



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
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P.O. Box 83720  
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PHONE: (208) 334-6626  
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October 20, 2016

Mark High, Administrator  
Idaho State Veterans Home-- Lewiston  
821 21st Avenue  
Lewiston, ID 83501-6389

Provider #: 135133

Dear Mr. High:

On **October 6, 2016**, a survey was conducted at Idaho State Veterans Home - Lewiston by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency 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. If applicable, a similar State Form will be provided 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." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) 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.

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 31, 2016**. Failure to submit an acceptable PoC by **October 31, 2016**, may result in the imposition of penalties by **November 10, 2016**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- 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.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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 **November 10, 2016 (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 **January 4, 2017**. A change in the seriousness of the deficiencies on **November 20, 2016**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **November 10, 2016** includes the following:

Denial of payment for new admissions effective **January 4, 2017**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, 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 **April 4, 2017**, 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, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; 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 **January 4, 2017** 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 non-compliance 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>

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

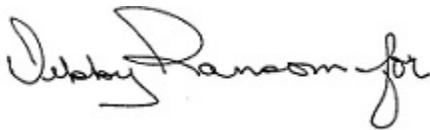
- BFS Letters (06/30/11)

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

This request must be received by **October 31, 2016**. If your request for informal dispute resolution is received after **October 31, 2016**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink that reads "Nina Sanderson for". The signature is written in a cursive style.

Nina Sanderson, LSW, Supervisor  
Long Term Care

NS/lj  
Enclosures

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

PRINTED: 11/07/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135133</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/06/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO STATE VETERANS HOME - LEWISTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>821 21ST AVENUE LEWISTON, ID 83501</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 000	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification survey conducted at the facility from October 3, 2016 to October 6, 2016.  The surveyors conducting the survey were:  Brad Perry, BSW, LSW, Team Coordinator Jenny Walker, RN Juanita Steman, RN  Survey Definitions: ADL = Activities of Daily Living CNA = Certified Nursing Assistant DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed	F 000			
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 failed to ensure residents were clothed and/or covered when in public view. This was true for 1 of 7 (#16) random residents. This resulted in the exposure of Resident #16's legs, buttock, and clear adult brief, to anyone in the hallway outside his room. This created the	F 241	F241 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.	10/31/16	

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

TITLE

(X6) DATE

Electronically Signed

10/27/2016

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	<p>Continued From page 1</p> <p>potential for Resident #16 to experience embarrassment and humiliation if observed by passersby. Findings include:</p> <p>On 10/5/16 from 4:10 pm to 4:20 pm, Resident #16's door was observed open. Resident #16 was observed in bed and could be seen from the hallway. His bed covers were off and he had socks on which ended just above the ankles. His bare legs were exposed up to his waist and his left buttock was observed through his clear adult brief, which was also visible from the hallway. During the observation, four staff members passed by the room, with one of the staff members passing by the door twice.</p> <p>On 10/5/16 at 4:20 pm, LN #3 said she could see Resident #16's adult brief from the hallway.</p>	F 241	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #16 was affected by this deficient practice. Resident's privacy curtain was drawn to provide privacy while he is lying in bed. In addition, floor staff were in-serviced on the practice of drawing the privacy curtain when residents are in bed.</p> <p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Since all residents within the facility have the potential to be affected by the same deficient practice the facility has in-serviced all staff on the practice of drawing the privacy curtain when residents are lying in bed.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Root cause analyses showed that, aside from personal cares, privacy curtains were not being drawn when residents were lying in bed with their doors open to the hallway. All curtains will be drawn to the foot of the bed when residents are lying in bed. Ongoing training for all on boarding new</p>		

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F 241	Continued From page 2	F 241	<p>staff as well as routine monthly nursing training for current staff will be conducted to assure that all staff know the practice of drawing the privacy curtains when residents are lying in bed.</p> <p>How will the facility plan to monitor performance to ensure the corrective actions are effective and compliance is sustained?</p> <p>The RN Manager or designee will do random audits of the facility hallways specifically related to privacy curtain use weekly for 30 days, biweekly (x2) and then monthly (x1). All results will be reported to QA monthly (x3) to ensure compliance.</p>		
F 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, it was determined the facility failed to ensure residents received medications without 5% or greater error rate. This directly impacted 2 of 6 residents (#17 and #18) observed during medication pass. A total of 38 medications were observed administered with 2 errors made during administration, resulting in an error rate of 5.2%. This deficient practice placed residents at risk of not receiving medications as ordered by the</p>	F 332	<p>F332 The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p>	10/31/16	

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F 332	<p>Continued From page 3</p> <p>physician and had the potential to lessen the effectiveness of the medications administered. Findings include:</p> <p>1. During the medication pass on 10/4/16 at 9:00 am, Licensed Nurse (LN) #2 entered Resident #18's room to administer albuterol 0.083% nebulizer treatment (a medication that dilates the lung passages) via a hand held device. Prior to the breathing treatment Resident #18 received:</p> <ul style="list-style-type: none"> <li>* Nicorette gum (a smoking cessation aide)</li> <li>* Klor Con M 10 (a potassium replacement) one tablet</li> <li>* Senna (a laxative) 8.5 milligrams (mg)</li> <li>* trazodone (an antidepressant) 25 mg</li> <li>* Vesicare (a bladder medication) 5 mg</li> <li>* Vitamin D3 (a nutritional supplement) 2000 units (4 tablets)</li> </ul> <p>LN #2 stayed in the room to observe the respiratory treatment. No other medications were noted in the room. While reconciling the medications observed as administered, with Resident #18's 10/5/16 medication orders, it was determined Resident #18 should have received Spiriva HandiHaler (a medication that dilates the lung passages) 18 micrograms (mcg) one dose inhaled orally in the morning after the albuterol nebulizer treatment.</p> <p>During an interview on 10/6/16 at approximately 11:00 am, LN #2 was asked when she administered the Spiriva HandiHaler to Resident #18 on 10/4/16, the day of the medication pass. LN #2 stated she administered the inhaler prior to the medication pass observation. She went on to say she always administered the inhalers first,</p>	F 332	<p>Resident #17 and resident #18 were affected by this deficient practice. Both residents have had a medication review and LNs have been provided in-service training in regards to administration of albuterol inhalers before administration of Spiriva Handihaler and also the multi-vitamin Thera-M being administered with food.</p> <p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Since all residents within the facility have the potential to be affected by the same deficient practice the facility has in-serviced all LNs on the administration of breathing treatments and hand held medications. A medication review and audit to identify other residents who have the potential to be affected by these medication passes, including breathing treatments regarding albuterol and Spriva and those medications requiring food intake, has been done.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Root cause analyses showed that licensed nursing staff required further training on following medication orders specifically breathing treatments, hand held medication and medications</p>		

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F 332	Continued From page 4 then provided the albuterol treatment. When asked if she was aware of the order to provide the inhaler after the albuterol treatment, LN #2 replied she was not. Along with the surveyor, LN #2 reviewed the order for Spiriva on Resident #18's electronic medical record (EMR) and determined she had not followed the order.  2. On 10/3/16 at 4:10 pm, as Resident #17 sat at the nurses' station, LN #1 administered a caplet of Thera-M (multivitamin) along with other medications, using a preparation of Arginaid (a nutritional supplement) and water to aid swallowing of the medications. A review of Resident #17's 10/5/16 orders indicated the Thera-M was to be administered with food. The evening meal, on 10/3/16, for residents eating in the north hall dining room, where Resident #17 received his meal, began service at 5:20 pm. This was over an hour after Resident #17 received the Thera-M tablet.	F 332	requiring food intake.  All on boarding nursing staff will be oriented and trained on medication administration via a 16 hour orientation period before allowing them to perform medication passes individually. In addition, monthly in-service curriculum will include medication administration topics, specifically breathing treatments and hand held medications which require food intake.  How will the facility plan to monitor performance to ensure the corrective actions are effective and compliance is sustained?  The RN Manager or designee will do random audits of random licensed nurses performing medication passes, specifically breathing treatments and hand held medications that require food intake, weekly for 30 days, biweekly (x2) and then monthly (x1). All results will be reported to QA monthly (x3) to ensure compliance.		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control	F 441		10/31/16	

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F 441	<p>Continued From page 5</p> <p>Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, policy review, and review of a glucometer manufacturer's recommendations, it was determined the facility failed to ensure glucometers (used to assess blood glucose levels) were cleaned and disinfected according to policy and manufacturer's recommendations for 1</p>	F 441	<p>F441</p> <p>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.</p>		

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F 441	<p>Continued From page 6</p> <p>resident (Resident #19) out of a total of 6 diabetic residents who received blood glucose testing on the west hall. This failure placed diabetic residents at risk for blood borne illnesses related to cross-contamination from equipment that was not adequately disinfected. Findings include:</p> <p>During the medication pass on 10/3/16 at 4:35 pm, LN #1 performed a blood glucose check on Resident #19, as the resident sat in the lobby outside the nurses' station. LN #1 did not clean the glucometer prior to the testing. After returning to her cart, LN #1 cleaned the glucometer with an alcohol swab and replaced it in the cart. At that time, LN #1 confirmed the glucometer was used for all the residents on the west hall.</p> <p>The glucometer's manufacturer's instructions, dated 11/2015, related to cleaning and disinfecting devices used for more than one patient, noted the manufacturer recommended the use of germicidal wipes to clean and disinfect the glucometer after each use.</p> <p>The facility's policy titled, Performing a Blood Glucose Test, updated 1/2015, stated the "glucose machine" should be sanitized "...using a 10:1 bleach solution wipe ..."</p> <p>LN #1 was interviewed on 10/4/16 at 4:10 pm, regarding the glucometer cleaning procedure observed on 10/3/16 at 4:35 pm. LN #1 confirmed she used an alcohol swab to clean the device. She stated she had been using alcohol swabs to clean the glucometer since she began working at the facility just over a year ago.</p>	F 441	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #19 was affected by this deficient practice. Immediate corrective action was the cleaning of the glucometer via the manufacturer's instructions including the recommended use of germicidal wipes to clean and disinfect the glucometer after each use. LN #1 was in-serviced related to the facility policy which reiterates the manufacturer's recommendations of utilizing germicidal wipes to clean and disinfect glucometer after each use.</p> <p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents within the facility who utilize a blood glucometer have the potential to be affected by the deficient practice noted. All LN staff will be in-serviced related to the facility policy and the manufacturer's recommended utilization of germicidal wipes to clean and disinfect each glucometer after each use. Further training/in-servicing for on boarding staff upon orientation as well as continuing education related to the use of germicidal wipes to clean and disinfect glucometers after each use as per facility policy will be ongoing via the facility staff development</p>		

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F 441	Continued From page 7	F 441	<p>protocol.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Root cause analyses showed that this seemed to be an isolated incident with this LN but it had the potential for wide spread deficiency in the facility. Facility policy and procedures related to the cleaning of blood glucometers was reviewed by the Interdisciplinary team and approved to coincide with the manufacturer's recommendation of utilizing germicidal wipes to clean and disinfect glucometers following each use. On boarding LN will be trained upon hire to use the germicidal wipes to clean and disinfect glucometers following each use and ongoing LNs in-servicing will be performed via our staff development coordinator as part of our ongoing continuing education of nursing staff within the facility.</p> <p>How will the facility plan to monitor performance to ensure the corrective actions are effective and compliance is sustained?</p> <p>The RN Manager or designee will do random audits of the blood glucometer procedure with random LN staff weekly for 30 days, biweekly (x2) and then monthly (x1). All results will be reported to QA monthly (x3) to ensure compliance.</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>IDAHO STATE VETERANS HOME - LEWISTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>821 21ST AVENUE LEWISTON, ID 83501</b>		
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F 456 SS=F	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, it was determined the facility failed to ensure 2 out of 3 operating dryers were monitored and maintained in a manner to prevent potential fire hazards for 15 of 15 (#1 - #15) sampled residents, and the remaining 47 residents of the facility's census of 62. In addition, the facility failed to maintain resident equipment in a safe operating condition for 1 of 15 sampled residents (Resident #5). These deficient practices placed all residents in the facility at risk for fire danger related to lint build-up in the facility laundry dryers, and placed Resident #5 at risk for falls or injuries due to faulty brakes. Findings include:</p> <p>During the environmental tour, on 10/5/16 at 4:00 pm, observations were made in the facility laundry. The facility laundry was located on the south end of the main hallway inside the facility. The facility had 3 dryers, but only 2 were in operation (Dryers #1 and #3). The third dryer, Dryer #2, was out of service.</p> <p>a. During the environmental tour on 10/5/16 at 4:00 pm, the Laundry Manager was asked to open the lint compartment for Dryer #1. The Laundry Manager stopped the dryer and opened the compartment to reveal copious amounts of</p>	F 456	<p>F456</p> <p>The facility must maintain all essential mechanical, electrical and patient care equipment in safe operating condition.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>A. In regards to Lint build up in the laundry room dryers, all residents were affected by this deficient practice. Lint traps were cleaned and the laundry/housekeeping supervisor and all laundry/housekeeping personnel were in-serviced on the policy and procedures related to proper maintenance of facility dryers including when dryer lint screens are to be cleaned and the proper documentation of those cleanings.</p> <p>B. In regards to resident #5 and his missing left side auto-locking break. Resident #5 was affected by this deficient practice and the missing auto-locking break was replaced.</p>	10/31/16	

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F 456	<p>Continued From page 9</p> <p>lint collected along the walls. There was also a large sheet of lint draping down from the lint screen. Observations of Dryer #3, at this same time, also showed a large buildup of lint along the sides of the lint compartment. There was a large sheet of lint collected on the lint screen.</p> <p>During the above observations, the Laundry Manager was asked how often the lint screens/traps were cleaned. The Laundry Manager stated the lint traps were cleaned after every 3 loads. He stated this was the third load. When asked if there was a log of when the lint traps were last cleaned, the Laundry Manager provided a form titled, Dryer Lint Trap Cleaning. The form was dated October 2016. For 10/5/16, under the "A.M." column, "10:00" was noted. There were no other times documented for that date.</p> <p>b. On 10/6/16 at 11:20 am, additional observations of the laundry were completed. The 2 working dryers (Dryers #1 and #3) were still the only ones in operation. The lint compartments continued to have lint buildup on the walls of the compartments and a large layer of lint had fallen on the compartment floor, stacking up behind the lint trap in Dryer #1. Dryer #3 had a small amount of lint. The Laundry Manager at that time stated the lint traps had been cleaned approximately 45 minutes to an hour prior to the observations. However, the facility Dryer Lint Trap Cleaning log contained no documentation regarding when the lint traps had been cleaned for 10/6/16.</p> <p>The facility's undated Preventive Maintenance Instructions for the lint screen, instructed the laundry staff to clean the lint screen only daily.</p>	F 456	<p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>A. In regards to Lint build up in the laundry room dryers, all residents have the potential to be affected by the deficient practice. Corrective action includes in-servicing of the Laundry &amp; Housekeeping supervisor and the Laundry &amp; Housekeeping staff related to the policy and procedures related to the proper maintenance of facility dryers, including cleaning of the dryer vents after every 2-3 loads of laundry. New employee orientation for all on boarding staff who will be working in the laundry will also include training on cleaning of lint from the dryers per policy and procedure. New employee orientation for new laundry personnel as well as on-going in-servicing of current personnel in regards to proper documentation of the cleaning of the lint traps.</p> <p>B. In regards to missing auto-lock brakes, all residents have the potential to be affected by this deficient practice. All resident wheel chairs that utilize auto-locking breaks have been audited by the maintenance department and any discrepancies have been rectified.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?</p>		

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F 456	<p>Continued From page 10</p> <p>The instructions further indicated other specific cleaning of various interworking's of the dryers monthly, quarterly, semi-annually, and annually. The Preventive Maintenance Instructions provided no instructions for adjustment of the frequency of lint trap cleaning based on an increase in the workload of one or more of the dryers or based on the amount of lint buildup during the operation of the dryers.</p> <p>The lack of preventative maintainece of the dryers placed sample residents #1 - #15, and all other residents in the facility at risk of harm due to fire.</p> <p>2. Resident #5 was admitted to the facility on 2/22/16 with multiple diagnoses, including a history of falls.</p> <p>Resident #5's fall care plan documented an intervention on 4/6/16 of "Resident has auto-locking brakes to his wheelchair."</p> <p>From 10/4/16 to 10/5/16 Resident #5 was observed in his wheelchair nine times. Resident #5's wheelchair was missing the left side auto-locking brake.</p> <p>On 10/5/16 at 9:15 am, the Building Facility Foreman said the left side auto-locking brake was missing and was not sure how it became detached.</p>	F 456	<p>A. Root cause analysis showed that not all laundry staff were aware of the importance of documenting the cleaning of the lint screens, laundry/housekeeping supervisor will have daily checks of the dryer lint trap cleaning log added to their daily tasks.</p> <p>B. Root cause analysis showed that auto locking breaks were only noted to be missing and/or broken when it was noticed by personnel within the facility who would then thereby notify maintenance personnel. Maintenance personnel will now be given a weekly list of all residents whom are utilizing auto-lock brakes for weekly visual inspection by maintenance personnel.</p> <p>How will the facility plan to monitor performance to ensure the corrective actions are effective and compliance is sustained?</p> <p>A. The Maintenance Supervisor or designee will do random audits of the laundry room lint traps and dryer lint trap cleaning log weekly for 30 days, biweekly (x2) and then monthly (x1). All results will be reported to QA monthly (x3) to ensure compliance.</p> <p>B. The Maintenance Supervisor or designee will do random audits of the residents utilizing auto-lock brakes to assure proper placement and workability weekly for 30 days, biweekly (x2) and</p>		

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

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F 456	Continued From page 11	F 456	then monthly (x1). All results will be reported to QA monthly (x3) to ensure compliance.		