



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

September 11, 2015

Josiah C. Dahlstrom, Administrator  
Idaho State Veterans Home - Pocatello  
1957 Alvin Ricken Drive  
Pocatello, ID 83201-2727

Provider #: 135132

Dear Mr. Dahlstrom:

On **August 28, 2015**, a survey was conducted at Idaho State Veterans Home - Pocatello by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be 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. 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 **September 24, 2015**. Failure to submit an acceptable PoC by **September 24, 2015**, may result in the imposition of civil monetary penalties by **October 14, 2015**.

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 **October 9, 2015 (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 **October 9, 2015**. A change in the seriousness of the deficiencies on **October 9, 2015**, 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 **October 9, 2015** includes the following:

Denial of payment for new admissions effective **November 28, 2015**. [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 **February 28, 2016**, 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 **August 28, 2015** 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 **September 24, 2015**. If your request for informal dispute resolution is received after **September 24, 2015**, 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,



NINA SANDERSON, L.S.W., Supervisor  
Long Term Care

NS/dmj  
Enclosures

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

PRINTED: 09/11/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135132</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/28/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>IDAHO STATE VETERANS HOME - POCATELLO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201</b>
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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 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from August 24 to August 28, 2015.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Amy Barkley, RN, BSN</p> <p>Survey Definitions: BG = Blood Glucose CNA = Certified Nurse Aide DNS = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record NC = Nasal Cannula PRN = As Needed SDC = Staff Development Coordinator TAR = Treatment Administration Record</p>	F 000	<p>Preparation and execution of this Plan of Correction (PoC) is not an admission of guilt nor does the provider agree with the conclusions set forth in the Statement of Deficiencies rendered by the Bureau. The Plan of Correction is prepared and executed simply as a requirement of federal and state law. We maintain that the alleged deficiencies do not individually, or collectively, jeopardize the health and safety of our residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of skilled nursing facilities, and this document, in its entirety, constitutes this providers claim of compliance.</p>	
F 279 SS=D	<p><b>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</b></p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under</p>	F 279	<p>Completion dates are provided for the procedural procession purposes to comply with the state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in compliance with the requirements of participation or that corrective actions were necessary.</p> <p><b>F279</b> <b>Corrective Actions:</b> 1 of 13 sampled residents was affected and no other residents were receiving dialysis at the time of survey. A dialysis care plan was implemented for resident #9 on 8/27/15. <b>Identification of others affected and corrective actions:</b> All residents in the facility were reviewed and no others were receiving dialysis</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Gosia Dabstow* TITLE: *Administrator* (X6) DATE: *9/22/15*

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 279	Continued From page 1 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a dialysis care plan was developed for a resident who received dialysis services. This affected 1 of 1 (#9) residents sampled for dialysis. This failure created the potential for harm if residents experienced complications and/or compromised medical status. Findings included:  Resident #9 was admitted to the facility on 5/28/15 with multiple diagnoses including end stage renal disease.  The resident's August 2015 Medication Review Report (Recapulation order) documented the resident had dialysis Monday, Wednesday and Friday.  A dialysis care plan was not found in the resident's medical record. Refer to F309 regarding dialysis care.  On 8/27/15 at 5:30 PM, the DNS was interviewed. She said the facility had not developed a specific care plan for the resident's dialysis care.	F 279	services, therefore no others had the potential to be affected. <b>Measures to ensure the deficient practice does not reoccur:</b> A comprehensive dialysis care plan was developed and implemented for resident #9. All residents are reviewed as an inquiry to our home prior to admission. Any residents receiving dialysis cares will be noted by the review team to ensure quick implementation of a dialysis plan of care upon admission. <b>Monitor corrective actions:</b> The IDT will review care plans for all residents on a quarterly basis, or more often if deemed necessary by the IDT. Specific medical concerns will be addressed on the care plan and audited by the DNS/designee during these reviews and the DNS/designee will address concerns as they arise and report findings to the home's monthly QA committee for further monitoring and discussion as deemed necessary to maintain compliance. <b>Corrective Actions will be completed:</b>	9/28/15
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged	F 280	<b>F280</b>  <b>Corrective Actions:</b> 2 of 13 sampled residents were affected by care plan revisions not being completed for	

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F 280	<p>Continued From page 2</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, it was determined the facility failed to revise care plans for 2 of 13 (#s 3 &amp; 7) sampled residents. The care plans: *Did not include Resident #3 received BG checks after meals; *Did not document Resident #3 had oxygen; and, *Was not revised when Resident #7 received oxygen during the day. This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in their care plans. Findings included:</p> <p>1. Resident #3 was readmitted to the facility on 12/10/13 with multiple diagnoses including</p>	F 280	<p>residents #3 and 7. Revisions were made to these two care plans prior to the exit of the survey team on 8/28/15.</p> <p><b>Identification of others affected and corrective actions:</b> Any residents receiving blood glucose checks or oxygen could have been affected. All resident care plans have been audited to ensure appropriate revisions regarding blood glucose checks and oxygen. All necessary revisions have been made to the care plan and physician's orders.</p> <p><b>Measures to ensure the deficient practice does not reoccur:</b> All residents care plans are reviewed by the IDT at least quarterly to ensure appropriate revisions are made. Any residents receiving blood glucose checks or oxygen have been reviewed and revisions have been completed where necessary. All current physician orders have also been checked with the resident care plan to ensure they are accurate and up to date.</p> <p><b>Monitor corrective actions:</b> The IDT will review care plans for all residents on a quarterly basis, or more often as deemed necessary by the IDT. The orders will be verified against the care plan to ensure accuracy and the DNS/designee will provide an audit as often as these IDT meetings are held. The DNS/designee will report findings to the home's monthly QA committee for further monitoring and discussion as deemed necessary to maintain compliance.</p> <p><b>Corrective Actions will be completed:</b></p>	9/28/15	

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F 280	<p>Continued From page 3</p> <p>diabetes type II and acute respiratory failure.</p> <p>A. The resident's 8/8/15 Physician's orders documented the resident received HumaLog insulin on a sliding scale after meals.</p> <p>The care plan did not indicate BGs were to be checked after meals.</p> <p>B. The resident's 6/5/15 Physician's Orders documented the resident to have oxygen at 3 liters per minute via NC and to titrate to resident comfort and wife's request. Refer to F328.</p> <p>The resident's current care plan did not document the resident used oxygen.</p> <p>From 8/24 to 8/26/15, the resident was observed seven times to have oxygen on via NC at 3 liters and was observed four times without any oxygen on.</p> <p>On 8/27/15 at 4:45 PM, the DNS was interviewed regarding the care plan. She said the insulin order to check BGs and administer insulin after meals was unique and it should have been on the care plan. She also said oxygen was not on the current care plan and must have fallen off when the care plan was updated.</p> <p>2. Resident #7 was readmitted to the facility on 8/24/13 with multiple diagnoses including acute respiratory failure and sleep apnea.</p> <p>The resident's 10/31/13 O2 Physician's order documented the resident was to receive 2 liters per minute via NC as needed for signs and symptoms of hypoxia, monitor oxygen saturation</p>	F 280			

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F 280	Continued From page 4 PRN and was to receive 2 liters per minute every night shift related to sleep apnea.  The resident's care plan documented a revised intervention on 6/4/15 for, "Uses oxygen at night..."  From 8/24 to 8/26/15, the resident was observed three times to have his oxygen on via NC at 2 liters while in bed and one time in his wheelchair, during daytime hours.  On 8/26/15 at 12:15 PM, the resident was interviewed. He said he used oxygen whenever he laid down and occasionally used it when he was in his wheelchair too.  On 8/27/15 at 4:40 PM, the DNS was interviewed. When asked if the resident used oxygen during the day, she said he used it when he laid down and the care plan needed to be updated to reflect that.	F 280			
F 281 SS=D	<b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b>  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interview, it was determined the facility failed to ensure oxygen (O2) was not administered by unlicensed staff. This was true for 1 of 5 (#7) residents sampled for oxygen. This created the potential for harm if Resident #7's O2 to be administered incorrectly. Findings included:	F 281	<b>F281</b>  <b>Corrective Actions:</b> 1 of 5 sampled residents was affected by this deficient practice. The facility policy and procedures have been updated to allow the nurses to delegate certain tasks to staff that would allow a competent staff member to turn on/off an oxygen concentrator without adjusting the liter flow of oxygen. Nursing staff have been updated to this policy change.  <b>Identification of others affected and corrective actions:</b> Any residents receiving oxygen from a concentrator could have been affected. The facility policy has been updated to allow		

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F 281	Continued From page 5  The facility's Nursing Procedure Manual documented, "1. a) Oxygen is administered by licensed staff and/or by the resident under supervision of the licensed nurse."  Resident #7 was readmitted to the facility on 8/24/13 with multiple diagnoses including acute respiratory failure.  The resident's 10/31/13 O2 Physician's order documented the resident was to receive 2 liters per minute via NC as needed for signs and symptoms of hypoxia.  On 8/25/15 at 8:58 AM, the resident was observed to be transferred from his wheelchair into his bed by two CNAs with a mechanical lift. After the transfer CNA #3 gave the resident his NC and then turned on the O2 room air concentrator next to the bed. The liter flow was set at 2 liters per minute. The surveyor spoke with the resident another minute and then left the room. The CNAs then went to assist other residents. A licensed nurse was not observed in the resident's room to check the concentrator's level.  On 8/25/15 at 9:12 AM, CNA #3 was interviewed about the concentrator. She said the CNAs were told they were allowed to turn on the O2 concentrators, but not the O2 wall units or oxygen tanks.  On 8/27/15 at 4:40 PM, the DNS was interviewed and asked about CNAs turning on concentrators. She said the facility allowed the CNAs to turn on the concentrators and said it was not considered administering medications since the levels should	F 281	delegation of duties for oxygen to competent staff (per IDAPA 23.01.01, accessed through <a href="http://adminrules.idaho.gov/rules/2014/23/0101.pdf">http://adminrules.idaho.gov/rules/2014/23/0101.pdf</a> . Staff have been educated and found competent and there is documentation as proof of this education. The SDC contacted the Idaho Board of Nursing on 9/16/2015 and spoke with the Executive Director for Practice and Education regarding the practice of competent staff turning on pre-set concentrators when moving oxygen use from a canister to a concentrator for a resident. The final decision was twofold: 1) if staff will not be required to do any type of assessment and 2) if staff will not change the oxygen rate flow. If these 2 conditions are met then "it is not unreasonable if the task of turning on the concentrator were delegated to trained and competent personnel." <b>Measures to ensure the deficient practice does not reoccur:</b> Home staff have been educated and trained regarding the change in policy that would allow staff delegated authority to turn on/off oxygen concentrators as long as they are not adjusting the liter flow of oxygen. The LN will also provide a list of all residents on each hall with orders for oxygen and delegate to the competent staff to observe and report that the flow rate on the concentrators matches the orders on the list provided by the LN. <b>Monitor corrective actions:</b> The LN/designee assigned to each hall will audit oxygen concentrator flow rate every shift x 2 weeks, daily x 2 weeks, weekly x 2 weeks to ensure this practice is followed per facility policy and state of Idaho Board of Nursing standards. The DNS/designee will		

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F 281	Continued From page 6 already be set prior to the CNAs turning on the concentrators. When asked about the potential for the liter flow to be adjusted by others prior to the CNAs turning it on, she said the LNs would check it after it was turned on.	F 281	report findings to the home's monthly QA committee for further monitoring and discussion as deemed necessary at which point the QA committee may adjust the monitoring to ensure sustained compliance. <b>Corrective Actions will be completed:</b>	9/28/15	
F 309 SS=E	<b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure: *Staff received direction regarding Resident #9's dialysis care, Resident #9 had an order for hypoglycemic events, and the resident did not experience a delay in treatment for Speech Therapy; *Residents admitted without specific sliding scale insulin orders had appropriate standing orders in place; and, *Resident #2 did not experience a delay in treatment for Occupational Therapy. This affected 2 of 13 (#s 2 & 9) sampled residents and any resident admitted without specific sliding scale insulin orders. These failures created the potential for harm if residents experienced complications and/or compromised medical status. Findings included:	F 309	<b>F309</b>  <b>Corrective Actions:</b> 2 of 13 sampled residents were affected and any resident admitting with orders for dialysis or insulin related to blood glucose checks or orders for OT and/or ST could have been affected. A dialysis care plan was implemented for resident #9 on 8/27/15, an order for hypoglycemic events was also obtained for resident #9 and a new contracted therapy provider began services in our home on 9/1/2015. <b>Identification of others affected and corrective actions:</b> Any resident with orders for BG checks and/or OT/ST and/or dialysis could have been affected. An audit of all residents receiving BG checks and all residents with orders for therapy has been conducted. There are no other residents in the facility on dialysis at this time. Physician standing orders have been removed regarding BG checks and all residents with a need for BG checks has an individualized plan in place. A reference guide for hypoglycemia has also been implemented for LN to follow and is included in the MAR of each resident. <b>Measures to ensure the deficient practice does not reoccur:</b> See "Identification of others affected and corrective actions" listed above. All LN staff have been in serviced regarding these		

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NAME OF PROVIDER OR SUPPLIER  IDAHO STATE VETERANS HOME - POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201		
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F 309	Continued From page 7  1. Resident #9 was admitted to the facility on 5/28/15 with multiple diagnoses, including end stage renal disease and diabetes Type II.  A. The resident's August 2015 Medication Review Report (MRR) documented the resident received dialysis each Monday, Wednesday and Friday.  A dialysis care plan was not found in the resident's medical record. Refer to F279.  On 8/27/15, when asked about his dialysis care in the facility, the resident displayed his upper right arm and said the AV (Arteriovenous) fistula site was "never" checked by facility nurses and the nurses did not listen for the thrill and bruit with a stethoscope after dialysis care.  On 8/27/15, when asked to describe the resident's post-dialysis care, LN #1 said he was weighed, blood glucose level checked, and staff ensured he ate lunch. She said the AV fistula site was not checked nor were the thrill and bruit assessed.  On 8/27/15, the DNS said there was not a dialysis care plan for the resident. In addition to weighing the resident and ensuring he ate lunch following dialysis, the DNS stated the dialysis communication sheets were reviewed and any follow up recommendations by the dialysis center was completed. She said the AV fistula site was not checked nor were the thrill and bruit assessed.  B. The facility's Nursing Procedure Manual documented residents with a BG from 40-60	F 309	changes and the proper documentation regarding hypo/hyperglycemia. The MDS coordinator/designee will audit all residents with orders for therapies weekly in the weekly UR meeting to ensure treatment is not delayed and the new therapy contract will have a Director of Rehab beginning on 10/5 that will attend the daily stand up meeting to ensure that all new admits with orders for therapy receive treatment without delay.  <b>Monitor corrective actions:</b> DNS/RN designee will audit all BG documentation daily x 2 weeks, twice weekly x 2 weeks and weekly x 4 weeks. The MDS coordinator/LN designee will audit all therapies weekly in the weekly UR meeting to ensure treatment is not delayed. The DNS/LN designee will report findings to the home's monthly QA committee for further monitoring and discussion as deemed necessary by the QA committee to ensure sustained compliance.  <b>Corrective Actions will be completed:</b>	9/28/15	

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F 309	<p>Continued From page 8</p> <p>milligrams per decaliter (mg/dl) and 60-70 mg/dl should receive 15 grams of carbs and staff should notify the resident's physician.</p> <p>Resident #9's August 2015 MRR documented the resident received NovoLog insulin on a sliding scale for diabetes. The August Report and MAR did not document hypoglycemic parameters.</p> <p>The resident's August 2015 MAR documented that from 8/1/15 to 8/24/15 the resident had four BGs between 51-59 mg/dl and four BGs between 60-70 mg/dl. The resident received juice for 3 of 8 low BGs, but the MAR and Progress Notes did not indicate the physician was notified on any of the identified low BGs.</p> <p>On 8/26/15, RN Manager #2 and the SDC were interviewed regarding the resident's diabetic management. RN Manager #2 reviewed the order and said there should have been a hypoglycemic parameter for the resident, but it must have been missed when the order was transcribed. The SDC said nurses are expected to know and follow the procedure for low BGs.</p> <p>C. Resident #9's Progress Notes documented: -7/3/15, "...small amount of emesis..;" -7/21/15, "...Res[ident] has c/o [complained of] trouble swallowing;" -8/4/15, "Res to have a swallow evaluation for dysphagia and regurgitation;" -8/20/15, "Resident c/o nausea. Scant emesis..;" and, -8/26/15, "Resident requested hall tray after leaving the dining room stating he felt nauseous [sic]. Resident found in room vomiting in his trash can. Reports he has done this before and it is not specific to any meal or time of day...On 8-24-15</p>	F 309			

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F 309	<p>Continued From page 9</p> <p>therapy was given a referral for ST [Speech Therapy] to evaluate for swallow."</p> <p>Physician Orders, dated 8/3/15, documented the resident was to receive a ST evaluation for swallowing, dysphagia, and regurgitation issues.</p> <p>On 8/26/15, the resident said he told staff before when he felt nauseated and had vomited, but staff "did not do anything" about it.</p> <p>On 8/27/15, the Director of Rehabilitation said the ST evaluation was not yet completed because the facility did not have a Speech Therapist on site and had trouble getting one to come to the facility to evaluate the resident.</p> <p>2. The facility's Nursing Procedure Manual documented residents with a BG under 40 mg/dl, who were alert and able to swallow, were to receive oral glucose gel and staff were to wait 30 minutes before rechecking the resident's BG level. Residents unable to swallow or who were unresponsive with a BG under 40 mg/dl were to receive a Glucagon injection in the upper arm or thigh and staff were to recheck the resident's BG 10 minutes after the injection.</p> <p>Standing Orders located on the nurses medication cart documented residents with BG under 40 mg/dl were to receive "Glucagon 1 mg. PO [by mouth] or IM [Intramuscular] if unable to take PO. Recheck blood sugar in 15 minutes."</p> <p>The Standing Orders signed by the Medical Director on 12/10/14 documented that residents with BG under 40 mg/dl were to receive "Glucagon 1 mg. PO or IM if unable to take PO. Recheck blood sugar in 20 minutes."</p>	F 309			

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F 309	<p>Continued From page 10</p> <p>On 8/26/15, RN Manager #2 and the SDC were interviewed regarding the conflicting Nursing Procedure Manual and the Standing Orders. The SDC said there was a discrepancy between the two documents, which would be addressed. Both RN Manager #2 and SDC said they were not sure why the facility had a standing order for sliding scale insulin since each resident had specific BG parameters based on their diabetic management history. The SDC said the insulin information should be taken out of the standing orders.</p> <p>On 8/27/15, the Medical Director said the facility would use the standing orders only if an admitting physician did not issue specific sliding scale insulin orders for a newly admitted resident. He said if the admitting physician did not update the standing orders, then he or one of his physician assistants would review and adjust the orders within 24 hours of the admission for the specific resident. The Medical Director stated he was not aware of the conflicting BG-recheck times on the three different documents. He said nurses are expected not to rely on facility protocol, but rather follow the specific orders for the resident.</p> <p>3. Resident #2 was admitted to the facility on 8/14/15 for aftercare following a fracture of the acetabulum. The resident's admission orders directed Physical- and Occupational Therapy to evaluate and treat.</p> <p>On 8/17/15, the resident was evaluated by Physical Therapy and ordered physical therapy 3 times a week for 4 weeks for bed mobility, transfers, gait, therapeutic exercise/activities,</p>	F 309		

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F 309	Continued From page 11 positioning, posture and safety. The resident's treatment notes documented physical therapy was provided on 8/17, 8/18, 8/20, and 8/24.  On 8/19/15, Occupational Therapy evaluated the resident and ordered occupational therapy 3 times a week for 4 weeks for therapeutic exercise, functional mobility, and self care to increase independence in Activities of Daily Living. The resident's treatment notes documented the resident was not seen by occupational therapy until 8/25/15.  On 8/27/15, when asked why the resident did not receive occupational therapy until 8/25/15, the Therapy Director stated he was instructed by the previous director that physical therapy and occupational therapy could not occur on the same day.	F 309		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and	F 328	<b>F328</b>  <b>Corrective Actions:</b> 2 of 5 sampled residents were affected and any resident with orders for oxygen could have been affected. The orders for oxygen for these 2 residents have been clarified to reflect the current status of the residents. Lack of oxygen saturation monitors for August were not available because as noted in the findings on page 13 and 14 of the 2567, resident #7 "Physician's Orders documented the resident was to receive 2 liters per minute via NC as needed." Resident #7 did not exhibit symptoms of hypoxia in August and therefore did not require documentation of such. <b>Identification of others affected and corrective actions:</b>	

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F 328	<p>Continued From page 12</p> <p>resident and staff interview, it was determined the facility failed to ensure residents who used oxygen:</p> <ul style="list-style-type: none"> <li>*had orders with liter flow parameters;</li> <li>*received oxygen according to the physician's orders; and,</li> <li>*were monitored for signs and symptoms of hypoxia (oxygen deficiency).</li> </ul> <p>This was true for 2 of 5 (#s 3 &amp; 7) residents sampled for oxygen and created the potential for harm should residents received oxygen therapy contrary to physician orders. Findings included:</p> <p>1. Resident #3 was readmitted to the facility on 12/10/13 with multiple diagnoses, including acute respiratory failure.</p> <p>The resident's 6/5/15 Physician's Orders documented the resident was to receive oxygen at 3 liters per minute via NC. The order allowed titration per resident comfort and family request every shift "for comfort measures."</p> <p>From 8/24/15 to 8/26/15, the resident was observed seven times to have oxygen on via NC at 3 liters per minute and was observed four times without oxygen.</p> <p>On 8/27/15, the DNS said the titration order appeared to be "an open book" and the order needed clarification.</p> <p>2. Resident #7 was readmitted to the facility on 8/24/13 with multiple diagnoses, including acute respiratory failure and sleep apnea.</p> <p>The resident's 10/31/13 Physician's Orders documented the resident was to receive 2 liters per minute via NC as needed for signs and</p>	F 328	<p>Any residents receiving oxygen could have been affected. All residents on oxygen have been audited to ensure the orders match the current practice of oxygen delivery. All necessary revisions have been made to the care plan and physician's orders. LN's have been in serviced to ensure that all residents on oxygen have oxygen saturations documented per the physician's order.</p> <p><b>Measures to ensure the deficient practice does not reoccur:</b></p> <p>All Residents with orders to titrate oxygen will continue to have saturations monitored daily in the TAR. The DNS/designee will audit the documentation daily to ensure compliance as noted above.</p> <p><b>Monitor corrective actions:</b></p> <p>The DNS/designee will audit the documentation daily x 2 weeks, twice weekly x 2 weeks and weekly x 4 weeks to ensure compliance. The DNS/designee will report findings to the home's monthly QA committee for further monitoring and discussion by the QA committee to ensure sustained compliance.</p> <p><b>Corrective Actions will be completed:</b></p>	9/28/15	

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F 328	Continued From page 13 symptoms of hypoxia, oxygen saturation levels were to be monitored as needed, and the resident was to receive 2 liters per minute every night shift related to sleep apnea.  The resident's August 2015 TAR included spaces to document O2 saturation levels, but the spaces for August were blank.  The resident's August 2015 Progress Notes did not document O2 saturation levels were monitored.  From 8/24/15 to 8/26/15, the resident was observed three times to have his oxygen on via NC at 2 liters while in bed and one time in his wheelchair. The resident was also observed five times without oxygen while in his wheelchair.  On 8/26/15, the resident said he used oxygen whenever he lied down and occasionally used it when he was in his wheelchair.  On 8/27/15, when asked about the oxygen night shift order, the DNS said the resident used it when he lied down and upon request. The DNS stated the order should have been clarified. When asked about the lack of oxygen saturation monitors, the DNS stated the physician's orders needed updating to meet the resident's needs.	F 328			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State	F 425	<b>F425</b>  <b>Corrective Actions:</b> 1 of 8 sampled residents was affected and any resident with orders for phosphate binders could have been affected. The pharmacist and physician have reviewed resident medications and the administration		

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F 425	<p>Continued From page 14</p> <p>law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to collaborate with the physician regarding significant interactions between medications or educate Licensed Nurses to specific time parameters for the administration of identified medications. This was true for 1 of 8 (#9) sampled residents. Findings Included:</p> <p>Resident # 9 was admitted to the facility 5/28/15 with diagnoses including hypothyroidism and end stage renal disease.</p> <p>Physician's Orders, dated 7/26/15, documented: * Levothyroxine Sodium 75 mcg (micrograms) by mouth one time a day, at 7:00 AM, for hypothyroidism. * Fosrenol (lanthanum carbonate) 500 mg chewable tablet by mouth, at 7:00 AM, 12:00 PM, and 5:00 PM, with meals related to end stage</p>	F 425	<p>times of the phosphate binders have been corrected. Hypothyroidism is being monitored through the TSH every 3 months for resident #9.</p> <p><b>Identification of others affected and corrective actions:</b> All residents with orders for phosphate binders could be affected by this deficient practice. The home's pharmacist has performed an audit of all medications and potential interactions. No other residents are of concern for this interaction. Any resident with orders for phosphate binders will be reviewed by the pharmacist, who will contact the physician regarding any concerns and the pharmacist will educate the nursing staff regarding appropriate medication administration times.</p> <p><b>Measures to ensure the deficient practice does not reoccur:</b> Enhanced communication will be initiated through the "Physician Action Reports" and "DNS Month End Report". The medication labels will state administration warnings for these medications. TSH will be monitored every 3 months for any resident with these medications. LN's have been educated regarding specific time parameters for the administration of these medications.</p> <p><b>Monitor corrective actions:</b> The pharmacist will perform a monthly medication pass audit to ensure administration times are adhered to and residents with new orders for phosphate binders will also be audited. All findings will be reported to the DNS who will also report to the monthly QA meeting for further monitoring and discussion by the QA committee to ensure sustained compliance.</p> <p><b>Corrective Actions will be completed:</b></p>	9/28/15	

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F 425	<p>Continued From page 15</p> <p>renal disease.</p> <p>* Phoslo (calcium acetate) 1334 mg capsule by mouth before meals, at 7:00 AM, 12:00 AM, and 5:00 PM, related to end stage renal disease.</p> <p>Scheduled times for administration of the medications were determined and implemented by the Pharmacist.</p> <p>Review of the Manufacturer's specifications documented Levothyroxine should be administered "at least 2 hours before or 2 hours after the Fosrenol related to decreased bioavailability of the Levothyroxine" when taken together. Additionally, the administration of Levothyroxine and calcium acetate should be separated by 4 hours due to decreased bioavailability of the levothyroxine. Bioavailability refers to the degree and rate at which a substance is absorbed into a living system.</p> <p>On 8/25/15 at 7:55 AM, Resident #9 was observed simultaneously taking Levothyroxine, Fosrenol, and calcium acetate administered by LN #4.</p> <p>The resident's Electronic Medication Record and the resident's medication cards were reviewed and did not include specific instructions related to administering Levothyroxine and Fosrenol 2 hours apart, and the Levothyroxine and calcium acetate 4 hours apart.</p> <p>On 8/25/15, the pharmacist stated she was aware of the interactions between the identified medications if administered together. When asked why that information was not documented on the medication cards and/or the Resident's Electronic Medication Record, the pharmacist</p>	F 425			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135132</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO STATE VETERANS HOME - POCATELLO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	Continued From page 16 stated she did not feel the interactions were sufficiently significant to include that information or to alert the Licensed Nurses. When asked if she notified or obtained physician input related to interactions between the medications, the pharmacist stated facility staff depended upon her to make clinical decisions every day in regards to medication and she did not feel the interactions warranted collaboration with the physician or Licensed Nurses.	F 425			