>F 156</p> <p>Scope and Severity of C</p> <p>Admission Packet – right to choose a physician and right to have copies of medical records.</p>	<p>RECEIVED</p> <p>APR - 3 2014</p> <p>FACILITY STANDARDS</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kenneth A. Shell</i>	TITLE <i>ADMINISTRATOR</i>	(X6) DATE <i>4/1/14</i>
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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 156	<p>Continued From page 1</p> <p>made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which</p>	F 156	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Admission Coordinator has changed the verbiage regarding resident rights in the handbook to meet the standards of the Federal and State regulations. The new chapter regarding resident rights will be given to the residents and the POA's by the Admission Coordinator.</p> <p>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.</p> <p>Since all residents have the potential of harm from this deficient practice, the Admission Coordinator has changed the verbiage regarding resident rights in the handbook to meet the standards of the Federal and State regulations. The new chapter regarding resident rights will be given to the residents and the POA's by the Admission Coordinator.</p>		

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F 156	<p>Continued From page 2</p> <p>cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility's admission packet and staff interview, it was determined the facility failed to ensure residents were fully informed of their rights. This had the potential to affect all residents including sample residents #s</p>	F 156	<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>Admission coordinator or her designee will ensure that the revised version of the handbook is given out to all new admissions to the facility.</p> <p>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.</p> <p>Admission Coordinator or designee will do random audits of admissions weekly for 30 days (four weeks), bi-weekly for an additional 30 days (2 weeks) and then monthly for an additional thirty days. All results will be reported to QA for three months to ensure compliance.</p> <p>Dates when corrective action will be completed.</p> <p>April 1, 2014</p>	4/1/14	

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F 156	Continued From page 3 1 - 13. Findings include: When surveyors reviewed the facility's admission packet which included resident rights, it was determined that the packet did not inform residents and their families that residents' medical records could be viewed or purchased, "upon an oral or written request" as required by federal requirement. In addition, the packet failed to inform residents that, "The resident has the right to - Choose a personal attending physician." Instead, it documented, "8. The resident has the right to be informed of the name and way of contacting the primary physician responsible for his or her care." On 3/12/14 at 1:30 p.m. SW#1 was interviewed. She stated upper management came after the previous year's survey and put the new resident rights packet in place. The Administrator and DON were informed of the finding on 3/13/14 at 4:15 p.m. No further information was provided that resolved the finding.	F 156			
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private	F 164	F 164 Resident Rights Privacy regarding administration of medications/treatments. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?		

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F 164	<p>Continued From page 4 room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and record review, it was determined the facility failed to ensure privacy was maintained when eye drops, inhalers and medications were administered to residents in the hallway, dining area, and during activities. This was true for 4 out of 11 residents (#s 16, 18, 19 and 24) observed during medication pass. The failed practice created the potential for a negative effect on the resident's psychosocial well-being related to the need for privacy. Findings included:</p> <ol style="list-style-type: none"> 1. On 3/12/14 at 11:20 AM, LN #13 approached Resident #16 in the hallway next to the crafts room and said, "Hi [resident], ready for your eye drops?" The resident nodded and LN #13 applied gloves and administered eye drops in the hallway. 	F 164	<p>SS met with residents 13, 16, 18, 19, 20 (resident 24 not on resident list) to ensure that they were not affected by receiving non oral meds in public.</p> <p>All LN staff will be in serviced by the RN Mgr. or designee on the correct procedure for administering eye drops and inhalers in public areas.</p> <p>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.</p> <p>Since all residents have the potential of harm from this deficient practice, all LN staff will be in serviced by the RN Mgr. or designee on the correct procedure for administering eye drops and inhalers as related to privacy and dignity preferences.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>LN Nursing staff will ask each resident prior to administering eye drops and/or inhalers if the resident wishes to be taken to a private area for his treatments.</p>

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APR 17 2014

FACILITY STANDARDS

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F 164	<p>Continued From page 5</p> <p>Several other staff and residents were within view of the medication administration. Following the medication administration, the LN was asked about Resident #16's privacy. LN #13 said, "We are all care planned for it. I asked him if he was ready, but not... It was my understanding of the policy here. Not insulin or blood glucose checks in the hallway but everyone here is care planned to do these things."</p> <p>Resident #16's Care plan under the focus area, The resident has impaired visual function documented the goals were initiated 1/2/14: "The resident will use glasses to promote participation in ADL's and other activities, and the resident will have no indication of acute eye problems through the review date." Interventions include in part, "[The resident] prefers to have his eye drops given to him at the medication cart. Offer and assist him to have a private area if he should wish these done elsewhere." This intervention was initiated 3/12/14.</p> <p>NOTE: Although the resident agreed to receive eye drop administration at the medication cart per his care plan, it is inappropriate because other residents were in the area and in view of his treatment.</p> <p>2. On 3/12/14 at 11:40 AM, LN #13 assembled the medication for Resident #24 and proceeded to look for the resident. The LN found Resident #24 participating in activities in the activity room adjacent to the nurse's station. LN #13 said, "He is just sitting at the table; I'm going to interrupt them." LN #13 entered the activity room and gave the resident his medications and said, "I didn't realize you were talking, I thought you were just sitting here." The resident was sharing a story when the LN went in to give him his medication;</p>	F 164	<p>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.</p> <p>RN Mgr. or designee will audit a minimum of 10 medication passes for proper protocols weekly for 30 days (four weeks), bi-weekly for an additional 30 days (2 weeks) and then monthly for an additional thirty days. All results will be reported to QA for three months to ensure compliance</p> <p>Dates when corrective action will be completed.</p> <p>April 1, 2014</p>	4/1/14	

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F 164	<p>Continued From page 6</p> <p>he had to stop participating in the activity to take his medication. The activity personnel and 4-5 other residents were present during the activity.</p> <p>3. On 3/12/14 at 12:00 PM, Resident #18 approached the medication cart in the hallway and sat at a chair beside the nurse's station. LN #16 gave inhaler puffs, applied gloves and administered eye drops to Resident #18 beside the medication cart at the nurse's station. When asked if that was where he usually received his eye drops, LN #16 said, "Yes, he usually comes to the nurse's station with his walker. He also comes in his wheelchair sometimes."</p> <p>4. On 3/12/14 at 4:15 PM, LN #20 saw Resident #19 in the hallway and administered his medications with applesauce and gave his eye drops beside the medication cart in the hallway. Several other residents were within view at the nurses station and in the hallway.</p> <p>NOTE: During medication pass observation, LN #s 13, 16, and 20 did not ask for permission to give medication in a public area, nor did they ask the resident if they would prefer a more private setting to administer treatments such as eye drops or inhalers. Additionally, the facility did not address the other residents who were within view of treatments given.</p> <p>On 3/13/14 at 11:05 AM, the DNS and Assistant DNS were interviewed regarding resident privacy and observations. The Assistant DNS said, "We offer the resident's privacy before we start [medication pass]." When asked how they determine if residents need more privacy with medication pass the DNS said, "If they were a brand new patient, we would ask them. We would</p>	F 164		
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F 164	Continued From page 7 cover that with admission." When asked how individual staff would know who requires more privacy, the DNS said, "We don't let the nurses run wild here, we give them intense training. If they have to disrobe, that's no question." On 3/13/14 at 4:00 PM, the Administrator and the DNS were informed of the observation. No other information or documentation was received from the facility regarding the privacy issue.	F 164		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, record review, and facility policy review, it was determined the facility failed to ensure that 1 of 15 sampled residents (#2) and 2 random residents (#20, #21) were assessed to be safe to administer their own nebulizer treatments. The treatments were administered by 4 LNs (#6, 13, 16, 18). This deficient practice put the residents at risk to not obtain the maximum benefits from their treatments. Findings included: The facility's Self-Administration of Medication Policy dated December 2012, documented: *Policy Statement: "Residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of	F 176	Resident Rights Resident Self Administer drugs if deemed safe. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents 2, 20 and 21 will be reassessed by RN Mgr. or her designee with a new self-medication assessment form, which has the criteria outlined in the survey findings, to ensure the residents are able to safely self-administer. In addition, staff have been in serviced by the RN Mgr. or designee on proper protocol for nebulizer administration to ensure that the patient gets the full value of his/her treatment.	

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F 176	<p>Continued From page 8 doing so." *Policy Interpretation and Implementation: -1. "As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications." -2. "In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the resident's: a. Ability to read and understand medication labels; b. Comprehension of the purpose and proper dosage and administration time for his or her medications; c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) them; and d. Ability to recognize risks and major adverse consequences of his of her medications." 1. Resident #2 was admitted to the facility with diagnoses that included dementia other with behavioral disturbance. The resident's Quarterly MDS dated 12/23/13, documented: -BIMS score: 99- Resident was unable to complete the interview. -Short-term Memory: Memory Problem. -Long-term Memory: Memory Problem. -Cognitive Skills for Daily Decision Making: Moderately impaired-decisions poor; cues/supervision required. The resident's Physician orders dated 3/1/14, documented:</p>	F 176	<p>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.</p> <p>The RN Manager or her designee will complete an audit of all residents who self-administer medications using the new Self Administration Assessment to ensure they meet the criteria outlined in the Survey Findings. In addition, staff have been in serviced (by RN Mgr. and designee) on proper protocol for nebulizer administration to ensure that the patient gets the full value of his/her treatment.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>A new Self Administration Assessment tool has been initiated to include the criteria outlined in the survey findings. All residents wishing to self-administer their medications will be assessed using this tool to ensure that they are safe to do so. All nurses will be in serviced on proper protocol for</p>		

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F 176	<p>Continued From page 9</p> <p>-Albuterol Sulfate Nebulization Solution (2.5 MG [milligram]/ 3 ml [milliliter]) 0.083%. 1 capsule inhale orally via nebulizer three times a day for upper respiratory.</p> <p>The resident's Self Medication Administration Assessment dated 3/11/14, documented: *Nursing Assessment: -1. Mental Status: Memory Deficits Identified in MDS: Checked columns were: "Yes," "Short Term," "Long Term." -2. Physical Abilities: Use of upper extremities: Checked column was "Uses only one arm/hand well." Vision: Checked column was "Poor (unable to read small/large print with or without glasses)." -Recommendations: "Rsdtd [resident] cannot read. Rsdtd is not able to self administer own meds-3-12-14." NOTE: The assessment was completed after the resident was observed on 3/10/14 in the PM, and 3/11/14 in the AM, with his nebulizer treatment being administered without staff present.</p> <p>On 3/10/14 at 3:40 pm, during the initial tour of the facility, the resident was observed sitting in his wheelchair in his room with his nebulizer treatment mask on and misting. Staff were not present in the room with the resident.</p> <p>On 3/11/14 at 9:07 am, the resident was in bed, eyes were closed and his nebulizer treatment mask was in place on his face, with the machine on. The treatment was complete, there was no mist being administered. At 9:10 am, LN #16 entered the room and removed the mask. When asked if the resident had an assessment to self-administer his treatment, the LN stated, "I believe so, the breathing treatments. I am happy he held his finger over the hole. It's a good day</p>	F 176	<p>nebulizers by the RN Mgr. or designee. The RN Manager or designee will routinely monitor treatments for compliance.</p> <p>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.</p> <p>The RN Mgr. or designee will review a minimum of five self-medications and five nebulizer treatments weekly for 30 days (four weeks), bi-weekly for an additional 30 days (2 weeks) and then monthly for an additional thirty days. All results will be reported to QA for three months to ensure compliance</p> <p>Dates when corrective action will be completed.</p> <p>04/01/2014</p>	4/1/14

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F 176	<p>Continued From page 10</p> <p>when he does that. We do it when he is in bed, he won't always let us do it." The resident was asleep and did not awaken.</p> <p>On 3/12/14 a Self Medication Administration Assessment was provided to the surveyor (see above). The assessment was dated 3/11/14 and it was not clear whether the resident was safe to administer his own medications. LN #9 had completed the assessment. On 3/12/14 at 4:05 pm, LN#9 was asked to clarify the assessment. The LN stated, "he is not capable of doing it himself." When the LN was asked when she had completed the assessment, she stated "Yesterday evening when I was doing his Quarterly Assessment."</p> <p>2. Resident #20 was admitted to the facility on 12/31/13 with diagnoses that included Alzheimer's disease.</p> <p>The resident's MD Communication Fax dated 2/27/14, documented: -Concern/Need: "RsdT [resident] had incident of aspiration. LS [lung sounds] are coarse crackles throughout. Productive cough frequent. RsdT voice harsh/raspy. O2 [oxygen] sats[uration] > 90% on 2 L[liters] O2 via NC [nasal cannula]. [Increase] c/o [complaint of] pain r/t [related to] cough." -Background/Treatments/Code Status: "Current medication include DuoNeb Q4[every 4 hours]...." -What would you like to see done; orders, labs, office visit, other? "Begin Zithromax 500 qd [every day] x 3 d[days] if fever [and] or O2 sats drop send to ER [Emergency].</p> <p>Resident Physician orders dated 3/1/14- 3/31/14, documented:</p>	F 176		
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F 176	<p>Continued From page 11</p> <p>"DuoNeb Solution 0.5-2.5 (3) MG/3 ML (Ipratropium-Albuterol). 1 application inhale orally every 4 hours."</p> <p>On 3/12/14 at 1:40 pm, the resident was in bed asleep. The nebulizer treatment mask was displaced on his face. The mask was off his nose and hanging down on his mouth. The mist in the mask was completed. At 1:43 pm, LN #13 walked into the room and took the mask off the resident's face. When the surveyor asked about the displaced mask and how effective it was in that position on the face, LN #13 stated, "I know he knocks it off after he is done with it. He has been on an antibiotic for that cough and DuoNeb 4 times a day." When asked if the resident had been assessed to self-administer medications, the LN said, "No." LN#13 agreed the resident was asleep.</p> <p>3. Resident #21 was admitted to the facility on 1/14/14 with diagnoses which included, bronchitis unspecified, chronic airway obstruction.</p> <p>The resident's Physician orders dated 3/1/14-3/31/14, documented; -DuoNeb Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally via nebulizer every 4 hours.</p> <p>The resident's Self Medication Administration Assessment dated 3/11/14, documented: *Nursing Assessment: -1. Mental Status: Memory deficits Identified in MDS: Checked column was, "Yes." -2. Physical Abilities: Use of upper extremities: Checked column was, "Intact bilaterally." Vision: Checked column was "Good." -Recommendations: "Rsdtd. has good memory,</p>	F 176			

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F 176	<p>Continued From page 12</p> <p>retain information full use of arms [and] hands bilaterally." *Pharmacy Assessment: -1. Medications are all routine with condition stable. Checked column was, "Yes." -3. Resident can demonstrate ability to lock/unlock storage drawer: Column checked was, "Yes." *Interdisciplinary Team Review: Was not documented. NOTE: The assessment was not complete due to the practitioner [per facility policy] and the IDT were not involved in the assessment. The assessment was completed after the resident had been observed providing his own treatment.</p> <p>On 3/11/14 at 12:00 pm, the resident was in his room in his wheelchair with his nebulizer treatment mask in place and misting of medication. Staff was not present in the room. The resident was asked if his nurse had brought the treatment in to him, the resident stated, "Yes." The resident was asked if the nurses had always left him to do his own treatment and he stated, "Yes, I have done it for 4 years." At 12:04 pm, LN #6 entered the room and took the mask off and took it to the sink and rinsed it. LN#6 was asked if the resident was assessed to self-medicate and the LN stated, "I load it for him and then I come back and wash it for him. He gets it twice on my shift."</p> <p>On 3/12/14 at 4:56 pm, the resident was in his room in his wheelchair. The resident was asked about the nebulized treatment that was being administered, and he stated, "It's about done. It just takes a few minutes." When the resident was asked if the nurse had just brought it in, he stated, "yeah, a few minutes ago." When asked if</p>	F 176			

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F 176	Continued From page 13 the facility had completed an assessment for him to self-medicate, the resident stated, "They won't let me do my meds myself. It's a State law." At 5:00 pm, LN #18 was asked if the resident had orders and an assessment to self-medicate, the LN stated "They moved him here from the other hall and they told me he did. Let me check into it here." The LN#18 tried to pull up the orders in the Electronic Medical Record (EMR) and stated, "It's very hard to do that here. If he doesn't we will get that taken care of." On 3/12/15 at 5:15 pm, LN#19 provided the Self Medication Administration Assessment that was completed on 3/11/14. The LN verified the assessment stated the resident was able to self-administer his medications, and stated, "They got the MD order first and then [LN name] did the assessment." The LN was asked if the IDT was involved in the assessment, and she stated, "The nurse has to do the assessment and the pharmacist. I am not sure about the IDT." The RN Manager LN#7 stated, "Yes, it has to go through the IDT meeting." LN#19 stated, "So he can't do it until IDT ok's it." When LN#7 was asked how often the IDT met, she stated, "We have stand up every day."	F 176			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	F 280	F 280 Assessments Scope and Severity of D Right to participate planning, care revisions, Care plan.		

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F 280	<p>Continued From page 14</p> <p>comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review it was determined the facility failed to ensure the care plan was revised for 1 of 15 sampled residents (#6). The deficient practice had the potential to cause more than minimal harm when the resident developed an unstageable pressure ulcer and the care plan was not revised to reflect the implementation of interventions to prevent the pressure ulcer from increasing in severity, and Ted hose (compression stockings) were discontinued by the MD and not discontinued on the care plan. Findings included:</p> <p>Resident #6 was admitted to the facility on 2/6/14 with diagnoses which included schizoaffective disorder, bipolar disorder and generalized osteoarthritis.</p> <p>The resident's Physician Active Orders, date range, 2/6/14 -3/31/14, documented: **Offload B/L[bilateral] heels with bolster pad to allow heels to hang. Off load heels with offloading</p>	F 280	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The MDS Coordinator reviewed Dr. Orders and care plan to ensure accurate information was reflected. Care plan updated as needed for #6.</p> <p>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.</p> <p>All residents have the potential to be negatively impacted by this deficient practice. As a result, all resident care plans will be audited against the treatment orders and updated as needed by the MDS Coordinator.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>The MDS Coordinator or her designee will check all orders written the previous day(s) and update care plans as needed.</p>		

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F 280	<p>Continued From page 15</p> <p>boots. every shift for blister." Revision date: 2/25/14.</p> <p>NOTE: The interventions for the bolster pad or the heel boots were not implemented on the resident's current care plan.</p> <p>*"Ted Hose to be applied bilateral lower extremities every morning and removed every evening at HS (hour of sleep). every day and evening shift for Edema." Discontinued 2/24/14.</p> <p>The resident's care plan documented: *Focus: "The resident has Peripheral Vascular Disease (PVD)." Date Initiated: 2/16/14. *Interventions: -"Compression stockings per MD order." Date initiated: 2/16/14. NOTE: The physician's order to discontinue the Ted hose was not discontinued on the resident's current care plan.</p> <p>IDT (Interdisciplinary Team) Progress notes documented: *2/24/14 at 2:24 am - Nursing Note: "Area to right heel conts [continues] to be healing well with no s/s of infection. no odor. no drainage. no c/o [complaint of] pain to site. cont to relieve pressure to right heel while in bed. cont to turn every 2 hours and prn [as needed]. will cont to monitor." NOTE: The intervention to turn the resident every 2 hours was not identified on the resident's current care plan.</p> <p>On 3/13/14 at 8:10 am, the resident was asleep on the right side. The resident's bilateral feet had socks on them and the offload boots were not in place. The blue wedge pillow was high up under the legs and both feet rested on the bedwene on the bed. Ted hose was not in place. At 8:15 am LN #7 verified the placement of the feet and the</p>	F 280	<p>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.</p> <p>The MDS coordinator or her designee will audit a random selection of a minimum of 10 residents to ensure the orders and the care plans match weekly for 30 days (four weeks), bi-weekly for an additional 30 days (2 weeks) and then monthly for an additional thirty days. All results will be reported to the QA committee monthly for three months to ensure compliance.</p> <p>Dates when corrective action will be completed.</p> <p>April 1, 2014.</p>	4/1/14

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F 280	<p>Continued From page 16</p> <p>missing boots with the surveyor. LN #6 entered the room and stated, "I was under the understanding if the heels are floated, we did not need the boots." When the LN#6 was asked about the Ted hose that were on the care plan, LN #6 stated, "Dr. (physician's name) wanted the Ted hose held while the heel was healing." When asked if that was for both legs, LN#6 stated, "Yes." LN#7 was asked for the updated care plan and MD order for the discontinued Ted hose.</p> <p>On 3/13/14 at 8:39 am, LN #7 provided the order for the discontinuation of the Ted hose. When LN #7 was asked if the care plan had been updated, the LN stated, "It wasn't updated. I am going to do that."</p> <p>On 3/13/14 at 4:30 pm, the Administrator, DON and RN Manager were notified of the findings. No additional information was provided.</p>	F 280		
F 281 SS=D	<p>Refer to F314 for additional information related to pressure ulcers,</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's Nursing Services Policy and Procedure Manual, and staff interview, it was determined the facility failed to ensure LNs consistently followed blood glucose (BG) check procedures. This was true for 1 of 2 LN's (LN#13) and affected 1 of 2 residents</p>	F 281	<p>F 281</p> <p>Scope and Severity of a D</p> <p>Services provided meet professional standards.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p>	

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F 281 Continued From page 17

(#20) observed for BG check. Failure to sanitize the finger before puncturing the resident's finger and to wipe away the first drop of blood with a dry cotton ball and use the next drop of blood for the BG check placed the resident at risk for infection and inaccurate BG results.

The Facility's Nursing Services Policy and Procedure Manual procedure for Obtaining a Fingertick Glucose Level documented, "...7. Wash the selected fingertip, especially the side of the finger, with warm water and soap. (Note: If alcohol is used to clean the fingertip, allow it to dry completely because the alcohol may alter the reading...), 8...Discard the first drop of blood..."

Resident #20 was admitted to the facility on 12/31/13 with multiple diagnoses which included Diabetes type II, and generalized weakness.

Resident #20's Orders for February 2014 included "Blood glucose checks before meals and at bedtime related to DIAB [diabetes] W/O [without] COMP [sic] TYPE II/UNS NOT STATED UNCNTRL [sic]."

On 3/12/14 at 11:22 AM, LN #13 was observed as she performed a BG check for Resident #20. The LN did not clean the resident's finger with alcohol or wash the resident's hand or finger before puncturing the finger for a BG specimen. The LN used the first drop of blood in the glucose meter and received a reading of 324. Upon exiting the resident's room, the LN was asked if she wiped the resident's finger with an alcohol swab, she said, "No, I usually do. I have an alcohol swab right here. Sorry, I should have done that." When asked if she used the first drop of blood for the glucometer reading she said, "I used the first drop

F 281

SS met with resident #20 to ensure he/she is not effected by receiving blood glucose testing in public.

All LN staff will be in serviced on the correct procedure for obtaining blood sugars by the RN Mgr. or her designee. In addition, the RN Mgr. or designee will be holding a skills lab for the glucose monitoring for all LN staff.

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.

All LN staff will be in serviced on the correct procedure for obtaining blood sugars by the RN Mgr or her designee. In addition, the RN Mgr. or designee will be holding a skills lab for the glucose monitoring for all LN staff.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.

RN Mgr. or designee will in service and provide a skills lab for all LN staff in regards to the correct procedure for obtaining blood sugars.

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FACILITY STANDARD

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2014
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 821 21ST AVENUE LEWISTON, ID 83501		
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F 281	Continued From page 18 of blood. Are we not supposed to do that? I've never heard that before." On 3/13/14 at 2:15 PM the DNS was interviewed about policy and procedures for conducting a BG check. When informed of observations he said, "It's nice to see it, we have some education to do about that. I'm trying to standardize approaches here." On 3/13/14 at 4:00 PM, the Administrator and DNS were informed of the findings. No further information or documentation was received regarding this issue.	F 281	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. The RN Mgr. or designee will review a minimum of five blood sugar checks weekly for 30 days (four weeks), bi-weekly for an additional 30 days (2 weeks) and then monthly for an additional thirty days. All results will be reported to QA for three months to ensure compliance		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and observation it was determined the facility failed to ensure that residents who entered the facility without a pressure ulcer did not develop pressure ulcers. This was true for 3 of 3 sampled residents (#'s 1, 6, and 7) reviewed for pressure ulcers, and resulted in harm for two of the three residents. *Resident #1 was harmed when he developed	F 314	Dates when corrective action will be completed. April 1, 2014 F 314 Scope and Severity of a G Treatment and Services to prevent and heal pressure sores. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	4/1/14	

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F 314	<p>Continued From page 19</p> <p>multiple unstageable pressure ulcers on his right foot and ankle after compression wrappings were left on four days longer than was ordered; *Resident #6 developed blister to his right heel; and *Resident #7 experienced the potential for harm when he developed a stage II pressure sore to his finger two days after the facility implemented the use of a new hand splint. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 4/13/11 with multiple diagnoses which included dementia, edema, and peripheral vascular disease.</p> <p>Resident #1's annual MDS, dated 1/6/14, documented in part: -Was moderately cognitively impaired; -Required extensive assistance with 2 or more staff for bed mobility, transfers, and toilet use; -Did not reject cares; -Was at risk for developing pressure ulcers; and -Had no pressure ulcers.</p> <p>The Care Plan for Resident #1, dated 1/9/14, documented, "The resident has potential for impairment to skin integrity r/t [related to] edema, fragile skin, hx [history] of rash, fungal rash to toes, wears ted hose, hx of shearing to buttocks, and wound to feet/toes with a history of these wounds." The goals initiated on 1/9/14 and revised on 3/5/14 documented in part - "Keep skin clean and dry. Use lotion on dry skin (1/9/14); -[Resident] likes to sit in his chair and elevate his legs to help reduce swelling during the day (1/9/14); -The resident needs assistance to apply heel lift boots (1/9/14);</p>	F 314	<p>Wound Nurse will complete Skin Assessments for residents 1, 6, and 7 to ensure they reflect the most current information. Staff will be educated on proper protocol for the monitoring of skin/wounds by the Wound Nurse or his Designee. RN Manager or designee will monitor ongoing.</p> <p>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.</p> <p>The Wound Nurse or his designee will audit residents with wound treatments to ensure all proper devices and treatments are in place. In addition, the Wound Nurse or his designee will in service staff on the correct procedures.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>The Wounds nurse or his designee will in service all staff on correct protocols for skin assessments, treatments and devices. The Wound Nurse will monitor on an ongoing basis to ensure compliance.</p>		

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F 314	<p>Continued From page 20</p> <p>-Use Heel lift cushion when in bed as needed to provide pressure reducing relief to bilateral heels (1/9/14);</p> <p>-Weekly treatment documented to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations (1/9/14);</p> <p>-The resident needs air bed to protect the skin while IN BED (3/10/14); and</p> <p>-Avoid letting right heel rest on foot peddle [sic] (3/5/14)."</p> <p>The resident's Medication Review Report (Physician Recapitulation orders) dated 2/3/14, documented in part:</p> <p>"Blue Heel Float Boots When in Bed. every shift...;</p> <p>-Ted Hose on in AM, Off in PM every day and evening shift...; and</p> <p>-Weekly Skin Assessments every day shift every Wed [sic]..."</p> <p>The resident's Physician Rounding Orders, dated 2/3/13, documented in part:</p> <p>"-Order Unna boots to be applied to b/l [bilateral] lower extremities[LE] and #2, 4 inch and #2, 6 inch Ace bandage to be applied to b/l LE and changed weekly...; and</p> <p>-[Resident's physician] will apply. Until arrival of unna boot and aces apply skin repair cream adaptic and Kerlix bandage to Dermatitis lesion of [left] leg. Discontinue once supplies arrive."</p> <p>Note: An Unna boot is a compression dressing for varicose veins or ulcers consisting of a paste made of zinc oxide, gelatin, glycerin, and water that is applied to the lower leg, covered with a bandage, and then applied to the outside of the bandage.</p>	F 314	<p>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.</p> <p>The Wound Nurse or designee will review a minimum of five residents with skin issues, devices and treatments weekly for 30 days (four weeks), bi-weekly for an additional 30 days (2 weeks) and then monthly for an additional thirty days. All results will be reported to QA for three months to ensure compliance</p> <p>Dates when corrective action will be completed.</p> <p>04-01-14</p>	4/1/14	

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F 314	<p>Continued From page 21</p> <p>The resident's Physician Notes documented in part, the following: -2/11/14: "Patient was seen today for treatment of edema and dermatitis to bilateral legs, with severity of dermatitis much more severe to left leg. Patient relates he has had this problem for quite some time... There's generalized erythema and flaking noted to the digits and plantar surfaces of bilateral feet... Ordered Unna boot dressing and Ace to be applied to bilateral legs upon arrival... - 2/18/14: ...Edema still noted bilateral legs however greatly improved. Edema is +4 bilaterally. Pedal pulses are still not palpable bilateral [sic]... Two layer compression dressing was applied to the right leg. Orders were written for this dressing to be changed every four days...</p> <p>The resident's Physican Orders, dated 2/18/14, documented, Unna-Flex Elastic Unna Boot to right lower leg to be changed every 4th day.</p> <p>The resident's Physician Notes documented in part, the following: -2/24/14: ...Edema to bilateral extremities is greatly improved. Edema two [sic] legs almost completely resolved. There is still significant Edema in bilateral feet but improved. Edema is currently +2-3 bilaterally. Erythema is greatly improved to left leg overall, superficial wound had some crust noted to it but no deep tissue involvement... Applied Unnaboot dressing to left leg. Two layer compressive dressing was applied to the right leg, to be changed every four days. Will reevaluate in one week."</p> <p>The resident's interdisciplinary progress notes (IDPN) documented in part:</p>	F 314		
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F 314	<p>Continued From page 22</p> <p>-2/24/14: "[Resident's Physician] was in to see rsdt [resident] today, rewrapped both legs with UNNA boots. No new orders;</p> <p>-2/26/14: Late entry, checked rsdt circulation in left foot, cap refill was >3 sec, was able to place 1 finger under wrap to check for tightness, he had no c/o [complaints of] pain; and</p> <p>-2/26/14: Unna-Flex Elastic Unna Boot Miscellaneous Apply to Right Lower Leg topically every evening shift every 4 day(s) related to RASH AND OTHER NONSPECIFIC SKIN ERUPTIONS; EDEMA."</p> <p>Note: The writer on 2/26/14 did not specify what time of the late entry.</p> <p>The resident's Complex Alert Documentation Report [CNA documentation] was reviewed and the behaviors: "Resist/Rejects Care" documented Day, Evening and Night shift as "NA" from 1/23/14 to 3/11/14.</p> <p>Note: The documentation does not indicate that the patient had behaviors resisting or rejected care for the time leading up to the pressure ulcer development.</p> <p>Resident #1's Medication Administration Record Schedule for March 2014 documented in part: "-Unna-Flex Elastic Unna Boot Miscellaneous (Wound Dressings) Apply to Right Lower Leg topically every evening shift every 4 day(s) related to RASH AND OTHER NONSPECIFIC SKIN ERUPTION; EDEMA."</p> <p>Note: The wound dressing was scheduled to be changed 3/2/14, however "other/see progress note" is coded.</p> <p>A physician note, dated 3/4/14, documented in part, "...Compressive dressings were noted to be intact. It was noted that the dressing to the right</p>	F 314		

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F 314	<p>Continued From page 23</p> <p>leg was not changed from previous visit which was eight days ago and dressing appears to be tight. Upon removal of dressing to right foot several lesions were noted... There was a cyanotic appearance to the foot upon removal of dressing which improved slightly over time. There was a purplish black lesion to the right fifth metatarsal head and base on the lateral aspect. The wounds are not opened and are not draining. Wound on the fifth metatarsal head measured 5.0 x 3.0 cm and the lesion to the metatarsal base measured 2.0 x 1.6 cm. There is a black lesion to the medial first metatarsal head as well, no open wound. The lesion measured 1.4 x 1.4 cm. There were two lesions to the dorsal aspect of the foot located at the anterior ankle joint these lesions measured 1.2 x 1.2 cm laterally and 0.4 x 0.4 cm medially. There is a black lesion to the right posterior heel. It is not open and is not draining. It has a central eschar which feels thin and malleable measuring 4.4 x 8.2 cm. There is no evidence of periwound erythema or ascending cellulitis... Several deep tissue injuries right foot... Pressure ulcer unstageable... The wounds to the right lower extremity were treated with skin repair cream. They were then offloaded with restalin foam and a posterior heel cup, in addition to the offloading boot, and were dressed with a dry sterile dressing consisting of kerlix and an ace bandage applied loosely. Orders were written for all wounds to the right foot to be dressed with Granulex, gauze, offloading foam and dry sterile dressing to be changed daily... Podiatry will follow."</p> <p>The resident's Medication Review Report (Physician Recapitulation orders), dated 3/12/14, documented in part: -"Blue Heel Float Boots when out of bed every shift...;</p>	F 314		

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F 314	<p>Continued From page 24</p> <ul style="list-style-type: none"> -D/C [discontinue] Foot Board to bed; -D/C Foot tent; -Dress all wounds to right foot and ankle with granulex spray and dry sterile dressing daily. Every day shift for Venous Insufficiency To apply, spray granulex onto gauze and apply to wound. Offload wounds with foam padding, wrap with kerlix and ace bandages. On hold from 03/03/2014 to 03/06/2014; -Elevate foot rest every shift related to pressure ulcer unstageable; edema Elevate the foot pedals/leg rests to ensure that the resident's foot do [sic] not touch the floor while up in the wheelchair. Right heel is not to touch the foot rest; -Heels to be offloaded while in bed by using pillow or bolster pad under legs and allowing heels to hang every shift for Venous insufficiency; -Monitor left leg to ensure compression dressing is not too tight. every shift for Venous insufficiency; Discontinued 3/4/14; -Offload right leg while in wheelchair. Right heel cannot rest on foot pedal. Consult PT [physical therapy] if necessary to help accomplish this. every day and evening shift for Venous Insufficiency; and - Zinc Oxide Ointment 20% and Triamcinolone Cream 0.1% to affected areas to lower left leg BID [twice daily] two times a day related to other peripheral vascular disease." <p>The resident's IDPN documented in part: -3/4/14, "[Resident's physician] was in to see rstd [resident] today and change dressings, new order received, 1)Dress all wounds to right foot and ankle with granulex spray and dry sterile dressing daily...3)DC [discontinue] compression dressings to right leg...;</p> <p>-3/5/14 at 7:07 AM, Late entry: On 3-2-14</p>	F 314			

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F 314	<p>Continued From page 25</p> <p>Capillary refill was checked on the left and right foot of resident with a refill time of 4+ seconds per foot and the resident denied any pain to legs and feet;</p> <p>-3/5/14 at 9:05 AM, R[ight] lower extremity malleolus and lower, multiple areas of suspected deep tissue injury. No open areas at this time;"</p> <p>On 3/7/14, the Medical Director documented in part, "...On 3/02/14, the dressing was not changed and on 3/4/14, it was found that the resident developed multiple areas of a deep tissue injury related to the 2 layer compression wrap as well as his underlying vascular condition (PAD) [peripheral arterial disease] ...Multiple areas of deep tissue injury as described above secondary to 2 layer compression wrap. The initial recommendations for a 2 layer compression wrap were appropriate due to venous insufficiency and his underlying medical condition. The deep tissue injuries were related to Med error as well as patient's refusal of cares and medication."</p> <p>Note: The physician documented the resident refused medication, treatment, transfers to bed, incontinence care and placing pillows under his feet. He did not document the resident refused wound care or wrap changes, nor did the interdisciplinary notes or the wound care notes document the resident refused the ordered dressing change.</p> <p>The resident's IDPN documented in part: -3/9/14 at 9:40 PM, "Measurements for wounds on right foot done on 3/8/14. 6cm x 5cm, center of area is black with red around the edges. Area improving slowly. Area on interior side of the foot 6.3cm x 1.2cm, black with red and pink edges. Exterior side of foot 4cm x 1cm black areas with</p>	F 314		

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F 314	Continued From page 26 red and pink in the middle of the wound. All areas improving slowly. No areas are open all are closed; -3/10/14 at 1:48 PM, [The resident] has multiple ischemic-type wounds to his right foot. There is a pressure component as well as arterial insufficiency, and peripheral vascular disease, using a Doppler, the pulses are faint and difficult to find. The resident has a history of refusing treatment, medications and cares. The medication refusals of the Lasix, led up to a weeping stasis dermatitis, with 4+ pitting edema. treatment for this condition was 2 layer compression wraps changed by the physician on 2/24/2014, and again on 3/4/2014. The 4th day wrap change was not completed on 2/28. Although cap refill and general observation was conducted, x2 by licensed staff. As a result of this when the wraps were changed on 3/4 several dark ischemic areas were noted. These were classified as deep tissue injuries, of a mixed etiology, including pressure, arterial insufficiency and peripheral vascular disease. [The resident's physician] is in today to assess and treat the right foot of [the resident]. We are continuing frequent turns, heel floating, and the foot board and foot cradle have been removed per [the resident's physician] order. There is a marked improvement in the resident's skin tone, and +2 capillary refill, that was assessed this morning. Please see [the resident's physician] dictation as it becomes available." On 3/10/14, the resident's physician documented in part: "...Patient was seen on entering the facility sitting in his wheelchair with the right foot resting on the footpedal of his wheelchair. Orders were specifically written for patient to be completely nonweight bearing to this foot including resting his	F 314			

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F 314	<p>Continued From page 27</p> <p>foot on the foot pedal of his chair... Wounds to the right foot have all began draining serosanguinous fluid... Upon debridement of the wounds medially and laterally they were noted to be partial thickness with no evidence of purulence or ascending cellulitis... Several deep tissue injuries right foot [sic] upon debridement are stage II ulcers. Unstageable ulcer right heel... Discuss with nursing staff the importance of following orders exactly. The foot pedal on the patient's wheelchair was removed and replaced with a device which allows the patients leg to rest on the stirrup but allows the heel to float..."</p> <p>The facility conducted an investigation of the incident and reported it to the Bureau of Facility Standards on 3/7/14 at 9:00 AM. That report, and included in part, "...In the process of checking these orders, and treatments, it was found that [LN #9], on 2/26/14, while working the cart on the East Hall, had not done the dressing change. She had entered a "9" [Note: "9" indicated see note] and the follow-up note read: that the dressing was to be done by [resident's physician]. She made a medication error in the treatment, by not reading the actual order to ensure it was completed. So the treatment did not occur... On 3/2/14 [LN #10], also marked a "9" indicating that the treatment had not occurred, due to "no supplies". The supplies were in a cabinet placed outside the supply room. He had not seen them. The medication error occurred because the dressing was not changed. A subsequent meeting with LN #10 this AM, indicated that he had not thought of removing the dressing, had not notified the physician, and had not included the supply issue in the 24 hour report. There were no emails to supply asking for wraps. LN #10 failed to recognize the underlining [sic] vascular condition</p>	F 314		

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F 314	<p>Continued From page 28</p> <p>of the legs. He also failed to notify management of the missing equipment, and he failed to notify management or supply of the dressing being held. Upon removing the wrap, [the resident] had a degradation in skin condition. There were multiple areas of deep tissue injury, with no open wounds. New treatment orders were written, and the compression wraps were [discontinued]... Medication error reports were completed. Staff members were individually counseled on the application of compression wraps and their potential to cause an increased risk in skin integrity impairment, particularly for those who have predisposing diagnosis that are associated with impaired circulation."</p> <p>On 3/12/14 at approximately 1:45 PM, the DNS was interviewed and stated the resident had periodically refused his medications. He said, "That's why we ended up doing the treatment of two part compression wraps on the 18th of February. [The resident's physician] was managing the left leg wraps and he would look at the right leg too when he was here. Then we had a med[ication] error. We did an investigation and reported it to the State... I classified it as vascular even though it obviously has a pressure component... He didn't have pressure on his heels before..." When the DNS was asked if he believed Resident #1's pressure wounds were preventable he said, "I don't think that he would have had a pressure injury if the wraps were taken care of, but with all of the other medical issues, we don't know."</p> <p>Additional information was received by the facility on 3/17/14 at 4:35 PM. Although the narrative and documentation contained information the resident has had a pressure ulcer on his heel and left</p>	F 314			

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F 314	Continued From page 29 lateral foot in 2012, he did not have documented pressure sores prior to the initiation of the pressure wrap on 3/4/14 to his right foot and ankle. Per the interpretive guidance at F314, "... the resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing." The narrative written by the facility documented, "The medical director's notes indicated that extreme caution should be taken when applying compression wraps." This was not carried out by the facility. The facility did not consistently document capillary refill, sensation or color of the feet, and the ordered dressing change was missed by the facility making the dressing change late by four days. Additionally, on 3/10/14, the physician documented the facility was not following orders to facilitate wound healing for the resident when he observed the resident's right heel resting on the foot rest. The facility documented, "During the time that the wraps were on the the patient refused medications and treatments as well as ADL cares." This was not supported by the documentation provided or facility treatment logs. There was no indication the resident refused dressing changes or cares at the time the pressure wrap dressing was missed. 2. Resident #6 was admitted to the facility on 2/6/14 with diagnoses which included schizoaffective disorder, bipolar disorder and generalized osteoarthritis. The resident's admission MDS, dated 2/13/14, documented: -BIMS (Brief Interview Mental Status) score: 11 - Moderately impaired. -Rejection of care- Behavior not exhibited. -Bed Mobility: 3-3 Extensive assistance, 2 person	F 314			

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F 314	<p>Continued From page 30</p> <p>assistance.</p> <p>-Functional limitation in range of motion- Upper extremity: both sides. Lower extremity: both sides.</p> <p>-Risk of pressure ulcers-Yes.</p> <p>-Unhealed pressure ulcers- Stage 1 or higher- No.</p> <p>The resident's Braden scale -For Predicting Pressure Sore Risk, dated 2/6/14, documented: -Score: 20.0. Category: NA (not applicable).</p> <p>The resident's Admit/Annual Nursing Assessment dated 2/6/14, documented: -Skin- "Foot Problems: No." -Illustrate skin lesion, bruises, amputations, Etc: "3+ edema" (lower legs), "Bruising" (right and left back side of forearm, and left side of upper back), "scab .5 x .2" (forehead) and "Scratch to back of left ear."</p> <p>The resident's Physician Active Orders, date range, 2/6/14 -3/31/14, documented: -"Offload B/L[bilateral] heels with bolster pad to allow heels to hang. Off load heels with offloading boots. every shift for blister." Revision date: 2/25/14 -"Order Granulex. Dress wound to right heel with Granulex, 4 x 4 gauze and kerlix. Change every other day. OK to substitue [sic] granulex with bacitracin until granulex arrives. every day shift every other day for Blister." Revision date: 2/25/14 -"Weekly Skin Assessments as needed for prophylaxis on shower day." Revision date: 2/6/14.</p> <p>The resident's Physician phone order, dated 3/13/14, documented:</p>	F 314		
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F 314	Continued From page 31 -"Offload bilateral heels with bolster pad while in bed. Heel float boots to be worn at all times." NOTE: The order for "Heel float boots to be worn at all times" was obtained after the boots were not consistently implemented, and the surveyor brought the concerns to the facility's attention. The resident's Care Plan documented: *Focus: "The resident has potential for impairment to skin integrity r/t [related to] edema, fragile skin, and immobility. "Date initiated: 2/21/14. *Interventions: -"Identify/document potential causative factors and eliminate/resolve where possible. "Date initiated: 2/21/14. -"The resident needs pressure reducing mattress to protect the skin while IN BED. [sic]" Date intimated: 2/21/2014. *Focus: "I require extensive, assistance in most care area R/T Musculoskeletal impairment, Activity Intolerance, Limited Mobility, Confusion, Impaired balance." Date initiated: 2/16/14. *Interventions: "The resident requires Skin inspection when providing cares and on bath days. Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse. "Date initiated: 2/21/14. NOTE: The resident's care plan did not document the physician ordered interventions dated 2/25/14, for the bolster pad to float bilateral heels and the offloading boots. The interventions documented in a Skin/Wound Progress note dated 2/23/14, to turn every 2 hours and prn (as needed), was not documented in the care plan. The Physician progress note, dated 2/24/14, documented:	F 314		

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F 314	<p>Continued From page 32</p> <p>-Chief complaint: "Blister right lateral heel."</p> <p>-Subjective: "Staff had noted over the weekend during a routine skin examination that a blister had formed on the lateral aspect of the right heel. Nursing placed the patient in a heel cup and offloading boots to offload the lesion. Nursing noted the patient usually wears slippers and does not wear shoes."</p> <p>-Objective: "Dermatologic: There is evidence of a trained blister to the lateral aspect of the patient's right foot measuring approximately 2 x 2 cm. [centimeters] some purpleish [sic] discoloration noted to the center of the wound. There is no evidence of lesions on the contralateral extremity."</p> <p>"Musculoskeletal: Rigidity noted to knee and hips with range of motion. Pain was elicited with internal rotation at bilateral hips. feet naturally rest and [sic] abducted position which appears to be cause of pressure/friction to the location of the lesion."</p> <p>-Assessment: "1. Friction blister vs. Deep tissue injury right heel. Diagnoses: Blister. Pressure ulcer, unstageable."</p> <p>-Plan:</p> <ol style="list-style-type: none"> "Patient was seen and evaluated." "The wound was dressed with bacitracin, dry sterile gauze and Kerlix." "Orders were written for Granulex spray and dry sterile dressing to be applied to wound QOD [every other day]." "Orders were written for feet to be offloaded in offloading boots and bolster which will allow feet to float freely and not touch the bed." "Will follow." <p>The resident's weekly skin and wound assessment form dated 2/27/14 at 7:33 pm, documented:</p>	F 314		

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F 314	<p>Continued From page 33</p> <p>-Site: "Right heel." Type: "Blister." Length, Width, Depth: "2 cm x 2 cm." Stage: "Unstageable." -Care plan has been updated: The box was not checked.</p> <p>The resident's IDTP notes documented: *2/23/14 at 6:42 am - Skin/wound Progress note: "Wound location and Etiology: outer aspect of right heel. Assessment: 2 cm x 2 cm intact blood blister. no s/s [signs or symptoms] infection. no odor. no drainage. no pain." *2/23/14 at 1:40 pm - Nursing Note: "new blister found to right heel this am. hard, intact blister measures 2.1 cm by 2.2 cm and is not raised from the surface of the dermal layer surrounding it. denies pain to site. off load boots used to bed as resident calls for assistance with all transfers." *2/24/14 at 2:24 am - Nursing Note: "area to right heel conts [continues] to be healing well with no s/s of infection. no odor. no drainage. no c/o [complaint of] pain to site. cont to relieve pressure to right heel while in bed. cont to turn every 2 hours and pm [as needed]. will cont to monitor." *2/24/14 at 10:34 pm - Nursing Note: "Dr. [physician's name] was in to see rsdt. [resident], new orders received,... Off load B/L heels with bolster pad to allow heels to hang..." *2/25/14 at 7:46 pm - Orders-Administration Note: "Bolster pad not arrived yet." NOTE: This note was written approximately 24 hours after the new Physician order was received on 2/24/14 at 6:55 pm. *2/26/14 at 2:53 pm - Nursing Note: "Resident with dressing change to blister site on right heel. blister intact, 2 x 2.2 cm, no drainage." *2/26/14 9:23 pm - Orders-Administration Note: "Off load B/L heels with bolster pad to allow heels to hang. Off load heels with offloading boots. every shift for blister. not arrived yet."</p>	F 314		

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F 314	<p>Continued From page 34</p> <p>NOTE: This note was written over 48 hours after the new Physician order was documented.</p> <p>*2/27/14 at 2:27 am - Nursing Note: "bolster pad in place. heels off loaded bilat[eral] r/t right heel blister. drsg [dressing] to right heel CD&I [clean, dry and intact]. No odor. will cont to monitor."</p> <p>*3/2/14 at 2:21 pm, Skin/Wound Progress Note: "Assessment: Resident with intact blister at 2 x 2.5 cm. No noted drainage. skin texture like leather. resident compliant with use of float boots and heel lift cushion."</p> <p>NOTE: The blister increased in size from initial 2 x 2 cm to 2 x 2.5 cm. The noted increase in size was approximately 9 days after the wound was first observed by staff and 7 days after the MD had ordered the heel lift cushion, and offload boots.</p> <p>*3/7/14 at 2:02 pm - Skin/wound Progress note: "Assessment: Skin check completed in shower. Resident continues with treatment to right heel blister, area intact. blister roof with leather feel. size 2 x 2 cm. resident compliant with heel float boots."</p> <p>The resident's Physician progress note dated 3/10/14, documented:</p> <p>-Chief complaint: "Follow up of lesion to right lateral heel."</p> <p>-Subjective: "Resident was seen today for follow-up of lesion to his right lateral heel."</p> <p>-Objective: "Dermatologic: There is still evidence of a drained blister to the lateral aspect of the patients right foot measuring approximately 2 x 2 cm. Some purpleish [sic] discoloration noted to the center of the lesion. While there is still subepithelial blood noted to the lesion, the lesion is essentially healed and is now primarily hyperkeratotic tissue."</p> <p>-Assessment: "1. Friction blister vs. Deep tissue</p>	F 314		

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F 314	<p>Continued From page 35</p> <p>injury right heel mostly resolved." -Plan:</p> <ol style="list-style-type: none"> "Patient was seen and evaluated." "Continue offloading measures." "Continue use of Granulex and dry sterile dressing." <p>On 3/11/14 at 8:15 am, the resident was in his w/c in his room. The resident's right foot had a blue offload boot in place. When the resident was asked about the boot, he stated, "It has a red spot on it."</p> <p>On 3/11/14 at 9:24 am, the resident was in bed asleep. The resident had blue offload boots to bilateral feet. The blue wedge pillow was behind the back of the legs, both feet were resting directly on the bed.</p> <p>On 3/11/14 at 12:39 pm, the resident was at the nurse's station watching television. The right foot had a blue offload boot in place. The right foot was in a dependent position resting on the w/c (wheelchair) foot rest.</p> <p>On 3/11/14 at 1:45 pm, the resident was awake in bed. The resident had a blue offload boot on the right foot. The wedge pillow was in place and bilateral heels were floated. When the surveyor asked the resident was if he had pain in the right heel he stated, "No."</p> <p>On 3/11/14 at 3:24 pm, the resident was in bed asleep. The resident had blue offload boots to bilateral feet, and the heels were floated off the wedge pillow.</p> <p>On 3/12/14 at 11:14 am, the resident was up in his w/c at the nurse's station with an offload boot</p>	F 314			

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F 314	<p>Continued From page 36 in place, on the resident's right foot.</p> <p>On 3/12/14 at 2:55 pm, the resident was awake in bed. The right foot had a blue offload boot on it and the left foot had a sock. The blue wedge was positioned below the knees of the resident's legs, both feet were directly on the bed. The resident was asked if he had pain in the right heel he stated, "Sometimes I can feel it."</p> <p>On 3/12/14 at 3:10 pm, LN #6 was asked about the pressure sore to the resident's right heel, she stated, "We had a blister show up on that heel. Dr. [physician's name] was the attending [physician] for it. It's like a callous on the heel part. It had fluid but it sealed itself." When asked what caused it, the LN #6 stated, "Initially when he came here he slept with his feet filleted." The LN #6 then demonstrated the heels together with the feet out.</p> <p>On 3/12/14 at 4:25 pm, the resident was asleep on his right side. The right foot had a blue offload boot in place, and the left foot had a white sock on it. The blue wedge pillow was directly under the feet and the heels were resting on the wedge pillow. At 4:27 pm, the RN Manager LN #7, observed the position of the feet and agreed the heels were not floated. LN#7 was unable to adjust the wedge pillow to float the heels and stated she would get a CNA to help her.</p> <p>On 3/12/14 at 5:05 pm, the surveyor observed the resident in his w/c in the dining room. The resident's blue offload boot was off of the resident's right foot and was on the floor behind the w/c's foot peg. The right foot was resting on the w/c's foot peg with a white sock on. LN #8 approached the resident and stated, "[Resident's</p>	F 314			

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	<p>Continued From page 37</p> <p>name] can I put your boot back on," and the resident stated "Yeh."</p> <p>On 3/13/14 at 8:10 am, the resident was asleep on the right side. The resident's bilateral feet had socks on them, the offload boots were not in place. The blue wedge pillow was positioned just below the resident's knees, and both feet were in direct contact with the bed. At 8:15 am LN #7 verified the placement of the feet and the missing boots with the surveyor. LN #6 entered the room and stated, "I was under the understanding if the heels are floated, we did not need the boots."</p> <p>On 3/13/14 at 8:39 am, LN #7 discussed the order for the boots and the wedge with the surveyor. LN #7 stated, "The order was more general and the nurses read more in to it. I am getting a clarified order that will state at all times," for the use of the boots. When asked if the care plan had been updated since the new wound to the heel, LN#7 stated, "It wasn't updated and I am going to do that."</p> <p>On 3/13/14 at 9:40 am, LN#6 was observed changing the dressing to the right heel pressure ulcer. LN #6 stated the dressing change is, "every other day." After touching the area, LN#6 stated, "it is leathery." LN#6 then measured the wound and stated it measured, "3 cm long by 2 cm wide, purple edges, yellow center, with one point where the purple comes to the center." NOTE: the wound had increased from the initial assessment of 2 cm x 2 cm to 3 cm x 2 cm.]</p> <p>Resident #6 was discovered with blister to the right lateral heel on 2/24/14 that measured 2cm X 2cm. On 2/25/14, Resident #6 's physician ordered relief of pressure to the resident ' s</p>				

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F 314	<p>Continued From page 38</p> <p>bilateral heels via a bolster pad and that offloading (pressure) boots were to be on the resident ' s feet every shift, as well as whenever the resident was in bed. None of these interventions ordered by Resident #6 ' s physician were included in the resident ' s Care Plan, and IDT Notes documented the bolster pad, ordered by the resident ' s physician on 2/25/14, was not put into place until 2/27/14, two days after it was ordered. On 3/13/14, the wound was documented as measuring 3 x 2cm. During the facility ' s annual recertification and licensure survey, surveyors observed Resident #6 without one or more of the physician-ordered pressure-relieving interventions in place on nine separate occasions.</p> <p>3. Resident #7 was admitted to the facility on 8/6/08 with diagnoses which included myasthenia gravis, osteoporosis and depressive disorder.</p> <p>The resident's Quarterly MDS, dated 1/20/14, documented: -BIMS score: 9 - Moderately impaired. -Rejection of cares- Behavior not exhibited. -Functional limitation in range of motion- Upper extremity: both sides. Lower extremity: both sides. -Risk of pressure ulcers- Yes. -Unhealed pressure ulcer- No.</p> <p>The resident's Braden Scale- for Predicting Pressure Sore Risk, dated 10/19/13, documented: -Score- 14: Moderate risk.</p> <p>The resident's Physician phone order, dated 2/10/14 at 2:16 pm, documented:</p>	F 314			

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F 314	<p>Continued From page 39</p> <p>-"Clean area to inner left little finger, apply small piece of medihoney, apply tape to hold in place. Change twice a weel [sic] on Mondays and Fridays every day shift every Mon., Fri for open wound."</p> <p>The resident's Physician phone order dated 2/13/14 at 2:23 pm, documented: -Finger separator is to be on at all times, to be removed for skin check every shift. every shift for Prophylaxis."</p> <p>The resident's Physician Progress note, dated 3/5/14, documented: -Physical Exam: "His hands show contractures. He recently had a small ulceration between the webspace of the fifth and fourth digit. This is healed and he has had a new brace fitted."</p> <p>The resident's Care Plan documented: *Focus: "The resident has an ADL [activity of daily living] self-care performance deficit r/t Dementia, Limited ROM [range of motion], Limited Mobility, Disease Process myasthenia gravis, confusion, and depression." Date initiated: 10/23/13. *Interventions: -"Contractures: The resident has limited mobility in both upper and lower extremities. Provide skin care q [every] shift to keep clean and prevent skin breakdown." Date initiated: 10/23/13.</p> <p>*Focus: "The resident has potential for pressure ulcer development r/t disease process, diabetes, Immobility, anticoagulant therapy, IVIG (Intravenous immune globulin) therapy, and incontinence.: Date initiated: 10/23/13. Revision on: 1/2/14. *Interventions:</p>	F 314		

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F 314	<p>Continued From page 40</p> <p>-Follow facility policies/protocols for the prevention/treatment of skin breakdown." Date initiated: 10/23/13.</p> <p>-Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate." Date initiated: 10/23/13.</p> <p>*Focus: "The resident has limited physical mobility r/t contractures." Date initiated: 1/2/14</p> <p>*Interventions:</p> <p>-Assist resident with supportive device to L [left] upper extremity-on for 2 hours during the day." Date initiated: 3/3/14</p> <p>-Has 'carrot' to left hand, bigger side of carrot to pinky finger. On at all times, can be taken off for showers, or for NSG [nursing] to assess skin." Date initiated: 3/11/14.</p> <p>The resident's IDT (Interdisciplinary Team) Progress note documented: * Date 2/10/14 at 2:04 pm. Type: Skin/ Wound Progress note.</p> <p>-Wound Location and Etiology: "Right little finger." -Assessment: "Noted an open wound that is 1 cm(centimeter) x 0.4 and less than 0.1 cm deep. Area has small amount of exudate with some red granulated tissue, edges are dry." -Recommendations: "New order to clean area, cover with small piece of Medihoney with tape over change twice a week."</p> <p>The resident's weekly skin and wound assessment documented: *Date 2/10/14 at 2:11 pm. -Site: "left little finger" -Type: "Pressure" -Units of measure: centimeters: L(length) "1 cm," W(width) "0.4," D(depth) "<(less than) .1," Stage</p>	F 314			

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F 314	<p>Continued From page 41</p> <p>"II."</p> <p>-Description: "open wound that is 1 cm x 0.4 and less than 0.1 cm deep. area has small amount of exudate with some red granulated tissue, edges are dry."</p> <p>[NOTE: The IDT note stated right finger and the weekly skin and wound assessment of the same date stated left finger.]</p> <p>*Date 2/18/14 at 8:39 am. -Site: "Right little finger" -Type: "Pressure" -Units of measure: centimeters: L "1," W "0.4," D "0," Stage "II."</p> <p>-Description: "Right little finger are [sic] is scabbed over, no S/s infection noted. No redness. No drainage noted."</p> <p>*Date 2/28/14 at 7:46 pm. -Site: "left little finger." -Type: "Pressure" -Units of measure: centimeters: L "1," W "0.4," D "<0.1," Stage: "II." -Description: "Left little finger- bed of wound has pinkish tissue forming, edges are dry. No drainage, redness or odor noted. Improving." [NOTE: The weekly skin and wound assessment dated 2/18/14 and 2/28/14 had different sites for the wound.]</p> <p>On 3/11/14 at 2:00 pm, the resident was in bed awake, with the blue carrot clenched in his left hand. The left pinky finger had a band aid in place. The resident was asked if he had pain to the finger he stated, "No."</p> <p>On 3/12/14 at 9:57 am, the surveyor observed Restorative LN#11 and CNA #12 repositioning the resident in bed. The resident had blue boots on</p>	F 314			

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F 314	<p>Continued From page 42</p> <p>bilateral feet and a blue carrot in the left hand. When the surveyor asked LN#11 what she knew about the pressure ulcer to the resident's left hand, the LN stated, "He had a soft splint that went between his fingers, it was thicker. They have another splint for him, but are waiting til the wound heals." The LN was asked about the contractures of the left hand, the LN#11 stated, "Yes, his fingers are so tight and contracted." When LN#11 was asked how long he had the splint prior to the wound, LN#11 stated "I am not sure," while CNA#12 stated, "he has had several."</p> <p>On 3/12/14 at 4:35 pm, LN#11 was asked if the resident was part of the Restorative program, the LN stated, "OT [Occupational therapy] was working with him with the braces/splints. The RNA [Restorative Nursing] program was not involved with the brace prior to the pressure sore. The RNA got involved after it appeared. It was decided to have us check the carrot daily." At 4:53 pm, LN#11 approached the surveyor and stated, "It was the plan of correction," to have Restorative involved in the resident's care when the pressure ulcer was found.</p> <p>On 3/13/14 at 9:29 am, the surveyor observed LN#13 changing the Band-Aid to the resident's left pinky finger. The wound was at the base of the inner aspect of the pinky finger, with a pink base. LN#13 stated, "It's considerably smaller than it was." When asked if she was going to measure the wound LN#13 stated, "It's measured once a week. We measure wounds on Monday." LN #13 then applied Medihoney dressing with a band aid to the area.</p> <p>On 3/13/14 at 9:34 the LN #7 was asked what</p>	F 314			

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F 314	Continued From page 43 caused the pressure ulcer to the left pinky finger, the LN#7 stated, "We noticed the hand was contracting. OT provided the splint and 2 days after applying it, when he had a bath the blister was noticed. We discontinued the splint. OT is still working with him with the contractures. The brace wrapped around the fingers." On 3/13/14 at 4:30 pm, the Administrator, DON, and RN Manager were notified of the findings. On 3/17/14 an e-mail was recieved from the facility with additional information. The additional information did not resolve the issues.	F 314			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure two residents received interventions to prevent a decrease in range of motion (ROM). This was true for 2 of 13 (#s 1 & 5) sampled residents who had the potential to sustain harm when they did not receive services necessary to prevent the deterioration of existing ROM limitations. Findings include: 1. Resident #5 was admitted to the facility on	F 318	F 318 Scope and Severity of a D Increase/Prevent Decrease in range of motion. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents 1 and 5 have both been placed in the Restorative Program by the Restorative Nurse. 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. The Restorative Nurse will complete a screen of all residents not on restorative program and/or therapies to determine if placement on the Restorative program would be beneficial. In addition, the Restorative Nurse will in service all Licensed Staff and CNAs in range of motion procedures.		

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F 318	<p>Continued From page 44</p> <p>7/24/09 with diagnoses of congestive heart failure, depressive disorder, and dementia condition classified elsewhere with behavior disturbance.</p> <p>The 2/10/14 quarterly MDS assessment documented the resident required extensive assistance with transfers, was no longer able to ambulate and range of motion impairment to both lower extremities. The MDS documented the resident was not receiving ROM</p> <p>The most recent care plan, dated 1/3/14 documented, "The resident has limited physical mobility [related to] weakness." One of the interventions was, "Provide gentle range of motion as tolerated with daily care." NOTE: The intervention did not include any parameters of how often or what part of the body required ROM therapy.</p> <p>The resident's record lacked documentation that the resident was receiving any ROM therapy.</p> <p>The Rrestorative LN was interviewed on 3/13/14 at 8:15 a.m. about ROM for the residents. She stated Resident #5 did not have a formal restorative program, but staff were to be providing the resident with ROM during cares. The Restorative LN stated the facility did have an EMR system to document ROM. It was not set up for CNAs to document on residents who were not on formal restorative programs.</p> <p>When interviewed on 3/13/14 at 8:45 a.m., the DON said the restorative program had been discontinued in October 2013. The program was restarted in February 2014. He further said not everyone who needed ROM was getting it, but</p>	F 318	<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>The Restorative Nurse and all nursing staff will monitor for resident declines by using the MDS, assessments and observations as their tools. Recommendations for Restorative program will be made and reviewed by the Restorative Nurse.</p> <p>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.</p> <p>The Restorative Nurse or designee will review a minimum of five residents not on a program weekly for 30 days (four weeks), bi-weekly for an additional 30 days (2 weeks) and then monthly for an additional thirty days. All results will be reported to QA for three months to ensure compliance</p> <p>Dates when corrective action will be completed.</p> <p>April 1, 2014</p>	4/1/14	

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F 318	<p>Continued From page 45</p> <p>that he understood resident care plans needed to specify frequency and number of repetitions. No further information was provided by the facility that resolved this finding.</p> <p>2. Resident #1 was admitted to the facility on 4/13/11 with multiple diagnoses which included dementia, edema, and peripheral vascular disease.</p> <p>Resident's #1's Quarterly MDS, dated 10/7/13, documented in part: -Was moderately cognitively impaired; -Required extensive assistance with 2 or more staff for bed mobility, transfers, and toilet use; -Rejected cares occasionally; and -Had impaired range of motion to upper and lower extremities to both sides.</p> <p>Resident #1's Annual MDS, dated 1/6/14, documented in part: -Was moderately cognitively impaired; -Required extensive assistance with 2 or more staff for bed mobility, transfers, and toilet use; -Did not reject cares; -Had impaired range of motion to upper and lower extremities to both sides; and -Was not in physical therapy, occupational therapy or restorative nursing programs.</p> <p>The resident's Care Plan documented in the focus area initiated on 1/3/14: "The resident has an ADLself-care deficit [related to] dementia, limited ROM, activity intolerance, limited mobility, CHF [congestive heart failure], HX [history of] prostate cancer and anemia, impaired balance. Goals are: [The resident] will be neat, clean and appropriately dressed on a daily basis through next review date. Revised 1/9/14." Interventions</p>	F 318			

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F 318	<p>Continued From page 46 included, in part:</p> <ul style="list-style-type: none"> - "Bathing/Showering: The resident requires extensive assistance) [sic] by 1-2 staff with showering 2 times/week and as necessary (1/3/14); -Toilet use: The resident requires extensive to total assistance) [sic] by 1-2 staff for toileting (1/3/14); -Dressing: The resident requires extensive assistance to total assistance) [sic] by 1-2 staff to dress (1/3/14); -Bed mobility: The resident requires extensive assistance) [sic] by 1 staff to turn and reposition in bed frequently and as necessary (1/3/14), The resident uses bilateral transfer bars to maximize independence with turning and repositioning in bed (1/9/14); -Transfer: The resident requires extensive assistance) [sic] by 1-2 staff to move between surfaces frequently and prn [as needed] (1/9/14), The resident uses bilateral transfer bars to maximize independence with transferring (1/9/14); -[The resident] uses bilateral transfer bars to assist with bed mobility, transfers, and changing his clothes (1/9/14); -[The resident] has limited mobility to his lower extremities. Provide skin care daily to keep clean and prevent skin breakdown (1/9/14); and -PT/OT [physical therapy and or occupational therapy] evaluation and treatment as per MD [physician] orders (1/9/14)." <p>The resident's Care Plan documented in the focus area initiated 1/3/14: "The resident has limited physical mobility r/t [related to] CHF, Weakness. Goals are: The resident will increase level of mobility by ([sic] decreased dependence on staff for locomotion on unit through the next</p>	F 318		

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F 318	<p>Continued From page 47</p> <p>review date; and The resident will remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown, fall related injury through the next review date."</p> <p>Interventions included, in part: -"Resident has bilateral transfer rails on bed to assist with bed mobility (3/4/14); -Locomotion: The resident requires extensive to total assistance) [sic] by 1 staff for locomotion using a wheelchair. At times he is able to self propel his wheelchair (1/9/14); -Activities: Invite the resident to activity programs that encourage physical activity, physical mobility, such as exercise group, walking activities to promote mobility (1/9/14); -Monitor/document/report PRN any [signs or symptoms] of immobility: contractures forming or worsening... (1/9/14); -Provide gentle range of motion as tolerated with care (1/9/14); -Provide supportive care, assistance with mobility as needed. Document assistance with mobility as needed (1/9/14); and -PT, OT referrals as ordered, PRN (1/9/14)." NOTE: The intervention failed to include any parameters for how often or what part of the body required ROM therapy.</p> <p>The resident's record did not include any documentation recording the provision of "Gentle range of motion with care" as required by Resident #1's 1/3/14 Care Plan.</p> <p>On 3/13/14 at 9:05 AM, The surveyor asked CNA #14 and #15 how they perform gentle ROM with cares for Resident #1. Staff #14 said, "Restorative does that, they have one nurse and</p>	F 318		
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F 318	Continued From page 48 two aids who do that... When we dress him we do ROM with that." When asked how they performed ROM for the resident, Staff #15 said, "We lift his arms to get him dressed." Both staff members stated they did not document ROM for the resident. On 3/13/14 at 11:15 AM, LN #8 was asked how "gentle range of motion" was provided for Resident #1. She stated, "Gentle ROM would include getting dressed and sitting at the bed with transfers. Him sitting up and lifting his feet for boots or shoes would be part of it too." The DNS stated, "[The resident] has skin issues and can be harmed with lots of ROM... Reaching over in bed and reaching out for transfers is also considered gentle range of motion." When asked how restorative programs and "Gentle ROM" differ, the DNS stated, "For Gentle ROM, no minutes are recorded, the time span is different." LN #8 stated, "There is no structure to it. It encompasses all the things he does during the day to take care of him." When asked why the resident was not in a structured restorative program the DNS stated, "He is not in the restorative program because the nurse is maxed out." On 3/13/14 at 4:00 PM, the Administrator, and DNS were informed of the findings. No further information or documentation was received from the facility regarding this issue.	F 318			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323	F 323 Scope and Severity of E Free of Accident Hazards, Supervision, Devices.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2014
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - LEWISTON		STREET ADDRESS, CITY, STATE, ZIP CODE 821 21ST AVENUE LEWISTON, ID 83501		
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F 323	<p>Continued From page 49 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview it was determined the facility failed to ensure the residents' environment was as free of accident hazards as was possible, when equipment that was not in use was blocking handrails in the West wing hall, and the resident smoking area did not have equipment to extinguish a fire should one start, this was true for 4 of 15 sampled residents (#6, 7, 8, 10), 2 random residents (#22, 23) and other residents that would use the West wing hall for independent mobility. This deficient practice created the potential for harm should the resident, slip, trip or fall in the West wing, or catch on fire in the smoking area. Findings included:</p> <p>1. On 3/13/14 at 10:25 am, during the Environmental tour, the resident smoking area was observed. The area did not have a fire extinguisher or a smoke blanket. When asked about these 2 items, the maintenance manager stated, "The closet one is right here in the hallway." The manager took the surveyor into the building and down the North hallway, which revealed a fire extinguisher. The manager then continued to the Nursing station and revealed a second fire extinguisher. The manager agreed the fire extinguishers were greater than 20 feet from the outside smoking area.</p>	F 323	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>1) Fire extinguisher and fire blanket have been installed in resident smoking area by the Building Facility Foreman.</p> <p>2) All equipment blocking hallway access was removed by Building Facility Foreman.</p> <p>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.</p> <p>1) Fire extinguisher and fire blanket have been installed in resident smoking area by the Building Facility Foreman.</p> <p>2) All equipment blocking hallway access was removed by the Building Facility Foreman.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>1) Building Facility Foreman or designee will monitor the fire extinguisher and blanket during the monthly fire extinguisher inspection.</p>	

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F 323	<p>Continued From page 50</p> <p>2. NOTE: For the examples below, unless it is states otherwise, the items that were "parked" on the West (W) hall were left unattended. The numbers behind the "W" are the rooms numbers.</p> <p>a) On 3/11/14 at 8:18 am: * A medication cart and housekeeping cart were parked between rooms W3 and W5; * A 4 bin laundry/garbage cart, a vital sign machine and a mechanical lift were parked between W7 and W9. This equipment blocked 3 of the 8 handrails on that side of the hall.</p> <p>b) On 3/11/14 at 9:30 am: * A medication cart was parked between W3 and W5; * A treatment cart was parked between W5 and W7; and * A mechanical lift was parked between W7 and W9. This equipment blocked 3 of the 8 handrails on that side of the hall.</p> <p>c) On 3/12/14 at 12:15 pm: * A charting computer cart was parked between W1 and W3; * A mechanical lift was parked between W3 and W5; * A housekeeping cart and 4 bin laundry/garbage cart were parked between W5 and W7; and * A treatment/charting cart was parked between W7 and W9. The equipment blocked 4 of the 8 handrails on that side of the hall.</p> <p>At that time Employee #21 was asked if the laundry/garbage cart was always parked in the hallway. Employee #21 stated, "Yes."</p>	F 323	<p>2) Staff will be in serviced by the Building Facility Foreman regarding the correct procedure for hallway storage and clearance.</p> <p>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.</p> <p>1) Building Facility Foreman or designee will do random audits weekly for 30 days (four weeks), bi-weekly for an additional 30 days (2 weeks) and then monthly for an additional thirty days. All results will be reported to QA for three months to ensure compliance.</p> <p>2) Building Facility Foreman or designee will do random audits weekly for 30 days (four weeks), bi-weekly for an additional 30 days (2 weeks) and then monthly for an additional thirty days. All results will be reported to QA for three months to ensure compliance.</p> <p>Dates when corrective action will be completed.</p> <p>April 1, 2014</p>	4/1/14	

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F 323	Continued From page 51 d) On 3/12/14 at 1:32 pm: * A charting computer cart was parked between W1 and W3; * A 4 bin laundry/garbage cart was parked between W3 and W5; * A mechanical lift was parked between W5 and W7; * A treatment/charting cart was parked between W7 and W9. The equipment blocked 4 of the 8 handrails on that side of the hall. e) On 3/12/14 at 2:55 pm: * A two- shelf cart with cups and pitchers in a rubber container was parked between the fire door and W1; * A snack cart was parked between W1 and W3; * A computer charting cart was parked between W3 and W5; * A mechanical lift was parked between W5 and W7; and * A treatment/charting cart was parked between W7 and W9. f) On 3/12/14 at 3:20 pm: * A computer charting cart was parked between W3 and W5; * A medication cart was parked between W5 and W7 and a LN was passing medications; * A treatment/charting cart was parked between W7 and W9; and * A mechanical lift was parked between W9 and W11. g) On 3/12/14 at 4:47 pm: * The vital sign machine and a computer charting cart were parked between W3 and W5;	F 323			

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F 323	<p>Continued From page 52</p> <ul style="list-style-type: none"> * The medication cart and the treatment cart were parked between W5 and W7; and, * A mechanical lift was parked between W9 and W11. <p>Resident #22 was propelling himself backwards up the hall from the Chapel to the Nurses station. Resident #22 was impeding traffic, due to the narrowed hallway, with Resident #23 walking, and another resident in a wheelchair that was propelling himself down the hallway following behind Resident #22.</p> <p>h) On 3/12/14 at 5:47 pm:</p> <ul style="list-style-type: none"> * The vital sign machine and a computer charting cart were parked between W3 and W5; * The medication cart and the treatment cart were parked between W7 and W9; and, * A mechanical lift was parked between W9 and W11. <p>Three of 8 handrails were blocked. Resident #22 was observed propelling himself backwards up the hall from the nurse's station to his room. The resident had to weave around the equipment to get to his room. When asked about propelling himself backwards down the hall, he stated, "I go down the hall that way all the time." When asked about having to go around the equipment, he stated, "I have to go around that all the time. I have trouble with my shoes." The resident pointed to the right foot which he propelled himself with, and stated, "It always falls off, so I go backwards."</p> <p>i) On 3/13/14 at 8:06 am:</p> <ul style="list-style-type: none"> * The computer charting cart was parked between the fire door and W1; 	F 323			

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F 323	<p>Continued From page 53</p> <ul style="list-style-type: none"> * The mechanical lift was parked between W3 and W5; * The treatment/charting cart was parked between W5 and W7; and, * A 4 bin laundry/garbage cart was parked between W7 and W9. <p>Resident #7 was propelling himself in his wheelchair, down the hall from the nurse station towards the Chapel.</p> <p>On 3/13/14 at 8:12 am, the medication cart was added to the equipment parked in the hall between W3 and W5.</p> <p>j) On 3/13/14 at 8:25 am:</p> <ul style="list-style-type: none"> * The medication cart was between W3 and W5; * The mechanical lift was parked between W5 and W7; * The treatment/charting cart was parked between W7 and W9; and * The housekeeping cart was by W11. <p>When was asked if the laundry/garbage cart was parked in the hallway all the time, CNA #22 stated, "Yeah, it is pretty much when we are getting them up or laying them down." When was asked where it was stored, the CNA pointed down the hall to a room marked "Soiled Linen," and stated, "It's really tight, but that's where it goes."</p> <p>On 3/13/14 at 8:30 am, CNA #23 was asked if the mechanical lift was kept in the hall. She said, "Yes, because that room is too small and we have one person in this hall that uses it, so we keep it close to that room. Those other halls have bigger storage rooms."</p> <p>k) On 3/13/14 at 9:19 am:</p>	F 323		

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F 323	Continued From page 54 * The computer charting cart was parked between the fire door and W1; * The medication cart was parked and the nurse was passing medications between W3 and W5; * The mechanical lift was parked between W5 and W7; and, * The treatment cart was parked between W7 and W9. The equipment was blocking 4 of 8 hand rails. l) On 3/13/14 at 1:00 pm: * The computer charting cart was parked between W1 and W3; * The mechanical lift was parked between W5 and W7; and, * The treatment/charting cart was parked between W7 and W9. Resident # 22 was walking up the hall towards the nurse's station with PT (Physical Therapist). The PT was pushing the resident's wheelchair and the resident was using his walker. As the resident approached the computer charting cart between W1 and W3, he was observed to get close to the cart and had to maneuver to the left to get around it. On 3/13/14 at 4:30 pm the Administrator, DON and RN Manager were notified of the findings. No further information was offered.	F 323			
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and	F 353	F 353 Scope and Severity of E Sufficient 24 HR Nursing Staff per care plans.		

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F 353	<p>Continued From page 55 individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on a resident group interview, record review, resident and staff interviews, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of most residents. This affected 6 of 13 sampled residents (#s 1-4, 6, & 9) and 7 of 20 residents who attended the group interview. And, it had the potential to affect all other residents who lived in the facility who required staff assistance with their ADLs. This failure created the potential for psychosocial and physical harm to the residents in the facility. Findings included:</p> <p>GRIEVANCES AND CALL LIGHT LOGS:</p> <p>1. On 3/10/14 the facility grievance file was requested. Upon review, the following complaints were documented:</p>	F 353	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Staff were in serviced on the importance of answering call lights in a reasonable time by the RN Manager or her designee. A tracking and trending report was created for resident 6 and 9. Weak areas were identified and measures implemented to ensure compliance.</p> <p>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.</p> <p>Staff were in serviced on the importance of answering call lights in a reasonable time by the RN Manager and her designee. A tracking and trending report was created for all residents. Weak areas were identified and measures implemented to ensure compliance.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p>		

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F 353	<p>Continued From page 56</p> <p>a. On 2/4/14 a Suggestions/Grievances Form from Resident Council documented, "Resident's stated concern that nursing aids [sic] are given so much work on computers that they are not able to tend to the residents or do there [sic] job efficiently." The Staff Investigation section of the form documented, "Nursing notified we are working with a new system and the time spent on computers will lesson [sic] with familiarity." The Resolution section documented, "Will explain at next council meeting." Note: The facility implemented a new computer based electronic medical records system about the time of the complaint.</p> <p>b. On 2/12/14 a Suggestions/Grievances Form from Resident #3 documented, "Put call light on to go to lunch @ 12:15 pm and it was on for 20 min[utes] before [Staff Name] came to find her because she was missing from the dining room, resulting in her being late to lunch and out of air because oxygen tank was empty." The Staff Investigation section of the form documented, "Reviewed [with] Senior RN." The Resolution section of the form documented, "Senior RN to educate staff (CNA & LN) on east hall."</p> <p>2. On 3/12/14 at 11:45 AM, the computerized call light system was viewed for Resident #1's room from 12/12/13 to 3/12/14. Call light wait times for 6 out of 90 days, ranged from 20 minutes and 38 seconds to 29 minutes and 55 seconds.</p> <p>3. On 3/12/14 at 11:45 AM, the computerized call light system was viewed for Resident #2's room from 12/12/13 to 3/12/14. Call light wait times for 23 out of 90 days, ranged from 17 minutes and</p>	F 353	<p>All staff were in serviced on the importance of answering call lights in a reasonable time by the RN Manager and her designee. The staffing coordinator or designee will complete a tracking and trending report and make modifications and training to ensure compliance. Administrator, nursing leadership and staff coordinator will meet weekly to discuss the report and implement any changes to ensure compliance.</p> <p>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.</p> <p>Staffing coordinator or designee will do random audits weekly for 90 days. All results will be reported to QA for three months to ensure compliance.</p> <p>Dates when corrective action will be completed.</p> <p>April 1, 2014</p>	4/1/14	

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F 353	<p>Continued From page 57 25 seconds to 32 minutes and 12 seconds.</p> <p>4. On 3/12/14 at 11:45 AM, the computerized call light system was viewed for Resident #3's room from 12/12/13 to 3/12/14. Call light wait times for 9 out of 90 days, ranged from 17 minutes and 26 seconds to 25 minutes and 16 seconds.</p> <p>5. On 3/12/14 at 11:45 AM, the computerized call light system was viewed for Resident #4's room from 12/12/13 to 3/12/14. Call light wait times for 75 out of 90 days, ranged from 17 minutes and 14 seconds to 62 minutes and 6 seconds.</p> <p>6. On 3/12/14 at 11:45 AM, the computerized call light system was viewed for Resident #6's room from 12/12/13 to 3/12/14. Call light wait times for 24 out of 90 days, ranged from 18 minutes and 15 seconds to 70 minutes and 56 seconds.</p> <p>7. On 3/12/14 at 11:45 AM, the computerized call light system was viewed for Resident #9's room from 12/12/13 to 3/12/14. Call light wait times for 27 out of 90 days, ranged from 17 minutes and 23 seconds to 35 minutes and 42 seconds.</p> <p>RESIDENT INTERVIEWS:</p> <p>1. On 3/11/14 at 8:20 AM, Resident #4 was interviewed. When asked about the staff issues, the resident said he, "Couldn't ask for better aides," however he also said the facility was short staffed.</p> <p>2. On 3/11/14 at 10:30 AM during the resident Group Interview, 7 out of 15 residents complained call lights were still an issue. They said they normally waited 15 minutes or longer on a regular basis and call lights in the evenings and</p>	F 353			

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F 353	<p>Continued From page 58</p> <p>weekends were when the longest wait times occurred. One resident stated there was a, "lack of staff." Another resident stated, "They don't have enough help," specifically aides. A different resident stated regarding the aides, "They are not trained enough." And another resident stated the aides, "...don't have time..."</p> <p>STAFF INTERVIEWS:</p> <p>1. On 3/12/14 at 11:40 AM the Maintenance Supervisor was interviewed regarding the call light system. He said the computerized call light system monitored dates, times, room numbers, and how long call lights stayed on, but stated, "We can't print it [call light log]." He said the system was not connected to a printer and when a concern or complaint arose, he could only view the call log data.</p> <p>2. On 3/12/14 from 3:05 to 3:30 PM several CNAs and LNs were interviewed regarding staffing issues and the following statements were made:</p> <p>a. When asked if the facility was short staffed, CNA #3 stated, "Yes, I think they're short." CNA #3 then said it was hard to provide resident cares, especially for those residents who required a mechanical lift transfer because they required two staff members to assist the resident. When asked if the facility was short staffed more on the weekdays or on the weekends, CNA #3 stated, "Both, they need help on both."</p> <p>b. When asked about staff levels, CNA #5 said when they are short staffed due to call offs the staff work really hard to make due. When asked if having more staff would be helpful, CNA #5 stated, "Oh yes, but we do what we can do to</p>	F 353			

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F 353	<p>Continued From page 59 help out."</p> <p>c. When asked about staff levels, CNA #4 said the evenings and weekends were sometimes short staffed. When asked if having more staff would help with the staffing issue, CNA #4 stated, "More help would always be nice."</p> <p>2. On 3/12/14 at 4:20 PM, CNA #2 was interviewed regarding staffing assignments. CNA #2 said she was also the Staffing Coordinator and was responsible to set the staff schedules for CNAs and LNs in the facility. When asked about her knowledge of resident call light complaints, she stated, "I have heard about the call lights." When asked about staffing levels, she stated, "Weekends are probably our worst staffing times." When asked how she made sure there was enough staff to meet the residents' needs, she said she received input from the LN Manager and made sure the facility stayed above the state required hours. When asked if she ever used the call light system as a resource to track trends she stated, "I don't monitor call light [logs]." She said she did not have access to the call light system, but she would look into obtaining access to the system to help address the call light issue.</p> <p>3. On 3/12/14 at 4:40 PM, the DON was interviewed and the Administrator joined a few minutes after the interview began. When asked about staffing levels, the DON said the facility had the same amount of staff when he was hired in June of 2013, when asked what the resident census was then, he said approximately 49 residents and when asked what the census was at the time of the interview, he said it was 57 residents. The Administrator then stated, "We hire temps [temporary employees]," when</p>	F 353			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2014
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 821 21ST AVENUE LEWISTON, ID 83501		
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F 353	Continued From page 60 needed. When the DON was asked about the long call light response times documented above, he stated he had, "Not been trending," the call lights. The Administrator said call light issues went through the grievance process and issues were addressed as they come up. When informed of some of the surveyors findings regarding hour plus call lights, the Administrator stated, "I can't validate against it [call light log]." On 3/13/14 at 8:00 AM, the Administrator informed the surveyor the call light system had been connected to a printer and was provided copies of printed call logs for the facility along with a printed plan. Upon review, the documented plan included in part, to allow call light system log access for all management including the staffing coordinator and to pull the system log to monitor trends in order to provide staff when needed the most.	F 353			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 371	F 371 Dietary Scope and Severity of E Food procure, store, prepare, serve - sanitary What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All of the bowls were inspected by the Food Service Supervisor and staff. Any bowls that showed worn glaze were disposed of. New bowls purchased.		

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F 371	Continued From page 61 facility failed to ensure plastic soup and cereal bowls used by residents were able to be sanitized. This had the potential to affect many of the residents in the facility including 13 of 13 (#s 1-13) sampled residents, by creating the possibility for food-borne illness if bacteria remaining on unsanitary surfaces. Findings include: On 3/10/14 at 2:45 PM during the initial tour of the kitchen, a rack of plastic bowls were observed. Upon checking the bowls, 4 out of 8 bowls sampled were found to have pitting and scratches inside the upper quarter of the bowls. The Dietary Manager was present during the observation and stated the bowls were, "A little worn...they need to be replaced." The Dietary Manager promptly removed them from service. The 2009 FDA Food Code, Chapter 4, part 4-2, Design and Construction, Subpart 202.11 Cleanability, indicated, "(A) Multituse Food contact surfaces shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, inclusions, pits, and similar imperfections..." On 3/10/14 at 3:18 PM the Administrator informed the surveyor new bowls were just ordered and ceramic bowls were to be used until the new bowls arrived. On 3/17/14 the Administrator emailed additional documentation regarding the bowls. The additional documentation did not resolve the concern regarding the bowls.	F 371	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. All of the bowls were inspected and any bowls that showed worn glaze were disposed of. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Food Service Supervisor inserviced the kitchen staff regarding the correct procedure for identifying any questionable bowls (and other dishes). They will be pulled from the drying racks and given to Food Service Supervisor for inspection and disposal. 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. Food Services Supervisor will do random audits weekly for 30 days (four weeks), bi-weekly for an additional 30 days (2 weeks) and then monthly for an additional thirty days. All results will be reported to QA for three months to ensure compliance. Dates when corrective action will be completed. April 1, 2014		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY	F 372		4/1/14	

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F 372	<p>Continued From page 62</p> <p>The facility must dispose of garbage and refuse properly.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined the facility failed to ensure that numerous items of debris near the trash compactor were disposed of properly or in a contained environment. Debris was overflowing from behind the facility's trash compactor, that included items rodents and bugs were attracted to, including mattresses and open pop cans. Findings included:</p> <p>On 3/13/14 at 10:25 am, during the Environmental tour the Maintenance Manager and the surveyor walked out behind the building to observe the garbage area. To the left of the trash compactor was a dumpster with cardboard in it. To the left of the dumpster was a large maintenance building. A pile of miscellaneous debris that included a large lounge chair on top of metal items was noted near the back of the compactor on the left. When the maintenance manager was asked about the items he stated, "This is the bone yard. We pile it up until it's a dumpster truck full load. They are not serviceable anymore."</p> <p>Upon approaching the compactor to the right, items were overflowing from behind the compactor. The items were up to the back of the compactor and out as far as the facility's "Biohazard Isolation" shed. The shed was next to the compactor. The overflowing items included 7 black garbage bags. One of the black bags was open and contained used pop cans. The debris</p>	F 372	<p>F 372</p> <p>Scope and Severity of C</p> <p>Disposal of garbage and refuse.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>A large dumpster was ordered by the Building Facility Foreman and the maintenance department removed all items.</p> <p>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.</p> <p>A large dumpster ordered and the maintenance department removed all items.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>Maintenance department will be monitoring any items placed in the area and a gate will be installed.</p> <p>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.</p>	

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F 372	Continued From page 63 continued along the back of the shop, in an area that was approximately 40 feet long and 10 feet wide. There was a privacy fence along the back and to the "Biohazard Isolation" shed. The debris that was piled up the fence included: wheelchairs, tires, bed springs, pallets, a food cart, tables, mattresses, cigarette ashtrays, chair, the lounge chair and other miscellaneous items. On 3/13/14 at 1:14 pm, when discussing the area of debris with the administrator, he stated, "I can get a truck out here tomorrow" and "I work for the State. I have to get approval to move anything." On 3/13/14 at 4:30 pm, the administrator, DON and RN Manager were informed of the findings. On 3/17/14 the facility sent an e-mail with additional information. The information did not resolve the issue.	F 372	Building Facility Foreman or designee will do random audits weekly for 30 days (four weeks), bi-weekly for an additional 30 days (2 weeks) and then monthly for an additional thirty days. All results will be reported to QA for three months to ensure compliance. Dates when corrective action will be completed. April 1, 2014	4/1/14	
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation	F 425	F 425 Scope and Severity of an E Pharmacy Services. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All LN staff in serviced on the proper procedure for order entry and processing of orders by the RN Manager and her designee. 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.		

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F 425	<p>Continued From page 64 on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and policy review, it was determined the facility failed to ensure: *The pharmacist was involved in discussions about how physician orders were processed; *The presence of a policy for physician order processing to include the pharmacist's responsibility; and * Current procedures for dispensing drugs and biologicals. This had the potential to affect any resident who had medication changes requiring pharmacy review including 13 of 13 (#s 1 - 13) sampled residents. This put the residents at risk for not receiving needed medications. Findings include: The facility's undated pharmacy policy, "Prescriber Medication Orders," documented: "2. Documentation of the medication order a) Each medication order is documented in the resident's medical record with the date, time and signature of the person receiving the order. The order is recorded on the physician order sheet or the telephone order sheet if it is a verbal order and the Medication Administration Record (MAR)." On 3/12/14 at 11:55 a.m. the facility pharmacist was interviewed about Resident #9's Zyprexa. During the interview the pharmacist stated the facility changed how the resident's medication orders were processed and he no longer received</p>	F 425	<p>RN Mgr. or designee completed a chart audit of all residents to ensure that the orders for each resident were reviewed by the doctor, pharmacist and DNS and proper signatures obtained.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>A new procedure has been implemented for processing of orders that includes a check and balance system between the physicians ordering, nurses inputting and medical records processing. The new procedure ensures that pharmacy is notified of each order as well as the physician with signatures obtained in a timely manner. The RN Mgr, DNS and Pharmacist reviewed policies to ensure that the procedure being followed was consistent among all departments.</p> <p>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.</p>	

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F 425	<p>Continued From page 65</p> <p>the second page of the three part order form. He further indicated that the change occurred late the previous week or over the weekend. The pharmacist was not consulted prior to the change. The pharmacist stated he had to ask staff to do a printout to be able to track the changes in resident medication changes. He further stated that the "physician order sheet" and "telephone order sheet" were the three part forms of which he received the middle copy.</p> <p>On 3/13/14 at 10:00 a.m. the DON was interviewed about the pharmacy changes which occurred after the pharmacist left the previous week. The DON said the facility had discussions with the pharmacist sometime in the "previous months" and tried out a procedure. The procedure did not work, so the facility went back to using the three part forms. The DON was aware that the pharmacist needed a written copy of an order to process it. The pharmacy and the facility computers do not interface with each other. So when the nurses make an order change in the computer, the pharmacy does not know. The DON set up a process in the facility computer where all orders are phone orders. By that designation two copies are automatically printed. One copy was to go to the physician for signature and the other was to go to the pharmacy. The pharmacist was not involved in developing the process.</p> <p>The DON provided a Procedure, dated 3/6/14, for "Medication order Processing." This procedure was signed by the administrator. This procedure documented, "2. All orders must be printed." The distribution of the printed orders was not identified.</p>	F 425	<p>RN Mgr. or designee will audit a minimum of 10 random charts weekly for 30 days (four weeks), bi-weekly for an additional 30 days (2 weeks) and then monthly for an additional thirty days. All results will be reported to QA for three months to ensure compliance.</p> <p>Dates when corrective action will be completed.</p> <p>April 1, 2014</p>	4/1/14	

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F 425	<p>Continued From page 66</p> <p>On 3/13/14 at 3:00 p.m. the DON stated he had a discussion with the pharmacist and the three part forms were at the nurses station for use by staff and doctors.</p> <p>The Administrator and DON were informed 3/13/14 at 4:15 p.m. that the facility pharmacist was not included in the process of converting to electronic medical records, specifically handling a physician order; the pharmacy did not have a procedure to follow as a result. Information was emailed to the state agency which outlined a process that facility nursing staff was using at the time of the survey. However, the additional information did not include anything in writing regarding the participation of the onsite pharmacy in the process, and how that process related to electronic medical records. The additional information failed to resolve the concern.</p>	F 425			

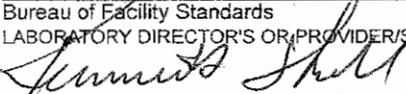
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001311	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/14/2014
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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 821 21ST AVENUE LEWISTON, ID 83501
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C 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 the annual State licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Arnold Rosling RN, BSN, QMRP Team Coordinator Brad Perry LSW Susan Gollobit RN Jana Duncan RN, MSN</p> <p>The survey team entered the facility on Monday March 10, 2014 and exited the facility on Friday March 14, 2014.</p>	C 000	<p>C 111 - See Plan of Correction for F 353 (Attached Report)</p>	4/1/14
C 111	<p>02.100,02,f Provide for Sufficient/Qualified Staff</p> <p>f. The administrator shall be responsible for providing sufficient and qualified staff to carry out all of the basic services offered by the facility, i.e., food services, housekeeping, maintenance, nursing, laundry, etc.</p> <p>This REQUIREMENT is not met as evidenced by: Refer to F353 related to adequate staffing levels to meet residents' needs.</p>	C 111	<p>C 117 - See Plan of Correction for F 156 (Attached Report)</p>	4/1/14
C 117	<p>02.100,03,c,i Fully Informed of Rights</p> <p>i. Is fully informed, as evidenced by the patient's/resident's written acknowledgement, prior to or at the</p>	C 117	<p>C 117 - See Plan of Correction for F 156 (Attached Report)</p>	4/1/14

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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 4/1/14
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C 117	Continued From page 1 time of admission and during his stay, of these rights and of all rules, regulations and minimum standards governing patient/resident conduct and responsibilities. Should the patient/resident be medically or legally unable to understand these rights, the patient's/resident's guardian or responsible person (not an employee of the facility) has been informed on the patient's/resident's behalf; This Rule is not met as evidenced by: Please refer to F 156 concerning residents' right to request a copy of their records via written or oral request.	C 117		
C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F 164 regarding privacy with treatments and medication pass.	C 125	C 125- See Plan of Correction for F 164 (Attached Report)	4/1/14
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by:	C 325	C 325 - See Plan of Correction for F 371 (Attached Report)	4/1/14

Bureau of Facility Standards

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C 325	Continued From page 2 See F371 regarding sanitization in the kitchen.	C 325		
C 338	02.108,03,c Sanitary Mantiance of Garbage Containers c. Garbage containers shall be maintained in a sanitary manner. Sufficient containers shall be afforded to hold all garbage and refuse which accumulates between periods of removal from the premises. Storage areas shall be clean and sanitary. This Rule is not met as evidenced by: Refer to 372 which pertains to debris storage.	C 338	C 338 - See Plan of Correction for F 372 (Attached Report)	4/1/14
C 745	02.200,01,c Develop/Maintain Goals/Objectives c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Please refer to F 281 regarding professional standards related to blood glucose check techniques.	C 745	C 745 - See Plan of Correction for F 281 (Attached Report)	4/1/14
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to 280 which pertains to revision of resident's care plan.	C 782	C 782 - See Plan of Correction for F 280 (Attached Report)	4/1/14

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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 821 21ST AVENUE LEWISTON, ID 83501
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 786	Continued From page 3	C 786		
C 786	02.200,03,b,ii Body Alignment, Excercise, Range of Motion ii. Good body alignment and adequate exercises and range of motion; This Rule is not met as evidenced by: Please refer to F318 concerning range-of-motion.	C 786	C 786 - See Plan of Correction for F 318 (Attached Report)	4/1/14
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please refer to F 314 as it relates to pressure ulcers.	C 789	C 789 - See Plan of Correction for F 314 (Attached Report)	4/1/14
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to 323 which pertains to equipment blocking handrails and fire extinguishing items.	C 790	C 790 - See Plan of Correction for F 323 (Attached Report)	4/1/14
C 824	02.201,01,e Formulation of Pharmacy Polcies/Procedures e. Participating in the formulation of pharmacy service policies and procedures in conjunction with the administrator, director of nursing service, and the physicians(s) responsible for the medical direction	C 824	C 824 - See Plan of Correction for F 425 (Attached Report)	4/1/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001311	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/14/2014
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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 821 21ST AVENUE LEWISTON, ID 83501
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C 824	Continued From page 4 of the facility. This Rule is not met as evidenced by: Please refer to F425 concerning pharmacy services.	C 824		
C 835	02.201,02,i Meds in Possession of Resident Limitations i. No medication shall be in the possession of the patient/resident unless specifically ordered by the physician on the patient's/resident's medical record, and in no case shall exceed two (2) units of dosage. All such medications shall be individually packaged by the pharmacist in units of dose, labeled with the patient's/resident's name, unit of dose, and date of distribution. The charge nurse shall maintain an inventory of these drugs on the patient's/resident's medical record. This Rule is not met as evidenced by: Please refer to F176 concerning the self administration of medications.	C 835	C 835 - See Plan of Correction for F 176 (Attached Report)	4/1/14