IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7007 3020 0001 4044 7151

May 22, 2013

James L. Roberts, Administrator
Idaho State Veterans Home - Boise
320 Collins Road, 83702, PO Box 7765
Boise, ID 83707

Provider #: 135131

Dear Mr. Roberts:

On **May 10, 2013**, a Recertification and State Licensure survey was conducted at Idaho State Veterans Home - Boise by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance**. WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 4, 2013**. Failure to submit an acceptable PoC by **June 4, 2013**, may result in the imposition of civil monetary penalties by **June 24, 2013**.

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 you will make to ensure that the deficient practice does not recur;

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:

  a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.

  b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.

  c. Start date of the audits;

- Include dates when corrective action will be completed in column 5.

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form 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 **June 14, 2013 (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 **June 14, 2013**. A change in the seriousness of the deficiencies on **June 14, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 14, 2013** includes the following:

Denial of payment for new admissions effective **August 10, 2013**. [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 **November 10, 2013**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 10, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

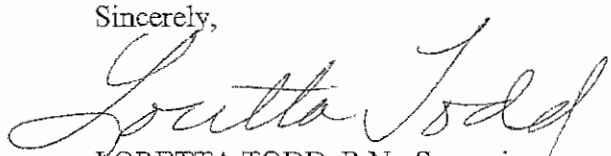
- BFS Letters (06/30/11)

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

This request must be received by **June 4, 2013**. If your request for informal dispute resolution is received after **June 4, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



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

LT/dmj
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135131	MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	DATE SURVEY COMPLETE: 5/10/2013
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 320 COLLINS ROAD, 83702 BOISE, ID		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, it was determined the facility failed to ensure the resident assessment accurately reflected the resident's status. This was true for 1 of 21 (#10) sampled residents. The assessment inaccurately documented the resident's height. Findings included:

Resident #10 was admitted to the facility on 1/19/12 and readmitted on 1/11/13 with multiple diagnoses including epilepsy, alcohol dementia, and depression.

The resident's quarterly MDS dated 11/18/12 documented height 68 inches. The resident's annual MDS dated 2/14/13 documented height 75 inches.

The resident's annual Nutritional Evaluation signed and dated on 2/18/13, documented the resident height was 74.5 inches.

The RD was interviewed on 5/8/13 at 2:00 PM regarding the height issue. She said she based his 2/18/13 nutrition evaluation off of the 74.5 inches height, but pointed out his weight was maintained despite the difference in height measurements.

On 5/8/13 at 2:25 PM, the RD informed the surveyor, the resident had just been measured again and his height was 71 inches.

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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 320 COLLINS ROAD, 83702 BOISE, ID		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	Continued From Page 1 On 5/9/13 at 3:10 PM, the Administrator, DNS, and AIT were informed of the issue. No further information was provided by the facility.
F 280	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 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to revise care plans for 1 of 21 sampled residents (#12). The care plan (CP) did not reflect revisions for sleep monitoring and discontinued medication. Findings included: Resident #12 was admitted to the facility on 12/6/11 with multiple diagnoses including, Alzheimer's disease and dementia. The Resident's most recent CP dated 2/27/13, documented under the problem section, "Alteration in sleep cycle related to history of insomnia." The approach section documented, "Monitor number of hours slept q [each] shift." and "Administer medication for sleep, monitor for s/sx [signs and symptoms] of adverse reaction." A physicians order dated 2/25/13 documented, "Restart Trazodone 100 mg PO QHS [by mouth at bedtime] (insomnia)." A physicians order dated 3/26/13 documented, "DC [discontinue] Trazodone." The Resident's April 2013 MAR on 4/9/13 documented, monitoring hours of sleep was discontinued. The MDS Coordinator was interviewed on 5/8/13 at 11:00 AM regarding the CP. She said the person who would have changed the CP in question was no longer employed at the facility, but stated, "I probably would have changed the CP." On 5/9/13 at 3:10 PM, the Administrator, DNS, and AIT were informed of the issue. No other information

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F 280	Continued From Page 2 was provided by the facility.

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

PRINTED: 05/17/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135131		05/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE VETERANS HOME - BOISE	320 COLLINS ROAD, 83702 BOISE, ID 83707

(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 recertification survey of your facility. The surveyors conducting the survey were: Karen Marshall, MS, RD, LD, Team Coordinator Arnold Rosling, RN, BSN, QMRP Amy Jensen, RN Bradley Perry, BSW, LSW Karla Gerleve, RN Survey Definitions: AIT = Administrator In Training BIMS= Brief Interview for Mental Status CNA = Certified Nurse Aide DC = Discontinue DNS = Director of Nursing BID= Twice a Day LPN = Licensed Practical Nurse MDS = Minimum Data Set assessment NS = Normal Saline O2 = Oxygen Peri = Perineal Q = Every R = Right Res = Resident RD = Registered Dietitian RN = Registered Nurse S/S = Signs and Symptoms TO = Telephone Order UM = Unit Manager W = With W/C = Wheelchair	F 000	Annual Survey completed on May 10, 2013. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. RECEIVED JUN - 4 2013 FACILITY STANDARDS	
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	F 164	F 164 PERSONAL PRIVACY/ CONFIDENTIALITY OF RECORDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James S. Roberts NHA — TITLE: ADMINISTRATOR — (X6) DATE: 06/04/2013

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 164	Continued From page 1 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 room for each resident. 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. 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation, Nursing Procedure Manual review, and staff interview, it was determined the facility failed to ensure resident privacy was maintained during toileting and private clinical information was displayed outside of resident rooms. This was observed for random resident #25 and 7 of 21 (#s 9-14 and 20)	F 164	This requirement was not met as evidenced by the determination that the facility failed to ensure privacy was maintained during toileting and private clinical information was displayed outside of the resident rooms. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. CNA #2 has been in serviced regarding the need for resident's personal privacy during personal cares. The blue, orange, and green dots located on resident's nameplate have been removed. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents residing in the facility have the potential for being affected by the deficient practice regarding personal privacy. All of the nursing staff will be in-serviced regarding the need for resident's personal privacy. All of the communication dots have been removed from resident nameplates. The Dot System procedure has been discontinued from the nursing procedure manual and all nursing staff have been in-serviced related to the discontinuation. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. Dot System procedure has been discontinued and removed from the ISVH-B Nursing procedure manual. CQI-Indicator Facility Environment has been updated to include a review to ensure resident nameplates are free from the Dot System. LN and CNA Orientation and Competency Checklist have been modified to include line item-Treats all residents with respect and is able to identify resident rights, including rights related to resident privacy during personal cares, medical treatment, visits with family...). All newly hired nursing personnel will receive this education.	

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F 164	Continued From page 2 sampled residents. This had the potential to negatively affect the residents psychosocial well-being related to the need for privacy. Findings included: 1. On 5/7/13 at 12:30 PM, CNA #2 was observed walking into random resident #25's room to answer a call light. The CNA did not close the door to the room, proceeded to the bathroom and did not close the bathroom door. Both doors were left completely wide open. The surveyor was located across the hallway from the opened door and saw partially into the bathroom. The surveyor observed approximately two feet of the back of the resident's wheelchair. The surveyor heard the resident and CNA talking, but could not identify what was said. However, the surveyor heard the resident on the toilet passing gas. Approximately a minute later, the resident's wheelchair was moved into the bathroom and the resident was seen moments later, fully dressed, in the wheelchair and in line of sight of the opened doorways. A few moments after the observation, the resident's roommate was observed opening his own closed privacy curtain and walking past the opened bathroom doorway and proceeded to leave the room into the hallway. On 5/7/13 at approximately 12:40 PM, CNA #2 was interviewed regarding the incident and was asked what was she helping the resident do and she stated, "Changing his clothes." When asked if there was anything else, she stated, "He was on the toilet." On 5/7/13 at 1:50 PM, CNA #2 was interviewed	F 164	4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. CQI- Facility Environment will be done q 2 weeks x 2, then monthly x 2, then no less than quarterly. Revised CNA and LN Orientation and Competency Checklists have been implemented and will be done for every newly hired CNA and LN ongoing. 5. Date Corrective action will be completed: June 14, 2013	

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F 164	Continued From page 3 for a follow-up question and was asked why she did not close the doors, she stated, "I normally do. I just spaced it." 2. On 5/6/13 from 1:17-1:22 PM and 5/9/13 at 10:10 AM, the following were observed: a. Resident #11's nameplate outside of resident room contained two orange and one blue nickel sized stickers with the following information printed on them, "Pressure Alarm w/c (wheelchair)", "Pressure and tag alarm bed", and "Non-skid rug." b. Resident #10's nameplate contained three orange stickers documenting, "Tag alarm to w/c", "Pressure alarm bed", and "Pressure alarm recliner." c. Resident #12's nameplate contained an orange sticker documenting, "Pressure alarm w/c & tag alarm bed." d. Resident #13's nameplate contained a green sticker documenting, "Prevalon Boots." Note: Similar results were found for Resident #9, #14, #19, and #20. The facility Nursing Procedure Manual DOT SYSTEM documented the purpose of the stickers, "The facility will use colored dot stickers to identify fall prevention and pressure relieving devices used on specific residents based on need/assessment." On 5/9/13 at 11:15 AM, the DNS was interview regarding the clinical information on the stickers. The DNS said the stickers were used for communicating to staff and, "Help to cue staff," to what the resident's needs were. She said she could take the words off the stickers to protect resident privacy.	F 164		

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F 164	Continued From page 4 On 5/9/13 at 3:10 PM, the Administrator, DNS, and AIT were informed of the privacy issue. No other information was provided by the facility.	F 164		
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, staff interview and record review, it was determined the facility failed to maintain dignity of a resident when his urinary leg bag was visible to others and a resident's clinical information was displayed and hanging on a sign on the back of his wheelchair. This affected 2 of 21 (#1 and #9) sampled residents. This failed practice did not enhance the resident's self worth or self esteem and had the potential of psychological harm. 1. Resident #9 was admitted to the facility on 9/24/10 and readmitted on 3/12/13 with diagnoses of cerebral vascular accident (CVA), chronic obstructive pulmonary disease, anxiety, and depression. Resident #9's May 2013 Physician Orders (Recapitulation) read, "O2 @ 3 L/Min per nc continuously" (Oxygen at 3 liters per nasal cannula continuously). On 5/6/13 at 11:30 am, 5/7/13 at 7:20 am, and	F 241	F 241 DIGNITY AND RESPECT OF INDIVIDUALITY This requirement was not met as evidenced by the determination that the facility failed to maintain dignity of a resident when his urinary leg bag was visible to others and resident clinical information was displayed and hanging on a sign on the back of his wheelchair. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. O2 liter flow signage has been removed from resident #1 and # 9's wheelchair. Resident #1 has had the straps on his leg bag adjusted so that the leg bag is not visible. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents using portable oxygen in the facility have the potential of being affected by the O2 liter flow signage – all of these residents have been reviewed to ensure that there is no O2 liter flow signage present with the portable oxygen. All residents using a leg bag or a bed side unit with an indwelling catheter are at risk. All of these residents have been reviewed to ensure that their drainage bag (leg or BSU) is covered. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. All nursing staff has been in-serviced related to the deficient practice and the need to remove any O2 liter flow signage and to keep all urinary drainage bags covered. CNA Orientation and Competency check list has been modified to include in catheter training and the need to ensure that the catheter drain bag is covered.	

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	135131		05/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE VETERANS HOME - BOISE	320 COLLINS ROAD, 83702 BOISE, ID 83707

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F 241	Continued From page 5 5/8/13 at 8:30 am, Resident #9 was observed in the dining room with a sign hanging, near the top left side, on the back of his wheelchair. The sign read, "[Resident #9's name] O2 @ 3 L/min/nc". The sign was laminated on white paper with black letters and was approximately 2 inches by 3 inches in diameter. On 5/9/13 at 10:00 am, RN Unit Manager #5 was asked about the laminated sign on the back of Resident #9's wheelchair that displayed the resident's name and the oxygen flow rate for the resident. The RN Unit Manager replied, "Is it up high? It should be down lower. Everyone on O2 has them, but they are down lower where you can't see them." On 5/9/13 at 3:10 pm, the Administrator, AIT, and the DNS were notified of the sign hanging on the back of Resident #9's wheelchair. No other information or documentation was provided that resolved the matter. 2. Resident #1 was admitted to the facility on 12/20/10 with multiple diagnoses including: non-psychotic brain syndrome, peripheral neuropathy, BPH (prostate enlargement), and anxiety. Resident #1's quarterly MDS dated 2/26/13, coded in part: *severely impaired cognition, *inattention, disorganized thinking, and psychomotor retardation; *he required 1 person limited assist for bed mobility and transfers, *he required 1 person extensive assist with toileting, and	F 241	CQI-Facility Environment has been modified to include item to ensure that portable O2 does not have any signage. CQI- Resident in Facility has been modified to include item to monitor urinary drain bags to ensure covered. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. CQI- Facility Environment will be done q 2 weeks x 2, then monthly x 2, then no less than quarterly. CQI-Resident in Facility will be done q 2 weeks x 2, then monthly x 2, then no less than biannually. Revised CNA Orientation and Competency Checklists have been implemented and will be done for every newly hired CNA ongoing. 5. Date Corrective action will be completed: June 14, 2013	

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F 241	Continued From page 6 * indwelling catheter Resident #1's catheter care plan, dated 9/10/12, documented,"Monitor placement of tubing and drainage leg bag." Resident #1's May 2013 Recapitulation Physician's Orders documented in part: "10/18/12- Indwelling foley catheter (16) FR[ench] to leg bag (BPH with urinary retention." On 5/7/13 at 8:30 am and 12:25 pm Resident #1 was observed sitting in a recliner, in the common area, on the Specialized Care Unit (SCU) with the bottom 1/3 of his urinary leg bag visible below his left pant leg. In addition, at 12:25 pm the bottom strap of the leg bag used to secure the bag to the resident's leg was hanging below his shoe and touching the ground. On 5/9/13 at 1:30 pm UM #5 was interviewed and said, she had not seen the leg bag exposed that way before and she hasn't really thought about it. She also said the leg strap should not be touching the floor.	F 241		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was	F 252	F 252 SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT This requirement was not met as evidenced by the determination that the facility failed to provide a homelike environment by serving meals to residents on trays. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All residents will be served their meals by having all the meal items taken off the tray and placed on the table. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.	

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F 252	Continued From page 7 determined the facility failed to provide a homelike environment by serving meals to residents on trays. This affected 10 of 21 (#s 1, 4, 6, 7, 9, 11, 14, 17, 19, and 21) sampled residents, seven additional residents in the Special Care Unit (SCU), and most of the residents served in the main dining room. This practice created the potential to negatively affect the residents' psychosocial well-being related to a comfortable and homelike environment. Findings included: 1. During breakfast observation on 5/6/13 at 7:40 AM, it was observed all eleven residents in the SCU dining area and most of the residents in the main dining were served their meals on a tray. Plates, cups, and utensils were not removed from the trays. Residents were not asked if they wanted to keep their plates on the trays. 2. During breakfast and lunch observations on 5/7/13 at 8:45 and 11:45 AM, residents in the main dining were served their meals on a tray. Plates, cups, and utensils were not removed from the trays. Residents were not asked if they wanted to keep their plates on the trays. On 5/9/13 at 11:15 AM, the DNS was interviewed regarding the tray issue. She stated using the trays have, "Never been an issue before" and "I can certainly take the trays away." On 5/9/13 at 3:10 PM, the Administrator, DNS, and AIT were informed of the tray issue. No other information was provided by the facility.	F 252	All residents served meals in the facility are at risk for being affected by this deficient practice. All meals will be served by taking all the meal items off the tray and placing them directly onto the residents table. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. All facility staff have been in-serviced as to the new expectation that all resident meals will be served to residents by taking all meal items off the tray and placing them directly onto the residents table. CQI-Dining Environment has been modified to include item that monitors that during meal delivery all meal items are placed directly onto the dining room table. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. CQI-Dining Environment will be done q 2 weeks x 2, then monthly x 2, then no less than biannually. 5. Date Corrective action will be completed: June 14, 2013	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314	F 314 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	

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F 314	Continued From page 8 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 observation, record review, and staff interview, it was determined the facility failed to prevent Resident #13 from developing an avoidable Stage II pressure ulcer to his right medial buttock. This had the potential to cause pain and/or infection to the resident. This was true for 1 of 1 (#13) sampled residents reviewed for pressure ulcers. Findings included: Resident #13 was admitted to the facility on 4/1/13 with diagnoses of dementia with agitation, depression, hand contractures, and history of pressure ulcers to the 2nd toe and heels. Resident #13's 4/7/13, Admission MDS stated in part: -BIMS Score-10, moderately cognitively impaired -Rejection of care-Occurred 1 to 3 days out of 7 days -Bed mobility, transfer, locomotion on and off the unit, dressing, toilet use, personal hygiene, and bathing- required extensive assistance of two persons -Walk in room and in corridor-did not occur -Urinary and bowel toileting program-yes -Risk for developing pressure ulcers-Yes	F 314	This requirement was not met as evidenced by the determination that the facility failed to prevent Resident # 13 from developing an avoidable stage II pressure ulcer to his right medial buttock. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #13 wound was healed on 5/6/2013; this resident continues to have all care planned pressure relieving interventions in place, including pressure relieving cushion in the recliner. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents who reside in the facility and choose to sit for extended periods of time in a recliner are at risk for skin breakdown. These residents have been identified and have been issued a pressure relieving cushion for use in the recliner and this intervention has been care planned. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. CQI- Skin Wound has been modified to include monitor residents for seating preferences and place preventative measures as needed. Temporary Care plan for Skin and/or Wound has been modified to include a specific interventions for a pressure relieving cushion in wheelchair, recliner and sitting chair. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. CQI-Skin Wound will be done q 2 weeks x 2, then monthly x 2, then no less than biannually. 5. Date Corrective action will be completed: June 14, 2013	

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F 314	Continued From page 9 -Does resident have one or more unhealed pressure ulcers at Stage 1 or higher-No -Pressure reducing device for chair, Pressure reducing device for bed, and a Turning/repositioning program-were in place for this resident Resident #13's Braden scale for predicting pressure sore risk stated in part: 4/1/13-Total Score 12, High Risk 4/6/13-Total Score 13, Moderate Risk Resident #13's "Admit Assessment/Nursing" form's body diagram indicated the resident had an abrasion on the right and left knee, an abrasion on the left foot, and a bruise on the left elbow. The form stated in part: Decubitus-No Wounds-No Note: There was no evidence of any skin issues on Resident #13's buttocks upon admission. Resident #13's 4/1/13, "Admission Physician's Orders for Admit" did not indicate any treatment orders for a pressure ulcer or skin issue on the buttocks. Resident #13's May 2013 "Physician's Orders" stated in part: "4/18/13, Monitor irritated area located buttocks Q PM until healed, then DC...." "4/18/13, Apply Lantiseptic cream to irritated area on buttocks BID & PRN. D/C when resolved." "4/24/13, Monitor pressure ulcer located (R) medial buttock Q day" "4/24/13, Cleanse (R) medial buttock pressure ulcer/NS. Cover site with duoderm dressing. Change dressing Q 3 days."	F 314		

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F 314	Continued From page 10 "4/24/13, Cleanse (R) medial buttock pressure ulcer/NS. Cover site with duoderm dressing. Change dressing PRN." "4/24/13, Ensure Rojo cushion in place while recliner in use by resident (promote skin integrity)." Note: The Physician Orders documented the cushion in the recliner was provided after Resident #13 received the Stage II pressure ulcer to his right buttock. Resident #13's April 2013 Treatment Record indicated the following treatment was initiated on April 18th, before the pressure ulcer occurred: *"monitor the irritated area on the resident's buttocks" and "apply lantiseptic cream to irritated area on buttocks BID and PRN" The same Treatment Record for April 2013 indicated the following treatments were initiated on April 24th, after the pressure ulcer occurred: *"monitor pressure ulcer located R medial buttock Q day" *"cleanse R medial buttock pressure ulcer w N/S. Cover site w/duoderm dsg (dressing). Change dsg Q 3 days." *"cleanse R medial buttock pressure ulcer w N/S. Cover site w/duoderm dsg. Change dsg PRN." *"ensure rojo cushion in place while recliner is use by resident (promote skin integrity)" Note: The treatment record documents the pressure relieving device was added to the recliner after Resident #13 received the Stage II pressure ulcer to his right buttock. The 4/16/13 Care Plan documented a skin at risk problem with multiple interventions which included, in part: *"Notify my nurse of any skin problems I may	F 314		

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F 314	Continued From page 11 have." *"Keep my skin clean, dry, and free from pressure." *"Encourage/assist me to change position Q 2 hours and assess my bony prominence's for pressure areas. Provide me with increased cueing. I generally change position between my bed, unit recliner, and wheelchair." Note: The facility recognized the resident changed positions between bed, recliner and wheelchair. However, they failed to provide a pressure relieving device when the resident sat in the recliner, until after the resident received a Stage II pressure ulcer on his right buttock. *"Apply barrier cream/lotion during my peri-care." *"Pressure relieving cushion is on my w/c." On 4/24/13, "and recliner" was added to the above sentence. *"Pressure relieving Panacea mattress is on my bed." On 4/24/13, "Air mattress to bed (promote skin integrity)" was added to the above sentence. *"I utilize a body pillow as needed for repositioning." The 4/1/1, Nursing Progress Notes stated in part, "Admit skin assessment performed today... Pressure relieving cushion noted to resident's w/c and pressure relieving Stg (stage) 3 mattress noted to his bed. Orders received to reposition resident frequently with pillows while in bed." The 4/18/13, Nursing Progress Notes stated in part, "TO received from [Resident #13's physician] to apply lantiseptic cream to irritated area on buttocks bid and PRN, to dc when resolved, to monitor irritated area located on buttocks Q PM until healed, then dc." Resident #13's 4/24/13, Nursing Progress Notes	F 314		

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F 314	Continued From page 12 stated in part, "Res [resident] has a Stg 3 Panacea ultimate mattress (Pressure relieving) on his bed. Res noted to sit in unit recliners periodically through out the day. Rojo cushion placed on resident's recliner to ensure he is benefiting from pressure relief." "Add protein enhanced to diet, air-mattress to bed...ensure rojo cushion in place while recliner is use by resident." Note: On 4/16/13, the Care Plan identified the resident changed positions between his bed, recliner and wheelchair. The special mattress and the rojo cushion to his wheelchair were put in place on admission. The rojo cushion was not added to the recliner until after the resident had received the Stage II pressure ulcer to his right medial buttock. Resident #13's "Weekly Pressure Ulcer Record" stated in part: Date of onset: 4/24/13 Site/Location: Right medial buttock Date:4/24/13: Stage: II, Size 1x1 cm Date 4/29/13: Stage: II, Size 1x0.3cm, improved Date 5/06/13: healed On 5/6/13 from 1:05 pm to 3:00 pm, and on 5/7/13 at 11:15 am Resident #13 was observed sitting in a recliner in front of the nurses station with his eyes closed. A rojo cushion was observed under the resident in the recliner. On 5/7/13 at 1:25 pm, the RN Unit Manager was interviewed about the pressure ulcer on Resident #13's right medial buttock. The RN Unit Manager stated, "In my opinion, it was an abrasion or sheering but we had to call it a Stage II. It could have been caused from peri care, and [the wound	F 314		

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F 314	Continued From page 13 nurse's name] will code for the most severe." At 2:00 pm the same day, the wound nurse was interviewed. The wound nurse stated,"He is rigid and sits very stiff in his wheelchair and the recliner. They called me when they saw it and we immediately put things in place. His mattress was changed from a pressure relieving to an air mattress and we recognized that he would sit in the recliner in front of the nurses station a lot. We added a rojo cushion to that recliner. He already had one in his wheelchair. It was healed on Monday, 5/6/13." Note: A rojo cushion was placed on Resident #13's wheelchair upon admission, but the facility failed to apply a rojo cushion to the recliner that the resident frequently sat on until after the pressure ulcer was discovered. On 5/9/13 at 3:10 pm, the Administrator, AIT, and the DNS were notified of the avoidable pressure ulcer for Resident #13. No documentation or information was provided that resolved the issue.	F 314		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS This requirement was not met as evidenced by the determination that the facility failed to ensure staff and contract employees adhered to standard infection control measures. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. LN #1 and CNA #6 have been in-serviced regarding hand washing procedures. Laundry Aide #3 has been in-serviced in the laundering of linen, particularly of Laundry Isolation Protocol (LIP) and handling of Emerging Infectious Disease (EID) linens. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.	

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F 441	Continued From page 14 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of laundry aide job description, and staff interviews, it was determined the facility failed to ensure staff and employees adhered to standard infection control measures. This affected 1 of 21 sampled residents (#1), had the potential to affect residents who received medications administered by LN #1, and any resident whose clothes or linens were laundered in the facility. Two staff members did not perform hand hygiene after direct contact and one housekeeping member had bare hand contact with a potentially	F 441	All residents who reside in the facility have the potential of being affected by this deficient practice. All nursing staff has been in-serviced related to proper hand washing procedures. All laundry staff – and those who may at any point be responsible for laundering linen have been in-serviced pertaining to the Laundry Isolation Protocol (LIP) and handling of Emerging Infectious Disease (EID) linens. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. CQI –Infection Control Nursing has been modified to include items specific to monitoring LN and CNA hand washing and proper glove usage. The LN and CNA Orientation and Competency Checklist have been modified to include items to educate newly hired staff to facility hand washing procedures. Housekeeping Manager has included LIP and EID education into the New Hire In-service training – to be instructed before beginning first day of work. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. CQI-Infection Control Nursing will be done q 2 weeks x 2, then monthly x 2, then no less than biannually. Revised CNA and LN Orientation and Competency Checklists have been implemented and will be done for every newly hired CNA and LN ongoing Housekeeping Manager will conduct all New Hire In-service training. New employees will have an in-service sheet to sign off on when completed. Laundry Supervisor will monitor all practices conducted during laundry operation to ensure proper handling procedures are taking place. All LIP and EID laundering will be completed with Laundry Supervisor and/or Housekeeping Manager present. Annual In-services will be conducted to re-educate all staff on LIP and EID protocol. This process will begin May 31, 2013 5. Date Corrective action will be completed: June 14, 2013	

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F 441	Continued From page 15 contaminated biohazard container. These failures created the potential for cross-contamination which could lead to transmission of disease causing pathogens. Findings included: 1. On 5/9/13 at 10:45 a.m. the Housekeeping Manager accompanied the surveyor during the facility's linen and housekeeping review. The laundry area had clean side and dirty side laundry areas separated by one set of swinging doors. On the dirty side were two different containers with red plastic bags in the containers. One container appeared to be a trash container with empty red plastic bags inside the container. These bags appeared to have been used and disposed of in the container. The other container appeared to be a laundry bin containing red plastic bags with what appeared to be dirty laundry inside the bags. -At 10:50 a.m., Laundry Aide #3 (LA #3) was folding clean laundry on the clean side of the laundry area. The surveyor asked LA #3 if she worked on the dirty side of the laundry area and washed dirty laundry. LA #3 nodded her head in an up and down motion and said "Yes." The surveyor asked LA #3 to explain the difference between potentially contaminated biohazard laundry and the non-biohazard laundry. LA #3 was not able to explain the difference between potentially biohazard contaminated laundry and non-biohazard laundry. The surveyor asked LA #3 to accompany the surveyor to the dirty side of the laundry area. The surveyor pointed to the trash container and the laundry bin with red bags of what appeared to be laundry inside the bags. The surveyor asked LA #3 what the containers were used for. LA #3 pointed to the trash container and stated, "That is for trash." LA #3 then walked over	F 441		

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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
F 441	Continued From page 16 to the laundry bin containing red bags with what appeared to be the potentially contaminated laundry inside and placed one of her bare hands on one of the red plastic bags, held the bag open, and with her other hand pointed to the laundry inside. The surveyor then asked LA #3 to stop and not touch any other items. The Housekeeping Manager also told LA #3 not to touch anything and escorted LA #3 to wash her hands. After LA #3 washed her hands, the Housekeeping Manager said, "She only does folding of clean laundry, [she] doesn't work on the dirty laundry side. I will obtain a copy of the job description for position #3 for you." On 5/9/13 at approximately 2:00 p.m., the Housekeeping Manager provided the surveyor with a copy of a job description titled, "Laundry 3 Routine." The job description identified, in part, "...1:40 pm - 2:10 pm Complete side work duties (or continue to wash and fold)...Side Work Monday - Clean and disinfect soiled linen bins...Friday - Clean washers inside and out..." The surveyor informed the Housekeeping Manager the job description did indicate LA #3 would work only the dirty side of the laundry area. On 5/10/13 at 11:00 a.m., the Administrator, DNS, and AIT were informed of the observation. The facility did not provide additional information. 2. On 5/7/13 at 7:57 am, LPN #1 was observed administering medication to random Resident #26. After receiving his medication, Resident #26 requested eye drops for his eyes. The LPN left the resident's room, got the eye drops from the medication cart near the nurse's station, and returned to Resident #26's room. The LPN instilled the eye drops into Resident #26's eyes,	F 441		

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	135131		05/10/2013

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F 441	Continued From page 17 blotted the resident's cheek with a paper towel, which he had obtained near the sink in the resident's room, and left the room. The LPN returned to the medication cart next to the nurse's station, and proceeded to retrieve a medication for another resident that was sitting close by. Note: The LPN was not wearing gloves, and did not wash his hands before or after instilling the eye drops. On 5/7/13 at 2:00 pm, the LPN was informed of the observation of instilling eye drops without gloves, and not washing his hands after the application. The LPN stated, "OK." Later in the day, at 2:30 pm, LPN #1 held up hand sanitizer, and said, "Thanks for reminding me, I'm using it." On 5/9/13 at 3:10 pm, the Administrator, AIT, and the DNS were notified of the handwashing issue. No information or documentation was provided that resolved the issue. 3. Resident #1 was admitted to the facility on 12/20/10 with multiple diagnoses including non-psychotic brain syndrome, peripheral neuropathy, BPH (enlarged prostate), and anxiety. Resident #1's quarterly MDS dated 2/26/13, coded in part: *severely impaired cognition. *inattention, disorganized thinking, and psychomotor retardation. *he required 1 person limited assist for bed mobility and transfers, and *he required 1 person extensive assist with toileting. The CDC (Centers for Disease Control and	F 441		

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F 441	Continued From page 18 Prevention) website (<Http://www.cdc.gov>), an accepted professional standard, listed indications for handwashing which included but not limited to: · Before having direct contact with residents · After contact with a resident's intact skin (when taking blood pressure or lifting a resident) · After contact with body fluids · If moving from a contaminated-body site to a clean-body site during patient care On 5/7/13 at 8:30 am, CNA #6 was observed toileting Resident #1. CNA#6 had gloves on and had just wiped bowel movement from Resident #1's peri-rectal area. She did not remove or change her gloves nor did she perform hand hygiene before pulling up the residents incontinent brief or pants. She then placed Resident #1's hands on his front wheeled walker and assisted him to a recliner in the common area. NOTE: CNA #6 did not wash her hands before placing the resident's hands on his walker, nor did she wash her hands prior to leaving the bathroom. On 5/9/13 at 1:30 pm, UM #5 was interviewed and said CNA #6, "Should have started fresh. She should have discarded the soiled gloves, washed her hands, and applied new gloves."	F 441		

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	MDS001313		05/10/2013

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the State licensure survey of your facility. The surveyors conducting the survey were: Karen Marshall, MS, RD, LD, Team Coordinator Arnold Rosling, RN, BSN, QMRP Amy Jensen, RN Bradley Perry, BSW, LSW Karla Gerleve, RN	C 000	Annual Survey completed on May 10, 2013. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
C 124	02.100,03,c,viii Confidentiality of Records viii. Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of his transfer to another health care facility, or as required by law or third-party payment contract; This Rule is not met as evidenced by: Refer to F164 as it related to clinical information posted on stickers outside of resident rooms.	C 124	C 124: Please refer to Plan of Correction Form CMS-2567 (02-99) F 164 RECEIVED JUN - 4 2013 FACILITY STANDARDS	
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 F164 as it related to privacy during	C 125	C 125: Please refer to Plan of Correction Form CMS-2567 (02-99) F 164 and F 241	

Bureau of Facility Standards

James E. Roberts NHA — TITLE: ADMINISTRATOR — (X6) DATE: 06/04/2013

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

Bureau of Facility Standards

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C 125	Continued From page 1 toileting. Please refer to F241 as it related to clinical signage on the back of the resident's wheelchair. Please refer to F241 as it relateds to keeping urinary leg bag covered	C 125		
C 422	02.120,05,p,vii Capacity Requirments for Toilets/Bath Areas vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water. This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to maintain the minimum number of bathing facilities for the number of licensed beds. This affected 21 of 21 (#s 1-21) sampled residents and had the potential to affect all residents who resided in the facility. Findings included: The facility was licensed for 131 certified beds. At the beginning of the survey process, 124 residents resided in the facility. On 5/8/13 at 8:20 a.m., the Maintenance and Operations Supervisor (MOS) accompanied the surveyor during the General Observations of the Facility (Environmental Tour). The following bathing facilities were found/evaluated: * One East bathing room, one bathtub and one	C 422	C 422 02.120.05,p,vii CAPACITY REQUIREMENTS FOR TOILETS/BATH AREAS This requirement was not met as evidenced by the determination that the facility failed to maintain the minimum number of bathing facilities for the number of licensed beds. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were identified as having been affected by this deficient practice. The facility has the same number of bathing facilities it had during construction. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. Facility has designated bath/shower days for each resident per the resident's preference and these bath/ showers are completed by a designated CNA. Residents within the facility require supervision to dependent assist with their bath/shower depending on individual needs. Each resident has been assessed and is care planned for their bath/shower preference and needs. Due to each resident requiring some type of assist and for reasons of privacy and dignity each resident receives their bath/ shower individually, therefore the current number of bathing facilities will continue to meet all resident needs. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. The facility is not able to physically construct additional bathing/shower facilities as this would mean structural changes to the facility and would be cost prohibitive. The facility is requesting a waiver for this state IDAPA rule,	

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C 422	Continued From page 2 shower stall. * Secure Care Unit bathing room, one bathtub and one shower stall. * Two West bathing room, one bathtub and one operational shower stall and one non-operational shower stall. Note: The non-operational shower stall space was occupied by a unit that was a wheelchair washer. The MOS stated the stall space was used for washing wheelchairs. * One West bathing room, one bathtub and two shower stalls. Note: The above identified bathing rooms were communal bathing rooms. There were a total of 9 operational bathing facilities. On 5/8/13 at 8:32 a.m., the following rooms had individual bathing capability as follows: * Rooms 113, 114, 213, 230, 303, 304, & 320 * Room 214 - no handle in shower. Non-operational, cannot be counted. * Room 229 - no shower head. Non-operational, cannot be considered. Note: The above identified rooms, 113, 114, 213, 214, 229, 230, 303, 304, & 320, were all private rooms. This was verified with the Administrator on 5/8/13 at approximately 11:30 a.m. On 5/8/13 at approximately 8:45 a.m., the surveyor informed the Administrator, DNS, and AIT the facility did not have one tub or shower for every 12 residents. The surveyor also informed the Administrator the number of individual resident rooms with individual bathing facilities (9 as identified above) could be subtracted from the total of certified beds (131) and then divided by the number of communal tubs and showers. (122 divided by 9 equals 13.5, or one bathing facility for every 13.5 licensed beds.) The Administrator	C 422	see attached letter. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The facility will request a waiver to this state IDAPA rule. 5. Date Corrective action will be completed: June 14, 2013	

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C 422	Continued From page 3 disagreed with the surveyor and stated we have communal bathing rooms with tubs and showers and we have individual rooms with either a tub or a shower. The individual rooms should be included in the number of tubs and showers to determine the ratio. The Administrator said the facility did have enough bathing facilities and met the state requirement as stated in the Idaho Administrative Procedures Act (IDAPA). On 5/9/13 at 2:00 p.m., the surveyor, the Administrator and DNS again discussed the ratio of bathing facilities per licensed beds. Both the Administrator and the DNS stated, "We feel, per the regulation we are well below the requirement [1 tub or shower for each 12 residents]." The surveyor asked if the number of private rooms with tubs and showers were to be included in the ratio, would the facility allow residents, other than the resident who resided in the room, to use the tubs and showers in the private rooms. The DNS stated, "No, we would not do that [allow a resident who did not reside in the room to use the tub or shower]." On 5/10/13 at 11:00 a.m., the Administrator was informed of the finding. The facility did not provide any additional information.	C 422		
C 644	02.150,01,a,i Handwashing Techniques a. Methods of maintaining sanitary conditions in the facility such as: i. Handwashing techniques. This Rule is not met as evidenced by: Please refer to F 441 as it related to maintaining sanitary conditions in the facility such as: Handwashing techniques.	C 644	C 644: Please refer to Plan of Correction Form CMS-2567 (02-99) F 441	

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C 672	02.150,03,c Staff Knowledge of Infection Control c. Exhibited knowledge by staff in controlling transmission of disease. This Rule is not met as evidenced by: Please refer to F441 as it related to laundry employee unable to describe the difference between potentially contaminated biohazard laundry and touched potentially contaminated laundry with bare hands, and as it related to a licensed nurse providing eye drops without gloves, not washing hands after instilling the eye drops, and then proving medication to another resident.	C 672	per telephone with Assistant Administrator Joyce Hudson on 6/14/13 at 11:10 Am. changed to C672: Please refer to Plan of correction Form CMS-2567 F441.	
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 F280 as it related to care plan not updated when insomnia medication was discontinued.	C 782	C 782: Please refer to Plan of Correction Form CMS-2567 (02-99) AH "A" FORM F 280	
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 F314 as it related to a resident who developed a pressure sore in the facility.	C 789	C 789: Please refer to Plan of Correction Form CMS-2567 (02-99) F 314	