



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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3232 Elder Street
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Boise, ID 83720-0009
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CERTIFIED MAIL: 7012 3050 0001 2128 3665

September 2, 2014

James L. Roberts, Administrator
Idaho State Veterans Home - Boise
320 Collins Road, PO Box 7765
Boise, ID 83707-1765

Provider #: 135131

Dear Mr. Roberts:

On **August 21, 2014**, a Recertification and State Licensure survey was conducted at Idaho State Veterans Home - Boise 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 and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 15, 2014**. Failure to submit an acceptable PoC by **September 15, 2014**, may result in the imposition of civil monetary penalties by **October 6, 2014**.

The components of a Plan of Correction, as required by CMS include:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring.
 - * It is important that the individual doing the monitoring have the appropriate experience and qualifications for the task.
 - * The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3.
 - * A plan for "random" audits will not be accepted.
 - * Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column (X5).

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

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

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **September 25, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **September 25, 2014**. A change in the seriousness of the deficiencies on **September 25, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 25, 2014** includes the following:

Denial of payment for new admissions effective **November 21, 2014**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 21, 2015**, 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, they will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional

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Office or the State Medicaid Agency beginning on **August 21, 2014** 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 **September 15, 2014**. If your request for informal dispute resolution is received after **September 15, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



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

LKK/dmj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/21/2014
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 320 COLLINS ROAD, 83702-4519 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 federal recertification survey of your facility. The survey team entered the facility on August 18, 2014 and exited on August 21, 2014. The surveyors were: Lauren Hoard RN BSN, Team Coordinator Linda Kelly RN Michael Case LSW BSW QIDP Linda Hukill-Neil RN Judy Atkinson RN Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide CP = Care plan DON/DNS = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MSDS = Material Safety Data Sheets PRN = As Needed	F 000	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.		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews, it was determined the facility failed to	F 226	F-226 This requirement was not met as evidenced by the determination that the facility failed to recognize and investigate a resident's derogatory statements about his roommate as possible verbal abuse. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. On August 20, 2014, the facility began an investigation into the identified issue between resident #12 and # 19. The Idaho Department of Health and Welfare Bureau of Facility Standards was notified of the investigation into potential verbal abuse per the directions in Idaho Department of Health and Welfare Bureau of Facility Standards	RECEIVED SEP 12 2014 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James S. Roberts NHA TITLE: ADMINISTRATOR (X6) DATE: 09/11/2014

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 226	<p>Continued From page 1</p> <p>recognize and investigate a resident's derogatory statements about his roommate as possible verbal abuse. The failure affected 2 of 21 sample residents (#s 12 and 19) and created the potential for psychological harm for both residents. Finding included:</p> <p>Resident #12 was admitted to the facility in September 2010, and readmitted in November 2010, with multiple diagnoses which included dementia and hearing loss.</p> <p>Resident #12's annual MDS assessment, dated 8/8/14, coding included: * Highly impaired hearing; and, * Intact cognition with a BIMS score of 14.</p> <p>The resident's care plan included the focus area, "Communication, Altered" with a history of impaired hearing and cochlear implant. It was revised 5/19/14. Interventions included, "I will refuse to wear my hearing aids...I will throw them and use profanity. My family has them now" [and] "speak in a loud voice."</p> <p>On 8/18/14 at 12:28 p.m., the resident was observed in his wheelchair (w/c) watching television (TV) in his room. When asked how things were going, the resident pointed to the privacy curtain drawn between him and his roommate's side of the room and loudly said, "He's an asshole." When asked to explain, the resident waved the surveyor away. The resident's roommate was not in the room at the time.</p> <p>On 8/19/14 at 2:30 p.m., when the surveyor knocked at the door, Resident #12's roommate, Resident #19, said "Come in." When informed the surveyor was going to talk with Resident #12,</p>	F 226	<p>Information Letter #2014-04.</p> <p>The investigation was completed and identified that there were staff aware that resident #12 was saying derogatory statements about his roommate and within his roommate's presence. Resident #19 stated when interviewed, that he had heard some of these statements from his roommate and he stated that they did not make him feel very good. Resident #19 was amenable to changing roommates. Resident #19 was offered a room change and he accepted. On 8/20/2014 he was assisted to relocate to his new room.</p> <p>On 8/20/14 and completed on 8/22/2014, facility staff in all departments were specifically in-serviced on the responsibility to report resident grievances; for example one roommate not liking or getting along with another roommate. This in-service also explained verbal abuse and the requirement to report any resident grievance to the social worker and the RN Unit Manger.</p> <p>On 8/28/14: Resident abuse as well as a resident who voices a grievance and the responsibility of all staff members to be aware and report any suspicion of abuse or resident grievance to Social Services Personnel and Nurse Manager Personnel were discussed at the 'All Staff In-Service'.</p> <p>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 home are at risk of being affected by the identified deficient practice.</p> <p>On 8/20/14 and completed on 8/22/2014, facility staff in all departments were specifically in-serviced on the responsibility to report resident grievances, for example one roommate not liking or getting along with another roommate. This in-service also explained verbal abuse and the requirement to report any resident grievance to the social worker and the RN Unit Manger.</p> <p>On 8/28/14: Resident abuse as well as a resident who voices a grievance and the responsibility of all staff members to be aware and report any suspicion</p>		

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F 226	<p>Continued From page 2 Resident #19 replied, "Okay."</p> <p>On 8/19/14 from 2:30 to 2:45 p.m., Resident #12 was interviewed. When asked about his room, Resident #12 pointed toward the privacy curtain and loudly said, "He's an asshole. Everybody knows it. He's a jerk." When asked to explain, Resident #12 said, "He shits all the time. He's a shitter. Need to get rid of him." The resident was asked if he had talked to staff about the problem. He said, "They all know. They won't get him out of here." Resident #12 did not recall to which staff he had talked.</p> <p>The resident's roommate was on his side of the room during the interview with Resident #12. Resident #19's silhouette was visible on the privacy curtain drawn between the two residents. He was sitting up. He did not make any sounds or movements during the interview.</p> <p>On 8/19/14 at 2:48 p.m., LN #3 was informed of the aforementioned interview with Resident #12 and that Resident #19 was in the room when the derogatory comments were made about him. The LN said she was aware Resident #12 disliked Resident #19 and that Resident #19 "has not voiced any concerns like that." The LN referred the surveyor to the Social Worker.</p> <p>On 8/19/14 at 3:05 p.m., Social Worker (SW) #4 was informed of the interview with Resident #12 and Resident #19 was in the room when the derogatory comments were made. The SW was also informed of the interview with LN #3. The SW said he was not aware Resident #12 disliked his roommate. The SW said Resident #12 did not voice any concerns when he interviewed him the previous week. The SW said Resident #19 "does</p>	F 226	<p>of abuse or resident grievance to Social Services Personnel and Nurse Manager Personnel were discussed at the 'All Staff In-Service'.</p> <p>3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. Social Services Department has a MSW designated to each of the three Skilled Nursing Units. The MSW Social Services personnel have amended their review of residents on at least a quarterly basis, in conjunction with the RAI schedule, to specifically query with the resident about their roommate status, and explore any grievances. All MSW's have been in-serviced to this new query and charting expectation. CQI- Indicator: Social Services has been amended to include following areas:</p> <ul style="list-style-type: none"> • Annual and Quarterly assessments are complete and reflective of residents psychosocial status including: Restraints; Mood/Behavior/ Cognition/Medications; Nutritional concerns; New preferences or needs; Roommate relationship status; DC status, advanced directives; and • Resident and/or family complaints/ grievances are acted upon and documented. LN Orientation and Competency Checklist and the CNA Orientation and Competency Checklist have each been revised to include line items: <ul style="list-style-type: none"> • Able to identify Abuse, Neglect and Exploitation and how to report them to Social Services, RNM, DNS; and • Able to identify what are resident grievances and how to report them to Social Services, RNM, DNS. <p>All newly hired nursing personnel will receive this education.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. CQI-Social Services will be done Q two weeks x two weeks, then monthly x two months and then no less than biannually.</p>	

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

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OMB NO. 0938-0391

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F 226	<p>Continued From page 3</p> <p>have defecation behaviors which have improved." The SW said the two residents were roommates before a temporary relocation because of a renovation project and they resumed being roommates on 7/1/14, at which time Resident #12 was "happy." When asked if nursing had communicated that Resident #12 disliked his roommate, the SW said, "No." The SW indicated that he would look into the issue.</p> <p>On 8/20/14 at 9:00 a.m., when asked about the aforementioned issue, SW #4 said he was about to look into it.</p> <p>Resident #12's clinical record contained Progress Notes (PN), dated 6/5/14 through 8/20/14. These PN did not contain any entries which indicated the resident made derogatory comments about his roommate.</p> <p>On 8/20/14 at 10:00 a.m., Unit Manager (UM) #5 was informed of the interview with Resident #12 and Resident #19 was in the room when the derogatory comments were made. The UM was also informed of the interviews with LN #3 and SW #4. The UM said she was aware Resident #12 had voiced dislike for Resident #19 prior to the temporary room change. The UM said the problem had "dissipated" and she was not aware Resident #12 had begun to voice dislike for Resident #19 again. The UM said both residents wanted to return to their old room after the renovation project. The UM said the issue would be investigated.</p> <p>On 8/20/14 at 12:50 p.m., UM #5 and SW #4 informed two surveyors the investigation had begun. The UM said all of the staff interviewed thus far were focused on Resident #19's</p>	F 226	<p>Revised LN and CNA Orientation and Competency Checklists have been implemented and will be done for every newly hired CNA and LN ongoing.</p> <p>5. Date Corrective action will be completed: September 25, 2014</p>		

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F 226	<p>Continued From page 4</p> <p>defecation behavior and all of them said Resident #12 had mumbled things under his breath. The UM said LN #3 confirmed she was aware that Resident #12 did not like his roommate, "But she didn't take it seriously and felt he was joking. She heard him mutter under his breath and once he asked her to poison [Resident #19's name]. When she told him she could not do that he laughed and said I know." The UM said, "We are now treating this like psychological abuse, res to res [resident to resident]." The UM said Resident #19 told them Resident #12 "uses profanity" and "it's not good" and the negative comments "did bother" him. The UM said documentation about Resident #12's dislike for his roommate and his negative comments about the roommate "would have been appropriate, but they were not done." The SW said Resident #12 "used the same three words" the surveyor heard and both residents said they would appreciate a roommate change.</p> <p>On 8/20/14 at 2:50 p.m., the UM and SW informed the surveyor that Resident #19 was moving to a different room that afternoon.</p> <p>On 8/20/14 at 3:45 p.m., the Administrator and DNS were informed of the issue.</p> <p>On 8/21/14 at 4:16 p.m., the Bureau of Facility Standards received a 4 page facsimile (fax) from the facility regarding the facility's investigation. The additional information did not resolve the issue.</p>	F 226		
F 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards</p>	F 323	<p>F-323 This requirement was not met as evidenced by the determination that the facility failed to ensure the environment was as free from accidents hazards as possible, potential for harm to any resident or visitor who could have ingested or come in contact with</p>	

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F 323	<p>Continued From page 5</p> <p>as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the environment was as free from accident hazards as possible. This was true for all residents and visitors on one-west, two-west, and one-east hallways. This deficient practice had the potential for harm to any resident or visitor who could have ingested or come in contact with hazardous materials. Additionally, this deficient practice had the potential for harm to any resident or visitor sitting on or near damaged or unsecured furniture. Findings included:</p> <p>1. During an observation on 8/18/14 at 2:40 p.m., the door to a cabinet under the sink in the one-west soiled linen room was observed to be ajar. The cabinet contained the following:</p> <ul style="list-style-type: none"> - 2 one-gallon bottles of Gone liquid detergent; - 1 bottle of Ecolab Glass Cleaner; - 1 can of Misty Carpet Spot Remover; - 1 can of 3M Stainless Steel Cleaner and Polish; and - 1 container of PDI sanitary cloths. <p>The MSDS were reviewed for the above and documented the following:</p> <ul style="list-style-type: none"> - Gone - ingestion could cause nausea and diarrhea, call a physician immediately if ingested; 	F 323	<p>hazardous materials and sitting on or near damaged or unsecured furniture.</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were directly affected by the deficient practice.</p> <p>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 and visitors to the three skilled nursing units had the potential to be affected by the deficient practice. Maintenance repaired the broken lock and secured the cabinet in the 1 West soiled linen room on 8/18/14. The unmarked spray bottle containing a green liquid was removed from the cabinet under the pantry on 8/20/14. On 8/20/14 Nurse Managers for each of the three units did an environmental check and found no other unsecured, unmarked bottles of chemicals. The door to the janitor's closet on the 1 East was the one identified by the survey team to be left slightly ajar. Maintenance Supervisor repaired the door so it would shut properly on 8/20/14. On 8/20/14 the Maintenance Supervisor checked the doors of all the janitorial closets in the facility and identified that all other janitor closet doors were closing properly. The bookcases identified on 2 West unit were secured to the wall and repaired on 8/20/14. The bookcase identified on 1 West unit has been removed on 8/20/14. The recliner on the 2 West unit identified as in need of repair has been repaired on 8/20/14 and has been placed back onto the unit for use. The recliner on the 1 West unit identified as in need of repair was removed on 8/20/14 and will no longer be used. Maintenance Supervisor has done an environmental check to ensure that all bookshelves four feet high</p>		

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F 323	<p>Continued From page 6</p> <ul style="list-style-type: none"> - Ecolab Glass Cleaner - could cause serious eye damage or irritation; - Misty Carpet Spot Remover - harmful if inhaled, could cause lung damage if swallowed, could cause respiratory tract irritation, and could be aspirated into the lungs and cause chemical pneumonitis; - 3M Stainless Steel Cleaner and Polish - seek medical attention if inhaled, exposure could increase myocardial irritability; and - PDI Sanitary Cloths - could cause irreversible eye damage and harmful if absorbed through the skin. <p>CNA #1, who was present during the observation, stated the cabinet should be kept locked. CNA #1 attempted to lock the cabinet, but found the lock was broken.</p> <p>NOTE: Once the issue was identified by the survey team, the maintenance department was notified and repaired the broken lock.</p> <p>2. During the environmental review, on 8/20/14 from 8:30 - 10:40 a.m., the following issues were identified:</p> <p>a. An unmarked spray bottle containing a green liquid was located in the one-west pantry. Housekeeping staff present stated the bottle contained the disinfectant used by the facility. LN #2 stated the bottle should have been labeled and locked. LN #2 removed the unmarked bottle.</p> <p>b. The door to the janitor's closet was found</p>	F 323	<p>or greater are secured and in good condition. Additionally, the furniture on each unit has been examined to ensure that the furniture is in good condition</p> <p>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-Indicator Facility Environment has been revised to include the following line items:</p> <ul style="list-style-type: none"> • Hazardous materials/chemicals are inaccessible to residents and stored in locked cabinets. • Furniture (bookshelves, recliners, sitting chairs, tables, etc) are in good repair (no rips/tears in upholstery, working properly and stable, bookshelves > than four feet tall are secured to the wall) <p>Stickers that say: '-----WARNING----- No Hazardous Materials Stored Here!' have been placed inside the shelves of all cabinets that aren't considered secure to remind staff to make sure that hazardous materials are not stored in these cabinets. All facility staff was in-serviced on 8/22/12 regarding the storage of hazardous materials. LN Orientation and Competency Checklist and the CNA Orientation and Competency Checklist have each been revised to include line items:</p> <ul style="list-style-type: none"> • All Hazardous Materials must be stored behind locked doors or in locked cabinets (Tub/shower room, soiled utility room) <p>All newly hired nursing personnel will receive this education. A random door closure inspection to be completed monthly has been added to the Preventative Maintenance Calendar to ensure that doors are closing.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. CQI-Facility Environment will be done Q two weeks x two, then monthly x two months and then no less than quarterly.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/21/2014
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 320 COLLINS ROAD, 83702-4519 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 323	<p>Continued From page 7</p> <p>slightly ajar, allowing it to be opened by pushing on the door. The closet contained the following:</p> <ul style="list-style-type: none"> - A 1-gallon container of Gone liquid detergent; - 5 containers of Scrubs Stainless Steel Wipes; - A 1-gallon container of Clean by Peroxy all purpose cleaner; - 1 spray bottle of Ecolab Glass Cleaner; - 1 bottle of D-Molish Deodorizer; - No less than 5 cans SparCling Restroom Disinfectant; - No less than 5 cans of Consume Natures Way; - No less than 5 cans of Fast & Easy Hard Surface and Glass Cleaner; - No less than 13 cans of 3M Stainless Steel Cleaner and Polish; - No less than 10 cans of Diversey Shine-Up Furniture Polish; and - An Ecolab fill station containing Floor Cleaner, Glass Cleaner, Disinfectant Cleaner 2.0, and Revitalize Carpet and Upholstery Cleaner plus refill packets. <p>The MSDS for the above were reviewed and documented the following:</p> <ul style="list-style-type: none"> - Scrubs Stainless Steel Cleaner Wipes - aspiration hazard, do not taste or swallow, harmful or fatal if swallowed; - Clean By Peroxy - caused eye irritation, skin irritation, harmful if swallowed, and breathing mist cause respiratory irritation; - D-Molish Deodorizer- could cause eye irritation, was harmful if swallowed, and could cause infections if in contact with open wounds; - SparCling Restroom Disinfectant - caused 	F 323	<p>Revised LN and CNA Orientation and Competency Checklists have been implemented and will be done for every newly hired CNA and LN ongoing.</p> <p>5. Date Corrective action will be completed: September 25, 2014</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/21/2014
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F 323	<p>Continued From page 8</p> <p>irreversible eye damage and skin burns, was harmful if swallowed, and inhalation of spray caused respiratory harm or irritation;</p> <ul style="list-style-type: none"> - Consume Natures Way - caused eye and skin irritation, was harmful if swallowed, and contained live bacterial spores that could cause infection if introduced into an open wound, broken skin, or mucous membranes; - Fast & Easy Hard Surface and Glass Cleaner - could be harmful if swallowed; - Shine-Up Furniture Polish - could cause eye irritation; - Ecolab Floor Cleaner - acutely toxic if inhaled, corrosive to skin, and could cause serious eye damage or irritation; - Ecolab Disinfectant Cleaner 2.0 - acutely toxic to skin and could cause serious eye damage or irritation; and - Ecolab Revitalize Carpet and Upholstery Extraction Cleaner - could cause serious eye damage or irritation and could cause allergic reaction to skin. <p>NOTE: See example "a" above for MSDS information related to Gone, 3M Stainless Steel Cleaner and Polish, and Ecolab Glass Cleaner.</p> <p>The Maintenance Supervisor, who was present during the environmental review, stated the door was not closing properly and should have been closed and locked.</p> <p>NOTE: The door was repaired after the issue was</p>	F 323			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 9</p> <p>identified by the survey team. The door was noted to be properly shut and locked during the remainder of the survey.</p> <p>c. Two 5-foot tall bookcases were noted in the lounge area in front of the two-west nurses station. Neither bookcase was secured to the wall. Additionally, the back of the right-side bookcase was detached causing the bookcase to sway back and forth when touched.</p> <p>A 2-shelf bookcase was observed in the television room on the one-west wing. The back of the bookcase was detached, and the bookcase was unstable and leaned to the left.</p> <p>The Maintenance Supervisor, who was present during the environmental review, stated the bookcases on the two-west wing had been detached from the wall during painting and had not been re-secured. The Maintenance Supervisor stated the right-side bookcase needed repaired and both bookcases needed to be secured to the wall. The Maintenance Supervisor stated the small bookcase needed repair.</p> <p>NOTE: During observation on 8/21/14 at 10:20 a.m., the right-side bookcase was noted to be repaired and both bookcases were secured to the wall.</p> <p>d. A black vinyl-covered lift-style recliner was located in the lounge area in front of the two-west nurses station. The back side-panel of the recliner was broken from the chair exposing the wood and padding underneath. Additionally, the right arm-rest upholstery was ripped along the seam exposing the wood and upholstery staples underneath.</p>	F 323			

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F 323	<p>Continued From page 10</p> <p>A second fabric-covered recliner was located in the television room on the one-west wing. The upholstery on the left arm-rest was ripped from the side of the chair exposing the plastic base and upholstery staples underneath the arm-rest.</p> <p>NOTE: Once identified by the survey team, the damaged recliners were removed for repair.</p> <p>On 8/20/14 at 3:50 p.m., the Administrator and DON were informed of the environmental issues. No further information was provided.</p>	F 323		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 320 COLLINS ROAD, 83702-4519 BOISE, ID 83707
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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 annual State licensure survey of your facility. The surveyors were: Lauren Hoard RN BSN, Team Coordinator Linda Kelly RN Michael Case LSW BSW QIDP Linda Hukill-Neil RN Judy Atkinson RN	C 000	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 176	02.105,01 Personnel Policies 105. PERSONNEL. 01. Personnel Policies. Personnel policies shall be developed and implemented and shall include: This Rule is not met as evidenced by: Refer to F226 as it related to implementation of the abuse policy and procedure.	C 176	C176 – Please refer to Plan of Correction form CMS-2567 (02-99) F226	
C 342	02.108,04,b,ii Toxics Stored Under Lock and Key ii. All toxic chemicals shall be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Refer to F323 as it related to unsecured chemicals.	C 342	C 342- Please refer to Plan of Correction form CMS-2567 (02-99) F323	
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or	C 790	C 790- Please refer to Plan of Correction form CMS-2567 (02-99) F323	

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FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>James S. Roberts NHA</i>	TITLE ADMINISTRATOR	(X6) DATE 09/11/2014
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001313	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/21/2014
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C 790	Continued From page 1 injury; This Rule is not met as evidenced by: Refer to F323 as it related to unsecured bookshelves and torn material on recliners.	C 790		