



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

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Boise, ID 83720-0009  
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**CERTIFIED MAIL: 7012 1010 0002 0836 1666**

May 6, 2014

Joshua R. Thompson, Administrator  
Idaho State Veterans Home - Pocatello  
1957 Alvin Ricken Drive  
Pocatello, ID 83201-2727

Provider #: 135132

Dear Mr. Thompson:

On **April 25, 2014**, a Recertification and State Licensure survey was conducted at Idaho State Veterans Home - Pocatello 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) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and

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return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 19, 2014**. Failure to submit an acceptable PoC by **May 19, 2014**, may result in the imposition of civil monetary penalties by **June 9, 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).

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.

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- 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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **May 30, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 30, 2014**. A change in the seriousness of the deficiencies on **May 30, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 30, 2014** includes the following:

Denial of payment for new admissions effective **July 25, 2014**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **October 25, 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, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **April 25, 2014** and continue until substantial

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compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **May 19, 2014**. If your request for informal dispute resolution is received after **May 19, 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,



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

LKK/dmj  
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  135132	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 4/25/2014
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NAME OF PROVIDER OR SUPPLIER  IDAHO STATE VETERANS HOME - POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 204	<p>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG</p> <p>A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a discharged resident's belongings were accounted for. This affected 1 of 1 (#12) closed records reviewed. Findings included:</p> <p>Resident #12 was admitted to the facility on 1/18/14 with multiple diagnoses which included lymphoblastic leukemia. The resident discharged on 1/30/14.</p> <p>Review of the resident's Inventory of Personal Items form and Interdisciplinary Progress Notes did not provide evidence the resident's belongings were accounted for.</p> <p>On 4/23/14 at 3:25 p.m., the Medical Records Supervisor was asked if Resident #12's medical records documented the personal belongings had been returned to the family or donated. After reviewing the Inventory of Personal Items form she stated, "It was missed." She added the family or senior CNA would sign the "Inventory Out" portion of the Inventory of Personal Items form when belongings were returned or donated. CNA #1 was standing nearby and said, "They did pick it all up."</p> <p>On 4/23/14 at 6:00 p.m., the Administrator and DON were informed of the personal belongings issue. No further information or documentation was provided.</p>
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F 281	<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, record review and staff interview, it was determined the facility failed to ensure licensed nursing staff did not document the administration of medications until after the resident was actually administered the medications. This affected 1 of 9 residents (#2) observed during medication pass. Findings included:</p>
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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

The above isolated deficiencies pose no actual harm to the residents

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F 281	<p>Continued From Page 1</p> <p>The Facility's Nursing Procedure Manual for Medication Administration and Medication Orders included: "Medication Administration Documentation 1. The nurse will make a small dot or small check in the box when the medication is removed from the blister pack/container. 2. Medications will be signed off/initialed after given."</p> <p>Resident #2 was admitted to the facility on 3/3/09 with multiple diagnoses which included CVA (stroke) and Dementia. The resident's most recent annual MDS assessment, dated 1/17/14, documented the resident was moderately cognitively impaired.</p> <p>The resident's Physician Orders dated 3/28/14, included: *"Fish Oil Capsule (Omega-3 Fatty Acids) Give 2000 mg by mouth two times a day related to other and unspecified hyperlipidemia; *Insulin Regular Human Solution Inject as per sliding scale: if 0-150 = 0 Unit; 151-200 = 2 Units...; *Iron Tablet (Iron Combinations) Give 325 mg by mouth two times a day related to Acute Posthemorrhagic anemia; and *Systane Balance solution (Propylene Glycol) Instill 2 drop in both eyes two times a day for Dry eyes..."</p> <p>On 4/22/14 at 4:20 PM, LN #2 was observed to sign the MAR prior to administering the following medications to Resident #2: (2) Fish oil Capsule (2000 mg), (1) tablet ferrous sulfate 325 mg, systane Gel eye drops, and 2 Units Regular Insulin.</p> <p>When LN #2 was asked if she signed the MAR prior to administering the medications she said, "I signed it in the MAR before giving it; I know we are not supposed to do that but I find it works better for me." Then continued to administer Resident #2's medications in his room.</p> <p>On 4/24/14 at 3:10 PM, the DNS and Administrator were informed of the issue. No further information was received from the facility.</p>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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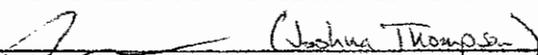
PRINTED: 05/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/25/2014
NAME OF PROVIDER OR SUPPLIER  IDAHO STATE VETERANS HOME - POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  The following deficiencies were cited during the annual federal recertification survey of your facility.  The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Lauren Hoard, RN, BSN Jana Duncan, RN, MSN  The survey team entered the facility on April 21, 2014 and exited on April 25, 2014.  Survey Definitions: ADL = Activities of Daily Living BIMS = Brief interview for Mental Status CNA = Certified Nurse Aide DNS = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment POA = Power of Attorney PRN = As Needed	F 000	Preparation and execution of this Plan of Correction (PoC) is not an admission of guilt nor does the provider agree with the conclusions set forth in the Statement of Deficiencies rendered by the Bureau. The Plan of Correction is prepared and executed simply as a requirement of federal and state law. We maintain that the alleged deficiencies do not individually, or collectively, jeopardize the health and safety of our residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of skilled nursing facilities, and this document, in its entirety, constitutes this providers claim of compliance.  Completion dates are provided for the procedural procession purposes to comply with the state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in compliance with the requirements of participation or that corrective actions were necessary.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure residents' privacy was protected. This was true for 1 of 12 sampled residents (#2) and a random resident	F 241	F241  Resident Specific 1 of 12 sampled residents (resident #2) and 1 random resident (resident # 13) were affected. Staff was educated as to the proper procedure to ensure the privacy of resident #2 and resident #13. Residents (#2, #13) were met with by Social Services to ensure that their concerns on privacy are taken care of. No concerns were noted by the Residents.  The deficient practice had the potential for residents to experience a lack of privacy when staff enters resident's rooms without knocking.	

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

TITLE

(X6) DATE

 Joshua Thompson

Administrator

5/18/14

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 (#13). The deficient practice had the potential for residents to experience a lack of privacy when staff entered residents room without knocking. Findings included:  1. On 4/22/14, the following observations were made during medication pass: - 4:07 PM, LN #2 was observed to enter Resident #2's room without knocking or asking permission to enter to obtain a blood sugar; and - 4:20 PM, LN #2 was observed to return to Resident #2's room and enter without knocking or asking permission to enter to give the resident medications.  2. On 4/22/14 at 4:13 PM, LN #2 was observed to enter Resident #8's room without knocking to obtain a blood sugar. Resident #8 was sitting near her bedside table with her back to the door.  During the observation the surveyor asked if the LN #2 had a moment to talk and she replied, "This is a very busy wing. I wish you would follow someone else and not me."  On 4/24/14 at 2:10 PM, The DNS was interviewed regarding resident privacy. She said, "We do ask that nurses knock and identify themselves before entering the room. I can see how it might happen during med pass."  On 4/24/14 at 3:10 PM, The DNS and Administrator were notified of the surveyor's findings. The facility offered no further information.	F 241	F241 continued...  Other Residents This deficiency has the potential to affect any resident who resides within the facility.  Facility Systems Staff has been educated on the proper procedure to enter a resident's room.  Monitoring Walking rounds will be performed by the DNS or her Designee. A monitor tool (see attached) will be completed during the walking rounds and individual counseling done with staff found to be out of compliance when entering a resident's room. The monitor tool will be returned to the DNS by designee.  Frequency of the monitoring will be: each shift two times per week for two weeks, then twice weekly for 1 month, then once weekly for one month.	5/16/2014	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323			

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F 323	<p>Continued From page 2</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility smoking policy, and resident and staff interview, it was determined the facility did not ensure 1 of 3 residents (#1) sampled for falls was provided adequate supervision. Resident #1 was harmed when he was left unattended in the tub room following a bath, attempted to stand without assistance and fell which caused a left hip fracture and required surgical intervention. In addition, the facility failed to identify safety hazards and ensure staff and residents who smoked, used the designated smoking areas. This failed practice had the potential to affect 1 of 11 (#3) sampled residents and any other resident who would have to pass by smokers in order to use the outside courtyard which could harm the resident if a fire broke out and there were no safety measures in place. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 4/4/11 with multiple diagnoses including abnormality of gait, hemiplegia affecting non-dominant side, delusional disorder and a history of falls.</p> <p>The resident's 11/8/13 quarterly MDS assessment, documented the following: * Required extensive assistance with two staff to</p>	F 323	<p>F323</p> <p>Resident Specific 1 of 3 sampled residents (resident #1) were affected due to inadequate supervision while bathing and 1 of 11 (resident #3) and any other resident who would have to pass by smokers in order to use the outside South courtyard. Resident #1 was sent to the hospital, upon re-admission to the home, a new care plan was built for Resident #1 following his return to the home. The care plan was updated to include changing in transferring from an easy lift to a hooyer lift and was changed to a 2 person assist at all times.</p> <p>The staff member involved with incident regarding resident #1 was suspended and had disciplinary action taken, additionally; staff was educated about the proper procedures for bathing.</p> <p>Education was provided to both staff and residents regarding the smoking policy of the facility. Education included explanation of the smoking assessment, smoking contract as well as a detailed explanation of the location of the smoking areas. New smoking signs were also hung.</p> <p>Other Residents Any resident who resides in the home and receives baths or goes into the South Courtyard</p> <p>Facility Systems Nursing staff have been educated on proper procedures when bathing residents.</p> <p>Staff and residents have been educated on the location of the designated smoking areas. The smoking policy has been updated and staff been educated to the updates.</p>		

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F 323	<p>Continued From page 3</p> <p>transfer in/out of tub; * Required extensive assistance with two staff to dress; and, * Was moderately cognitively impaired, BIMS =11.</p> <p>The resident's 2/7/14 quarterly MDS assessment documented the resident was cognitively intact, BIMS =14.</p> <p>The resident's Fall Risk Evaluation, dated 6/29/13, documented the resident was a high risk for falls.</p> <p>The resident's Falls care plan, dated 11/19/13, documented a focus of: "HX [history] of falls. Unable to maintain balance, Does not recognize own physical limitations, CVA [cerebrovascular accident] with hemiplegia, delusional disorder, dementia, weakness, poor eyesight...". With a goal of, "safety measures will be utilized this quarter."</p> <p>The resident's ADL care plan, dated 11/19/13, documented a focus of: "Extensive assistance for self care ADL's...Post CVA; depression, Paranoia; Hemiplegia, Slow to process information, Unable to maintain balance, Weakness, Poor eye sight...", With Interventions dated 8/27/13, "Use 2 person assistance to transfer into tub. Prefers tub bath in the evenings." and "Requires 2 person assistance with dressing related to weakness..."</p> <p>A facility "Fall Scene Investigation" dated 12/20/13 indicated the resident fell on 12/20/13 at 4:30 PM. The investigation documented the following: The "Recreation..." section documented, "Staff</p>	F 323	<p>F323 continued...</p> <p>Monitoring DNS or designee will conduct an audit weekly x 2 weeks then monthly x 2 months on the proper bathing procedures to ensure compliance.</p> <p>Social Services Director or designee will conduct an audit twice weekly x 2 weeks then weekly x 1 month then monthly x 1 month to ensure that staff and residents are compliant in smoking in the proper designated areas.</p>	5/16/2014	

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F 323	<p>Continued From page 4</p> <p>was waiting for assist[ance] and stepped away from res[ident] to check door/hallway. Resident impatient and tried to stand. Aide turned around and resident was laying on floor on left side." Note: The tub is approximately 13 feet from the door. There is a call light cord 2 feet from the tub and another call light cord in the shower stall approximately 11 feet from the tub.</p> <p>The "Fall Huddle" section documented, "Staff not prepared and stepped away from resident. Educated aides to work as team and check on each other during shift."</p> <p>The "Root Cause of This Fall" section documented, "Resident states 'I was in a hurry to get up and get dressed.' Resident tends to forget he is not wt. [weight] bearing..."</p> <p>The "Conclusion" section documented, "The aide used poor judgement [and] did not prepare properly for the bath."</p> <p>A facility investigation titled "Fall with Fracture" dated 12/21/13 documented: "The Veteran had just finished his bathing and was sitting at the edge of the tub to be transferred to the bathing chair and taken to his room. The staff member who was assisting went to the door to look down the hall for help for having a second person transfer per the Veterans care plan. The staff member did not pull the call light prior to leaving the side of the Veteran. The staff member turned and noticed the Veteran on the floor next to the tub; he immediately pulled the call light in the shower stall next to him and went to get help." NOTE: The tub contained a hinged water tight door which closed vertically allowing the tub to fill up with water and secure the resident's safety. The tub was then tilted backwards while the resident sat reclined in the tub. After the bath, the water was drained, the tub was tilted back leaving</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER  IDAHO STATE VETERANS HOME - POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201		
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F 323	<p>Continued From page 5</p> <p>the resident in a sitting position in the tub. Once the door was opened, the resident could swing their feet out to the left and step away from the tub.</p> <p>The resident's Progress Note documented the resident did not complain of pain to his left hip until 6:35 PM on 12/20/13 and was given pain medication, "...which helped." On 12/21/14 a note at 1:54 AM documented, "...left hip increase pain when staff turned him...decision to sent [sic] to ER [emergency room] for eval[uation]...left at 1:38 [AM] via ambulance."</p> <p>A local hospital record dated 12/21/14 documented, "He was brought into the Emergency Room and found to have a left hip fracture..." Note: Hospital records documented the hip fracture required surgical repair.</p> <p>On 4/22/14 at 1:38 PM Resident #1 was interviewed regarding the fall. He said he remembered the incident. He said during his bath, CNA #7 was the only staff member in the room and after his bath he was left alone by the CNA with his legs draped over the tub and became cold. At this point the resident stated to the CNA, "I'm done." The resident said he did not receive a verbal response from the CNA and could not see him in the tub room, so the resident stood up unassisted and fell.</p> <p>On 4/24/14 at 1:35 PM, the DNS was interviewed regarding the incident. She reviewed the "Fall Scene Investigation" and was asked what her conclusion was, she stated, "He [CNA #7] knew better...I think he made a bad decision." Note: CNA #7 no longer worked at the facility at the time of the interview.</p>	F 323		

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F 323	<p>Continued From page 6</p> <p>When asked why CNA #7 opened the tub door prior to having a second CNA to help dress and transfer the resident as indicated in the care plan, she said this was her question to CNA #7 and he did not give her an answer.</p> <p>The facility did not ensure they kept the resident safe, even though he was a high fall risk, was unable to maintain balance, and did not recognize his own physical limitations, when he was left unattended on the edge of a tub prior to his fall.</p> <p>2. The facility's Nursing Procedure Manual titled Smoking documented the following: "Smoking procedures for this facility are necessary for ensuring the safety of each resident, staff, and visitor. The Administrator has the ultimate responsibility for enforcing the facility smoking procedure..."</p> <p>A. Resident smoking is allowed only in designated areas around the facility. No other area is available for smoking by anyone.</p> <p>B. The only smoking area within the facility is the smoking room across from the nurses' station. This room is available for use by residents at scheduled times which are posted on the door. The room will be kept locked at all other times...</p> <p>E. Individuals who wear oxygen and smoke tobacco products must remove oxygen prior to smoking. If smoking outdoors, individuals who do not wear oxygen and smoke tobacco products will not smoke by a resident who is wearing oxygen."</p> <p>On 4/23/14 at 10:00 AM, during the Environmental tour, the outdoor smoking area was observed. When the Maintenance Director was asked if residents smoke outside he stated that residents do smoke outside in the courtyard, especially in the summertime. When asked about</p>	F 323			

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F 323	<p>Continued From page 7</p> <p>resident safety he said, "I don't know much about that. [CNA #1] would know about that." The Maintenance Director stated the courtyard had two exits from the facility; the locked chapel entrance at the end of the hallway, and the sliding door/puzzle room entrance, which is unlocked. Note: Any resident, staff member or visitor may exit through the sliding door/puzzle room entrance door to get to the court yard at any time. The chapel entrance was locked and required a code to enter and exit. The labeled smoking area for was located outside the locked door near the chapel entrance. There was a smoking sign, an ash tray and tables with chairs in this area.</p> <p>On 4/23/14 at 10:40 AM, approximately 26 cigarette butts were observed to be on the ground outside in the courtyard; the majority of the cigarette butts were between 12 and 18 feet from the sliding glass door entrance off the puzzle room. In this area no smoking sign or ash tray was visible and no aprons or fire extinguishers were observed near the entrance.</p> <p>On 4/23/14 at 10:45 AM, CNA #1 was asked about residents smoking outside. He reported residents occasionally go outside to smoke. CNA #1 said that the only resident who smokes and wears oxygen, leaves his oxygen tank at the nurses station before going outside to smoke.</p> <p>On 4/23/14 at 10:50 AM, the Administrator was shown the courtyard immediately outside the sliding glass doors off the puzzle room and asked about resident safety and smoking outside. The Administrator said, "You are right the sign is down." When asked how the Administrator ensures the area is safe for residents he replied, "We have independent smokers. Everyone has</p>	F 323		

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F 323	<p>Continued From page 8</p> <p>an individual assessment to determine whether or not they can come outdoors to smoke. It is determined by the assessment. I need to look at the policy." He also said, "The smoking area is only 12 feet away from the nurses station... If they have to be observed, they don't come outside."</p> <p>Note: The courtyard is 25 feet from the nurses station and is not visible from the nurses station because the puzzle room wall obstructs the view.</p> <p>On 4/23/14 at 11:00 AM, The administrator provided the facility's smoking policy, the Smoking Assessment form used to assess individual residents for smoking safety, Social Services Procedure for Smoking, and Title 39 Health and Safety Chapter 55 titled Clean Indoor Air. When asked how many residents in the facility smoke, the Administrator held up his hand and said, "I have something much more urgent to take care of right now."</p> <p>On 4/23/14 at 3:55 PM, the DNS was interviewed and asked how many residents smoked. The DNS stated there were five residents who smoked. Three residents were assessed to be independent smokers and two residents were assessed to need supervision with smoking. The residents who were assessed to require supervision have their cigarettes and lighters stored at the nurses station.</p> <p>On 4/23/14 at 5:30 PM, the Administrator stated he believed the cigarette butts found outside the double doors and throughout the courtyard were cigarettes staff members smoked and they were blown over to the area outside the sliding glass door entrance by the wind and the area had been cleaned up.</p> <p>Note: The smoking area outside of the locked</p>	F 323		

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F 323	<p>Continued From page 9</p> <p>entrance near the chapel is approximately 100 feet away and around a corner from the sliding glass door puzzle room entrance. Additionally, the only outside ash tray was located in the smoking area and was designed so wind could not blow cigarette butts out of the ash tray.</p> <p>Note: The facility's policy designates one indoor smoking area for residents and documented <del>no other area is available for smoking by anyone</del> to include staff members.</p> <p>Because the sliding glass door entrance is located off the puzzle room, it is not within line of sight of the nurses station. Additionally, all residents have access to the courtyard. Residents who wear oxygen who can locomote themselves, or visitors who take residents who wear oxygen out to this area have the potential to be in close proximity to staff members and/or residents who are smoking. This creates a hazard for fire as residents would have to pass by anyone smoking in the area in order to access the courtyard.</p>	F 323		
F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p>	F 328	<p>F328</p> <p>Resident Specific 1 of 3 sampled residents (resident #4) were affected due to the administration of oxygen not following physician orders. Resident #4 oxygen was set to proper amount and staff were educated as to the proper oxygen procedures.</p> <p>Other Residents All residents who have physician orders for oxygen have the potential to be affected.</p>	

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F 328	Continued From page 10  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure oxygen was administered per physician orders. This was true for 1 of 3 (#4) sample residents. This failure created the potential for increase in respiratory problems if residents' respiratory needs were not met. Findings included:  Resident #4 was admitted to the facility on 2/9/09 and readmitted on 10/2/13 with multiple diagnoses which included hypoxemia and congestive heart failure.  The most recent quarterly MDS assessment, dated 3/7/14, documented Resident #4 received oxygen therapy.  Resident #4's April 2014 recapitulated Physician's Orders documented, "O2 [oxygen] at 2L [Liters] per nasal cannula continuous, as needed related to HYPOXEMIA check SATS PRN [saturation levels as needed]."  The TAR [Treatment Administration Record] for Resident #4 documented the aforementioned Physician's Order for oxygen. The TAR included initials which documented the treatment had been performed.  Observations by the surveyor of Resident #4 included the following: * 4/21/13 at 4:00 p.m., the resident was lying in bed with the nasal cannula in place. The oxygen concentrator was set at 2.5 LPM (Liters Per	F 328	F328 continued...  Facility Systems Nursing staff have been educated on the facility resident oxygen procedures.  Monitoring DNS or designee will conduct an audit weekly x 2 weeks then monthly x 2 months of a minimum of 50% of the residents in the facility who receives oxygen through a physician's order.	5/16/2014	

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F 328	Continued From page 11 Minute); * 4/22/14 at 9:41 a.m., the resident was lying in bed with the nasal cannula in place. The oxygen concentrator was set at 2.5 LPM; * 4/22/14 at 10:30 a.m., the resident was still lying in bed with the nasal cannula in place. The oxygen concentrator continued to be set at 2.5 LPM; and, * 4/23/14 at 9:44 a.m., the resident was lying in bed with the nasal cannula in place. The oxygen concentrator was set at 2.5 LPM.  On 4/23/14 at 9:55 a.m., LN #3 was asked what liter flow of oxygen Resident #4 was to receive. She stated, "He's on 2 [LPM]" and verified on the MAR. LN #3 was asked to accompany the surveyor into Resident #4's room to check the liter flow. The LN observed the oxygen concentrator and said it was set to 2.5 LPM. The LN turned the liter flow down to 2 LPM.  On 4/23/14 at 6:00 p.m., the Administrator and DON were informed of the oxygen observations. No further information or documentation was provided.	F 328			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	F329  Specific Residents 3 of 4 sampled residents were affected (residents 1,6,8) due to the facility not considering the risk identified in the black box warning for antipsychotic medications. Residents #1, 6 & 8 had the black box warning consent form provided either to them or their DPOA to review the risks associated. The consent form was reviewed and education provided.		

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F 329	<p>Continued From page 12</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to consider the risk identified in the black box warning for antipsychotic medications. This was true for 3 of 4 sampled residents (#s 1,6 &amp; 8). This created the potential for harm if residents or their representatives did not have adequate risk versus benefit information prior to starting an antipsychotic medication which could lead to adverse reactions and health decline. Findings included:</p> <p>1. Resident #1 who was older than 78 years was readmitted to the facility on 12/24/13 with multiple diagnoses including delusional disorder and a history of falls.</p> <p>The resident's Admission Physician's Orders dated 12/24/13 documented, "Risperdal 1 mg P.O. [by mouth] daily..." with a diagnosis of delusional disorder. The March and April 2014</p>	F 329	<p>F329 continued...</p> <p>Other Residents All residents residing in the facility who receive an antipsychotic medication.</p> <p>Facility Changes A new consent form was built to include the black box warning that will be given to either the resident or the responsible party to review and approve prior to resident receiving an antipsychotic medication.</p> <p>Monitoring Social Services Director or designee will conduct an audit of 100% of the facility and provide the consent forms to all resident's or responsible parties. This audit will be conducted by 5/16/2014, with all consent forms being filed in the resident's record by 5/27/2014.</p> <p>Social Services Director or designee will conduct an audit twice weekly x 2 weeks then weekly x 1 month then monthly x 1 month to ensure that the consent form has been completed and is in the resident's chart.</p>	5/16/2014	

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F 329	<p>Continued From page 13</p> <p>MAR documented the resident had received the medication as ordered.</p> <p>The resident's medical record contained a document titled Physical/Chemical Restraint/Assistive Device Consent For Use and was signed by the resident's POA on 12/24/13 and contained potential risks and benefits, however, the document did not contain a warning of increased risk of death in the elderly for the antipsychotic.</p> <p>On 4/23/14 at 4:30 PM the DNS was interviewed regarding the consent form. When asked if the POA was informed of the risk of death with Resident #1's medication, she stated, "I don't think we have a specific consent for it."</p> <p>2. Resident #8 who is older than 90 years old was admitted to the facility on 11/5/07 with multiple diagnoses including phobia and hallucinations.</p> <p>The resident's Admission Physician's Orders dated 11/16/12 documented, "Quetiapine Fumarate [Seroquel]... 150 mg by mouth at bedtime for delusions/hallucinations related to Phobia..." The April 2014 MAR documented the resident had received the medication as ordered.</p> <p>The medical record lacked documentation of the risks outlined by the FDA warning elderly residents were at risk for death when using an antipsychotic medication.</p> <p>On 4/23/14 at 4:30 PM the DNS was interviewed regarding the consent form. When asked if the POA or Representative was informed of the risk of death with Resident #1's medication, she stated, "I don't think we have a specific consent</p>	F 329		

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F 329	Continued From page 14 for it"  3. Resident #6 who was older than 75 years old, was admitted to the facility on 4/14/08, with multiple diagnoses which included Depressive Disorder, and unspecified paranoid state.  The physician's recapitulation orders dated 3/28/14, documented the resident had an order for Risperdal 2 mg by mouth at bedtime related to unspecified paranoid state.  The medical record lacked documentation of the risks outlined by the FDA warning that elderly residents were at risk for death when using the medication.  On 4/23/14 at 4:10 PM, the DNS was interviewed regarding this issue. When asked if their was documentation regarding the resident or representative's awareness of the black box warning for Risperdal in the elderly the DNS replied, "We do have chemical restraint consents." She was unable to provide documentation regarding black box warning discussion with the resident or family.  On 4/23/14 at 6 PM, the Administrator and DNS were informed of the issue. No further documentation was provided by the facility.	F 329			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	F431  Specific Residents 1 of 4 medication carts and 1 random resident (resident 14) were affected. Resident #14's multi-dose bottle was immediately dated. A review of the medication carts was done to ensure that all multi-dose medication bottles had appropriate date labeling.		

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F 431	<p>Continued From page 15</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure: *Medications were stored in locked areas not accessible to residents, and *Opened multidose medications were labeled with the open date. This was true for 1 of 4 medication carts</p>	F 431	<p>F431 continued...</p> <p>Other Residents All residents who are cognitively impaired or are independently mobile have the potential of harm if they ingested the accessible medications.</p> <p>Facility Changes Nursing staff have been educated on proper procedures when leaving the medication cart.</p> <p>Nursing staff have been educated on the updated policy in the nursing procedure manual titled Administration of Medication. It states "multi-dose medications shall be labeled with the open date when the seal is first broken." (see attached)</p> <p>Monitoring DNS or designee will conduct an audit weekly x 2 weeks then monthly x 2 months on the licensed staff while giving medication pass to verify proper procedures of locking the medication carts.</p>	5/16/2014	

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NAME OF PROVIDER OR SUPPLIER  <b>IDAHO STATE VETERANS HOME - POCATELLO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 16</p> <p>observed during medication passes, and for a random resident (#14) who was administered eye drops which did not have an open date on the bottle. This created the potential for more than minimal harm for any cognitively impaired and independently mobile residents, if they ingested the accessible medications. Findings included:</p> <p>1. On 4/23/14, the following observations were made by the surveyor during medication pass: - At 11:40 AM, LN #4 entered Resident #15's room, leaving the medication cart unlocked. She closed the door, assisted the resident in the bathroom, and exited the room. The medication cart was unattended and still unlocked when she returned the the cart at 11:43 AM; - At 11:45 AM, LN #4 returned to Resident #15's room to assist her out of the bathroom and left the cart unlocked and unattended. Upon returning to the medication cart at 11:50 AM, the medication cart was observed to be locked; NOTE: Tthe medication carts were to automatically lock in approximately 3 minutes. - At 11:53 AM, LN #4 left the medication cart to give medications to Resident #16. The LN entered the residents room and closed the door for Resident 16's privacy. Upon returning to the medication cart at 11:55 AM, the cart was found to be unlocked; and, - At 12:15 PM, LN #4 left the medication cart unlocked to administer medications to Resident #17 in his room. The cart was still unlocked when the LN returned to the cart at 12:18 PM.</p> <p>On 4/23/14 at 3:55 PM, LN #4 was questioned regarding the security of the medication cart. The LN said, "Oh, I sometimes forget. I will try harder."</p>	F 431			

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/25/2014
NAME OF PROVIDER OR SUPPLIER  IDAHO STATE VETERANS HOME - POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201		
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F 431	<p>Continued From page 17</p> <p>2. Resident #14 was admitted to the facility on 5/13/13 with diagnoses which included anxiety and macular degeneration of retina.</p> <p>The resident's Physicians recapitulation orders dated 4/24/14 documented the resident had an order for Systane Balance Solution 0.6% (Propylene Glycol); Instill 1 drop in both eyes five times a day for Dry Eyes.</p> <p>On 4/23/14 at 5:15, during medication pass, LN #5 was observed to give Resident #14 eye drops. They were not labeled with the date they were opened. When the LN was asked about the open date she said, "There is no open date here. I'll look into that. I'm not sure."</p> <p>On 4/24/14 at 9:10 AM, Pharmacist #6 was asked about eye drops and open dates. She said, "The eye drops should be labeled with an open date." When asked if the expiration date is impacted by the bottle open date she said, "It depends on the medication."</p> <p>On 4/24/14 at 2:10 PM, the DNS was interviewed regarding eye drop labeling. She was informed of surveyor finding and replied, "I'll look up the open date protocol."</p> <p>On 4/24/14 at 3:10 the DNS and Administrator were informed of the issue. No further information was provided by the facility.</p>	F 431			

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FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001312</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/25/2014</b>
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NAME OF PROVIDER OR SUPPLIER  
**IDAHO STATE VETERANS HOME - POCATELLI**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**1957 ALVIN RICKEN DRIVE  
POCATELLO, ID 83201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	<p><b>16.03.02 INITIAL COMMENTS</b></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 State licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Lauren Hoard, RN, BSN Jana Duncan, RN, MSN</p>	C 000		
C 125	<p><b>02.100.03,c,ix Treated with Respect/Dignity</b></p> <p>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;</p> <p>This Rule is not met as evidenced by: Please refer to F241 regarding privacy and dignity.</p>	C 125	C125 Please refer to the response to F241.	5/16/2014
C 159	<p><b>02.100.09 RECORD OF PTNT/RSDNT PERSONAL VALUABLES</b></p> <p>09. Record of Patient's/Resident's Personal Valuables. An inventory and proper accounting shall be kept for all valuables entrusted to the facility for safekeeping. The status of the inventory shall be available to the patient/resident, his conservator, guardian, or representative for review upon request.</p> <p>This Rule is not met as evidenced by: Refer to F 204 as it relates to documentation of</p>	C 159	C159 Please refer to the response to F204.	5/16/2014

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

TITLE

(X6) DATE

*[Signature]*  
STATE FORM

*[Signature]*  
Administrator

*[Signature]*  
5/15/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001312</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/25/2014</b>
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C 159	Continued From page 1 belongings after discharge.	C 159		
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 F281 regarding prescribed medications and professional standards.	C 745	C745 Please refer to the response to F281	
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered  iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F328 at it relates to respiratory care.	C 788	C788 Please refer to the response to F328	
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 F323 regarding a resident left unsupervised resulting in a fall and smoking safety issues.	C 790	C790 Please refer to the response to F323	
C 838	02.201,02,I Secure Storage of Medications  I. All medications in the facility shall be maintained in a locked cabinet located at, or convenient to, the nurses' station. Such cabinet	C 838	C838 Please refer to the response to F431	

Bureau of Facility Standards

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C 838	<p>Continued From page 2</p> <p>shall be of adequate size, and locked when not in use. The key for the lock of this cabinet shall be carried only by licensed nursing personnel and/or the pharmacist.</p> <p>This Rule is not met as evidenced by: Please refer to F431 regarding storage of medications.</p>	C 838		
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