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

Corrected COPY

February 8, 2016

Randal Barnes, Administrator
Idaho State Veterans Home - Boise
PO Box 7765
Boise, ID 83707-1765

Provider #: 135131

Dear Mr. Barnes:

On **January 22, 2016,** a 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 a widespread deficiency that constitutes immediate jeopardy to resident health or safety, 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.) **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.

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 February 22, 2016 . Failure to submit an acceptable PoC by , may result in the imposition of additional civil monetary penalties by February 22, 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.

- 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*.

Based on the immediate jeopardy cited during this survey:

F0226 -- S/S: L -- 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey.

We are recommending to the CMS Regional Office that the following remedy(ies) be imposed:

A 'per instance' civil money penalty of **Federal Civil Money Penalty of $3,000.00 per instance for the instance on January 22, 2016 described at deficiency F0226 (S/S: L).**

(THIS REMEDY IS GENERALLY RESERVED FOR SITUATIONS OF SERIOUS NONCOMPLIANCE AS DESCRIBED IN THE STATE OPERATIONS MANUAL §7510) (42 CFR §488.430)

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 22, 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe the 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, 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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 February 22, 2016. If your request for informal dispute resolution is received after , 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/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135131	A. BUILDING _____ B. WING _____	C 01/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE VETERANS HOME - BOISE	320 COLLINS ROAD, 83702-4519 BOISE, ID 83707

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F 000	INITIAL COMMENTS An Annual Recertification and Complaint survey was conducted from January 19, 2016 to January 22, 2016. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Ann Monhollen, RN, MSN Paula Vines, RN, BSN Lorinda Scheier, RN Definitions: DSS = Director of Social Services HRA = Human Resource Associates RHT = Registered Health Technician	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.** RECEIVED FEB 22 2016 FACILITY STANDARDS	
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered	F 203	**F203** **Residents:** Resident #25 was identified as being affected by this deficient practice. As resident was discharged in September 2014, facility is unable to provide required discharge notification. **Other Residents:** All residents at the Idaho State Veterans Home – Boise (ISVH-B) have the potential to be affected by the discharge or transfer notification requirement.	**2/29/16**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 2-19-16

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 203	Continued From page 1 under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide notice of discharge and/or transfer to to the resident or the resident's interested party on 9/18/14 when one sampled Resident (Resident #25) was discharged to a hospital emergency room by his treating physician. The resident was not admitted to the hospital and was not accepted back into the	F 203	**Systemic Correction:** A discharge/transfer template has been developed. Leadership has been educated on the process of when a resident is to receive the letter. The Administrator of the home will issue the notice to the resident. **Monitoring:** Discharges will be discussed Monday through Friday at daily morning meetings. If a discharge/transfer letter was, is or does get issued, the process will be reviewed in the monthly QA meeting.	

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F 203	Continued From page 2	F 203		

facility upon discharge from the emergency room. This was true for 1 of 3 residents reviewed for discharge from the facility. Findings included:

On 1/22/16 at 8:10 am, the facility's Social Worker stated he recalled a resident was sent to the emergency room after charging toward his roommate about a year and a half before. He stated the family was notified by phone.

Record review of the resident admission handbook documented the following: "Upon determination by the Home Administrator that an emergency exists, a resident may be immediately discharged or transferred. The home administrator or his designee must notify the applicant or resident of any action to be taken regarding [the transfer or discharge] or his designee must notify the applicant or the resident of any action to be taken regarding rejection of an application or transfer or discharge from a home. The notice must state the following: a.Reason / reference to pertinent rule; b. effective date of action.; c. applicant's right to request a hearing according to the provisions in ... the rules; d. the procedure for requesting a hearing, as provided in ... these rules."

Review of the resident's record revealed no evidence that written notification was completed for the 9/18/14 discharge.

On 1/22/16 at 2:00 p.m., the physician stated he advised the hospital physician that the resident could not return to the facility as it was unable to meet the resident's needs.

On 1/22/16 at 10:10 am, the RHT stated there was no written notice provided for the emergency

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F 203	Continued From page 3 discharge of Resident #25. The RHT stated, "We don't have that paperwork because we weren't required to do that because he was discharged to the hospital, and then just didn't return here from the hospital ... as it was explained to me."	F 203		
F 226 SS=L	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 interview, record review, review of facility abuse policy, State of Idaho Contract, and review of contracted agency policies, it was determined the facility failed to ensure all employees received appropriate training of abuse protocols in a timely manner, and that all staff had completed background screens before working at the facility. This failure to ensure all staff had been trained in abuse prevention, identification, response, and reporting, as well as ensuring all staff had completed background screens prior to working at the facility, placed all residents of the facility in immediate jeopardy for possible abuse. The immediate jeopardy was identified 1/22/16 and was on-going. On 2/3/16, the facility provided an acceptable abatement plan, and on 2/5/16 at 10:50 am, an onsite visit to the facility confirmed the jeopardy was abated. Findings included: 1. On 1/19/16 at 1:15 pm, a Housekeeper (E8) identified she had not received education upon	F 226	**F226** **Residents:** No specific resident was identified on the Statement of Deficiencies (2567). Training of all identified staff (housekeeping) was completed on January 21, 2016. Training was also completed for all ESL (English as a Second Language) housekeeping staff on January 27, 2016 and again on February 2, 2016. **Other Residents:** All residents at the Idaho State Veterans Home – Boise (ISVH-B) have the potential to be affected by the alleged failure to ensure all employees received appropriate training of abuse protocols. Training of all identified staff (Housekeeping) was completed on January 21, 2016. Training was also completed for all ESL (English as a Second Language) housekeeping staff on January 27, 2016 and again on February 2, 2016.	**2/22/16**

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F 226	Continued From page 4 hire regarding abuse protocols. E8 revealed she was unable to differentiate between physical abuse and neglect. On 1/21/16 at 10:30 am, the DSS stated Housekeeping was a contracted service and the facility was not responsible for training contracted employees on abuse. On 1/21/16 at 11:30 am, the contracted Director of Housekeeping stated abuse in-servicing was provided annually and was due in February 2016. He said he did not provide abuse training upon hire, but employees received an employee handbook explaining resident rights. Review of the Employee Handbook at identified that it did not address regulatory requirements for abuse training. The Employee Handbook contained one page addressing consideration, dignity and respect, privacy, use and quiet enjoyment of his/her room, planning of total care and medical treatment, resident council, resident financial affairs, and confidentiality. None of the documents contained information related to the identification, prevention, response, or reporting of instances of potential abuse or neglect. On 1/21/16 at 2:10 pm, the HRA stated the facility did not maintain abuse training records for contracted employees as that this was the responsibility of the contracted company rather than the facility. On1/21/16 at 2:25 pm, the Administrator stated, "The contracted employees are not the responsibility of this facility." On 1/21/16 at 3:00 pm, E5 stated he was provided an Employee Handbook upon hire in	F 226	Prior to the survey team leaving the facility on January 22, 2016 the accurate background check information was provided and that portion of the "Notification to the Facility of Immediate Jeopardy" was deleted from the notification. A revised notification was given with the background portion deleted. **Systemic Corrections**: ISVH-B will notify Healthcare Services Group (HCSG), a corporation that provides housekeeping and laundry services within the facility of these requirements. The ISVH-B will provide HCSG employees the same training as those employees of the ISVH-B who provide direct patient care. Training to cover abuse prevention, identification, investigation and reporting of abuse, neglect, mistreatment, and misappropriation of property and resident rights from the facility Abuse Coordinator, 2 West Social Worker or Administrator. ISVH will require HCSG employees to receive the above mandatory training prior to entering the facility, and provide written proof of successful completion of the training.	**2/29/16**

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F 226	Continued From page 5 June 2015; but received no formal abuse training. When asked to define various forms of abuse, E5 stated he did not know the definition of mental abuse. E5 stated he was concerned because minutes before this interview he received a brief abuse training, but could not remember it. He stated he had been asked to sign a paper attesting that he received the Employee Handbook when he had only just been given a copy. E5 stated he could not recall the information when asked about it by a surveyor. The contract between the Idaho Department of Administration and the Department of Veterans Services, documented "The contractor shall ensure that Contractor's staff is trained in the following: "The Contractor and Contractor's employees are required to physically participate in and attend all in-services provided by the Home that concern subject relevant to the scope of work under the Agreement. Contract shall provide translator or trainer acceptable to the Home, at Contractor's sole cost and expense, if the Contractor's staff cannot participate in and understand training conducted in English. The Home shall, in its sole discretion, identify the in-services that concern subject relevant to the scope of work under the Agreement. Attendance at such in-services shall be at the Contractor's expense." The facility's Policy for Abuse documented, "The [facility] is committed to protecting our residents from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family	F 226	HCSG will be required to notify the ISVH-Boise's Administrative Assistant of all new hires and terminations. ISVH-Boise will provide on-going (no less than annually) training related to the above and provide proof of completion for each employee entering/working in the facility. ISVH-Boise will include HCSG employees in periodic mandatory training in the areas of resident abuse and neglect and resident rights and HCSG employees must attend the same training. ISVH-Boise will require that HCSG maintain complete personnel files within the facility for those employees working within the facility and ISVH-B will have access to their personnel files. All current HCSG employees received and completed the post test. ISVH –B will require that HCSG submit a monthly schedule to the facility Administrator. **Monitoring:** ISVH-Boise will maintain the training material along with the names of all HCSG contract employees working in the facility, as well as evidence of completion (signed document) of applicable training. These records will be maintained by the facility administrator.	

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F 226	Continued From page 6 members, legal guardians, surrogates, sponsors, friends, visitors or any other individual. [The facility] has a zero tolerance policy for resident mistreatment, neglect, abuse, or misappropriation of resident property." On 1/22/16 at 2:00 pm, the HRA said the facility could not provide a list of contracted staff working in the facility because the facility did not maintain records on any contracted personnel. 2. On 1/21/16 at 8:30 am, the Regional Director of Housekeeping provided a list contracted employee names, their fingerprint date and their completed background check to surveyors. That information revealed that all 15 Housekeeping/Laundry staff were hired before their background check was completed. On 1/21/16 at 2:35 pm, the Administrator, Director of Nursing, and Regional Director of Housekeeping stated Housekeeping/Laundry staff were not supervised by the facility and that those staff were hired before completed background checks had been returned. The facility's Policy for Abuse documented, "The [facility] conducts a through screening of all new employees before they are hired. [The facility] will not knowingly employ any individual who has been convicted of a crime that could adversely affect their relationship with fellow employees, residents, or families. All new staff personnel, volunteers, and potential admission(s) will be screened. Training on issues related to abuse prevention practices commences with the employee's orientation and continues on a regular basis throughout the employee's tenure at [the facility]."	F 226	**Monitoring:** (continued) ISVH-Boise Administrator will request an HCSG's roster and audit this against the training records provided by HCSG quarterly. Any discrepancies will be immediately communicated to HCSG Management personnel. Applicable employee(s) will not be allowed to enter/work in facility until proof is obtained of successful completion of approved training program. Monthly ISVH-Boise SDC and/or Social Service Department staff will randomly question HCSG staff related to resident abuse and neglect and resident rights and the responses will be documented and communicated to HCSG Management. HCSG employees unable to correctly respond to applicable questions will be required to obtain additional approved training within two working days and provide ISVH-B with signed documentation this occurred. ISVH-Boise will require that HCSG submit a monthly schedule to ensure all staff have received proper training. ISVH-Boise will also require that HCSG employees complete a post test to ensure understanding. A QA tool will be developed and maintained to verify completion of the above. Results will be brought to the Monthly QA meeting and reviewed for compliance.	

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F 309 F 309 SS=D	Continued From page 7 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 interview and record review, it was determined the facility failed to ensure that timely and complete neurological assessments were completed for one (#16) of 19 sampled residents reviewed for falls and resulted in the potential for neurological changes to go unnoticed. Findings include: Resident #16 (R16) was admitted to the facility on 9/2/15 with diagnoses that included Parkinson's disease, astrocytoma (brain tumor), and tremors. The Minimum Data Set Assessment (MDS), dated 9/9/15, documented the resident had moderate cognitive impairment with a BIMS score of 10. Resident #16's clinical record revealed the resident experienced 9 unwitnessed falls from 9/11/15 to 1/12/16. The facility's nursing procedure manual, dated January 2002, and reviewed November 2013, documented under "Neurological Assessment" that when a resident experienced a change in the	F 309 F 309	**F309** **Residents:** Resident # 16 identified had experienced falls prior to the survey and neurological assessments were not completed/done in a timely manner. As neuro assessments are time-sensitive it was impossible to re-institute this assessment for this resident. The resident's neuro status was and remains stable. **Other Residents:** All residents with an unwitnessed fall or having a fall with a potential for a head injury have the potential to be affected by the same deficient practice. **Corrective Measures**: Revision of the existing Neurological Assessment Procedure (located in Nursing Procedure Manual) to include initiating a Neurological Assessment (neuro checks) following an unwitnessed fall and defining how to completely and accurately document the neuro assessment on the Neurological Assessment Flow Sheet. (The procedure already included initiating the assessment if a resident experiences a change in the level of consciousness or a fall involving possible injury to the head.)	**2/29/16**

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F 309	Continued From page 8 level of consciousness and/or a fall involving a possible injury to the head staff must use a Neurological Assessment Flow Sheet to assess the resident's neurological status every 15 minutes for 1 hour; every 30 minutes for 2 hours; every hour for 2 hours; every 2 hours for 4 hours; every 4 hours for 8 hours; and once every 8 hours for 8 hours. On 9/11/15 at 7:30 pm, the resident experuienced an unwitnessed fall. A neurological assessment was not completed as required in the facility's "Neurological Assessment" procedure. On 9/18/15 at 3:40 pm, Resident #16 experienced unwitnessed fall. A neurological assessment was initiated, but not completed per the facility's "Neurological Assessment" procedure. Neurochecks started at 3:40 pm were not completed until 5:00 pm; neurochecks scheduled for 9/18/15 at 10:45 pm, 9/19/15 at 4:45 am, on 9/20/15 at 12:45 am, and on 9/21/15 at 12:45 am were documented with " ...sleeping ..." with no further assessment completed. There was no documentation for neurochecjks scheduled for 9/20/15 at 8:45 am, and 4:45 pm; or on 9/21/15 at 8:45 am and 4:45 pm. On 9/20/15 at 1:15 pm, Resident #16 experienced an unwitnessed fall. A neurological assessment was initiated, but not completed per the facility's "Neurological Assessment " procedure. Neurochecks were scheduled to start at 1:15 pm and end at 11:00 pm, but the neurocheck scheduled for 1:45 pm had no vital signs recorded and the neurochecks scheduled for 12:00 am, 2:00 am, 4:00 am, and 11:00 pm were documented as "sleeping ..." and further assessments were not completed.	F 309	**F309** Licensed Nursing Staff were educated on the change in the existing procedure as well as the proper use, assessment, and documentation requirements of the Neurological Assessment Flow Sheet on January 27, 2016. The newly implemented computerized incident report format was revised to include a space for the Licensed Nurse to verify that the neuro assessment had been initiated as part of the planned interventions in the event of an unwitnessed fall. **Systemic Correction**: Resident incidences are reported to the specific RN Unit Managers. RN Unit Managers are aware of the requirements to institute neuro checks in the event of an unwitnessed fall. RN Unit Managers have been instructed to ensure that neuro checks were started and assessments are completed per procedure and documented. The Incident Report form has an area where the Licensed Nurse documents that neuro checks were initiated. The facility's interdisciplinary team meets on a daily basis to review Incident/Accident reports and ensure appropriate interventions have been put into place and care planned. Ensuring that neuro checks were initiated and being completed accurately is part of this review process.	**2/29/16**

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE VETERANS HOME - BOISE	320 COLLINS ROAD, 83702-4519 BOISE, ID 83707

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F 309	Continued From page 9 On 10/29/15 at 12:07 am, Resident #16 experienced an unwitnessed fall. A neurological assessment was not implemented. On 11/7/15 at 3:05 pm, Resident #16 experienced an unwitnessed fall. A neurological assessment was initiated, but not completed per the facility's "Neurological Assessment" procedure. Neurochecks were scheduled for 7:00 pm had no vital signs recorded. The neurochecks scheduled for 11/8/15 at 12:00 am, 11/9/15 at 12:00 am and 11/10/15 at 12:00 am were documented with "sleeping" and no further assessment was completed. On 11/21/15 at 7:00 pm, Resident #16 experienced an unwitnessed fall. A neurological assessment was not completed at the time of the fall per the facility's "Neurological Assessment " procedure. On 11/28/15 at 8:15 pm, Resident #16 experienced an unwitnessed fall. A neurological assessment was initiated, but not completed per the facility's "Neurological Assessment" procedure. Neurochecks scheduled for 1:00 am had no vital signs recorded. On 12/22/15 at 6:15 pm, Resident #16 experienced an unwitnessed fall. A neurological assessment was initiated, but not completed per the facility's "Neurological Assessment" procedure. Neurochecks scheduled for 10:30 pm and for 12/24/15 at 6:30 am were documented with "sleeping" and no further assessment was completed. On 1/22/16 at 2:15 pm, when asked what staff	F 309	**F309** Licensed Nursing Orientation Checklist was revised to include education related to the Neurological Assessment procedure and use of the Neurological Assessment Flow Sheet. These completed checklists are reviewed by the specific RN Unit Manager and by the Human Resource Department to ensure completeness. **Monitoring:** The facility's Incident/Accident CQI tool was revised to include: a. Neurological Assessments are conducted on each resident who experiences an unwitnessed fall. b. Neurological Assessments are complete and consistent with nursing procedure/guidelines. The above CQI audit will be conducted q month x 3 months and then quarterly thereafter to ensure continued compliance.	

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F 309	Continued From page 10 should do in response to an unwitnessed fall, the DON stated, "Neurochecks would be started." The DNS stated that she was aware that neurochecks were not completed appropriately with Resident #16 and said nursing staff was not consistently implementing, or completing, neurological assessments for unwitnessed resident falls.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide a safe environment for vulnerable residents by not following manufacturing operation and safety practices for a trash compacto that had the potential to cause more than minimal harm to 19 of 24 mobile residents of the facility. Findings include: A trash compactor was observed uncovered and accessible to any vulnerable, mobile resident throughout the survey. The compactor was located near the back section of the facility, was not fenced or gated, and was readily accessible from the road. During the previous six months, from 7/30/15 to 11/28/15, six resident elopements	F 323	**F323** **Residents:** Statement of Deficiencies (SOD) stated 19 residents had the potential to be harmed by the trash compactor. As stated in SOD the elopements occurred in the past, no opportunity to correct for the 19 stated mobile residents. **Other Residents:** Other mobile residents have the potential to be affected by the trash compactor. Training for staff will be completed by February 29, 2016 by the Maintenance Supervisor. Gates were placed on trash compactor for increased safety. Mirrors were added to trash compactor for increased visibility inside trash compactor. **Corrective Measures:** The Maintenance Department conducted training on the operation of the trash compactor. The Maintenance Department installed gates on the trash compactor. The Maintenance Department installed mirrors on the compactor for increased visibility inside the trash compactor.	**2/29/16**

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F 323	Continued From page 11 were documented with one resident found near the loading dock in the area of the trash compactor. On 1/20/16 at 10:30 am, the open trash compactor was observed with trash visible in the section where rubbish is contained until compressed. The holding section measured 35 inches by 60 inches by 49 5/8 inches deep and was big enough for a resident to climb into. On 1/22/16 at 2:15 pm, a housekeeper was observed bringing out trash and dumping it in the compactor without first looking into the hopper. The housekeeper then activated the compactor for about 10 seconds before turning it off. This time period did not allow the trash to be compacted into the storage container section. On 1/22/16 at 2:26 pm, with the Director of Maintenance present, a second housekeeper was observed dumping trash into the compactor, and activating the compactor for a very brief periord before immediately turning it off. The Maintenance Director said to the staff member, "You should complete the cycle." The housekeeper looked briefly in the Maintenance Director's direction and walked back into the facility. On 1/22/16 at 3:05 pm, the Director of Maintenance was asked if staff running the compactor was supposed to look inside before operating the compactor. He stated, "If they can look in, they should look in." He stated the facility's housekeepers "can't see inside because of height reasons." He said he was unaware of the manufacturer's operation instructions, which he noted he had delegated to the Housekeeping	F 323	**Monitoring:** Maintenance Supervisor or designee will conduct monthly checks of the compactor to ensure safety measures are in place and functioning properly. Results of checks will be brought to monthly QA meeting.	

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F 323	Continued From page 12 Manager / Director of Environmental Services to review. Interviews with random housekeeping staff on 1/22/16 at 3:20 pm confirmed training was provided by the Housekeeping Manager / Director of Environmental Services and consisted of staff being directed to put all trash in the barrel; make sure everything is clear; press the handle; dump trash; and lower barrel back down to floor. When asked how the compactor had been working, the housekeeper stated there had been malfunctions in the winter and staff had to sometimes press "reverse" when the compactor can froze in the closed position. He stated the compactor is big enough for a person to get into and he looked inside before operating the compactor. He stated he was not trained to look inside before turning on the compactor and stated, "It's a common sense thing, no need to be trained." On 1/22/16 at 3:30 pm, the Housekeeping Manager / Director of Environmental Services stated he trained housekeepers how to take out the trash. He said, "As far as I know there is no formal training. There is nothing required to authorize staff to use. Anybody with a key can use. Anyone who needs to take out trash can use the compactor." The Housekeeping Manager / Director of Environmental Services stated he "shows" staff how to use the compactor (Put trash in actual compactor, turn key or put in lift barrel, turn key and use lift barrel to put trash in compactor, then compress and put barrel back on ground, clean up the area). He stated he does no other teaching and has no return demonstrations. He then said he had not seen the manufacturer's guidelines for operating the compactor nor looked inside the hopper for safety	F 323		

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F 323	Continued From page 13 reasons before operating the compactor. Manufacturing guidelines for the compactor documented: DANGER, DO NOT ENTER. There is an icon on the operations page of a person with a circle around it and a diagonal line extending from one side of the circle to the other. "Before starting the compactor, be sure no one is inside. Be certain that everyone is clear of all points of operation and pinch point areas before starting. THE EMPLOYER SHOULD ALLOW ONLY AUTHORIZED AND TRAINED PERSONNEL TO OPERATE THIS COMPACTOR. This compactor is equipped with a key operated locking system. The key(s) should be in the possession of the only authorized personnel. If the compactor is equipped with a security gate or doghouse with a security door. BE SURE THE SECURITY GATE OR DOOR IS CLOSED BEFORE THE COMPACTOR IS STARTED."	F 323	**F490:** **Residents:** No specific residents were identified on the SOD. **Other Residents:** All residents at the Idaho State Veterans Home – Boise (ISVH-B) have the potential to be affected by the alleged failure to ensure all employees received appropriate training of abuse protocols. Training of all identified staff (housekeeping) was completed on January 21, 2016. Training was also completed for all ESL (English as a Second Language) housekeeping staff on January 27, 2016 and again on February 2, 2016.	**2/29/16**
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and interview, it was determined facility Administration failed to ensure contract employees having unsupervised direct contact with residents had criminal background screenings or training to prevent, identify,	F 490		

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F 490	Continued From page 14 intervene, and report instances of resident abuse or neglect. The failure of the facility to ensure these administrative tasks were completed placed all residents in the facility in immediate jeopardy for experiencing abuse or neglect. Findings included: On 1/22/16 at 2:00 pm, the HRA stated the facility could not provide a list of contracted housekeeping staff working in the facility as the facility did not maintain records on contracted personnel. On 1/22/16 at 2:15 pm, the Administrator stated the facility did not maintain personnel records for contracted employees as contractors are responsible for keeping those records rather than the facility. The Administrator was unable to identify Housekeeping/Laundry staff working in facility and stated, "The contracted employees are not the responsibility of this facility." On 1/22/16 at 5:30 pm, the contracted Regional Director of Housekeeping said personnel records for the entire Housekeeping/Laundry staff lacked the date of hire and employee background checks. On 1/22/16 at 8:30 am, the Regional Director of Housekeeping provided the names of the contracted employees, their fingerprint date and their completed background check to the surveyor. The information documented that all 15 Housekeeping/Laundry staff were hired before background checks were completed. On 1/22/16 at 2:35 pm, the Administrator, Director of Nursing, and Regional Director of Housekeeping stated Housekeeping/Laundry	F 490	Prior to the survey team leaving the facility on January 22, 2016 the accurate background check information was provided and that portion of the "Notification to the Facility of Immediate Jeopardy: was deleted from the notification. A revised notification was given with the background portion deleted. **Systemic Corrections:** ISVH-Boise will notify Healthcare Services Group (HCSG), a corporation that provides housekeeping and laundry services within the facility, of these requirements. The ISVH will provide HCSG employees the same training as those employees who provide direct patient care, related to resident abuse prevention, identification, investigation and reporting of abuse, neglect, mistreatment, and misappropriation of property and resident rights from the facility Abuse Coordinator, 2 West Social Worker or Administrator. ISVH-B will require HCSG employees to receive the above mandatory training prior to entering the facility, and provide written proof of successful completion of the training. HSCG will be required to notify the ISVH-Boise's Administrative Assistant of all new hires and terminations. ISVH-B will provide on-going (no less than annually) training related to the above and provide proof of completion for each employee entering or working in the facility.	

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F 490	Continued From page 15 staff were allowed to work unsupervised and before their criminal background checks had been completed. The facility's Policy for Abuse documented, "The [facility] conducts a through screening of all new employees before they are hired. [The facility] will not knowingly employ any individual who has been convicted of a crime that could adversely affect their relationship with fellow employees, residents, or families. All new staff personnel, volunteers, and potential admission will be screened. Training on issues related to abuse prevention practices commences with the employee's orientation and continues on a regular basis throughout the employee's tenure at [the facility]." The facility failed to ensure effective administration of the facility when contract staff providing housekeeping services worked unsupervised in resident living space without first having criminal background checks completed, and without training to prevent, protect, identify, or report instances of resident abuse or neglect.	F 490	ISVH-B will include HCSG employees in periodic mandatory training in the areas of resident abuse and neglect and resident rights and HCSG employees must attend the same training. ISVH-B will require that HCSG maintain complete personnel files within the facility for those employees working within the facility and ISVH-B will have access to their personnel files. All current HCSG employees received and completed the abuse posttest. ISVH-B will require that HCSG submit a monthly schedule to facility Administrator. **Monitoring:** ISVH-B will maintain the training material along with the names of all HCSG contract employees working in the facility, as well as evidence of completion (signed document) of applicable training. These records will be maintained by the facility Administrator. ISVH-B Administrator will request an HCSG employee roster and audit this roster against the training records provided by HSCG quarterly. Any discrepancies will be immediately communicated to HSCG Management personnel. Applicable employee(s) will not be allowed to enter/work in facility until proof is obtained of successful completion of approved training program.	

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		F 490	**F 490** Monthly ISVH-B SDC and/or Social Service Department staff will randomly question HCSG staff related to resident abuse and neglect and resident rights and the responses will be documented and communicated to HCSG Management. HCSG employees unable to correctly respond to applicable questions will be required to obtain additional approved training within two working days and provide ISVH-B with signed documentation this occurred. ISVH-B will require that HCSG submit a monthly schedule to ensure all staff have received proper training. ISVH-B will also require that HCSG employees complete a posttest to ensure understanding. A QA tool will be developed and maintained to verify completion of the above. Results will be brought to the Monthly QA meeting and reviewed for compliance.	

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

March 17, 2016

Randal Barnes, Administrator
Idaho State Veterans Home - Boise
PO Box 7765
Boise, ID 83707-1765

Provider #: 135131

Dear Mr. Barnes:

On **January 22, 2016,** an unannounced on-site complaint survey was conducted at Idaho State Veterans Home - Boise. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006686

Allegation 1: An identified resident was wrongfully discharged from the facility.

Findings 1: An identified resident was discharged after an altercation with his roommate, witnessed by his treating physician. Documentation revealed that the identified resident was physically thrusting toward his roommate when the physician stepped between the two residents. The physician advised the resident that he would have to go through him (the physician) if he wanted to get to his roommate. Interviews with the physician and social worker confirmed the identified resident was physically approaching his roommate in an "unprovoked explosive anger." An emergency discharge was ordered for the identified resident by his treating physician to another facility.

The treating physician stated he advised the receiving facility's physician that the identified resident could not return, as the facility was unable to provide for his needs.

The identified resident was appropriately discharged per his physician's orders for documented behavior that posed an immediate threat to another resident witnessed by the identified resident's treating physician.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation 2: The facility failed to provide adequate notice that an identified resident was being discharged from the facility.

Findings 2: Based on record review and interview, it was determined the facility failed to provide notice of discharge and/or transfer of an identified resident to the emergency department of another facility. This allegation is substantiated. Please refer to Federal Report 2567 F203.

Conclusion #2: Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

D. Scott for N. S.

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt

IDAHO DEPARTMENT OF
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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

March 16, 2016

Randal Barnes, Administrator
Idaho State Veterans Home - Boise
PO Box 7765
Boise, ID 83707-1765

Provider #: 135131

Dear Mr. Barnes:

On **January 22, 2016,** an unannounced on-site complaint survey was conducted at Idaho State Veterans Home - Boise. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00006720

The complaint was investigated in conjunction with the facility's Federal Recertification and Complaint survey conducted January 19, 2016 to January 22, 2016.

Allegation #1: a. The facility continued to use a mechanical lift on an identified resident after the resident stated it caused him/her pain.
b. The staff were given orders not to touch the resident or they would be fired.
c. The mechanical lift sling used on the resident was the wrong size.
d. Nursing staff are not trained how to transfer the resident without the mechanical lift.
e. Staff who are trained to transfer the resident without the mechanical lift are not always assigned to the resident.

Findings #1: Certified Nursing Aides were observed using the appropriate size slings on each resident; transferring residents per facility policy/procedure via mechanical lift; and none of the residents were observed to complain of pain and/or discomfort during the mechanical lift transfers.

Grievances and Incident/Accident reports from July 2015 to January 2016 were reviewed and did not document concerns regarding mechanical lift transfers and/or staff not assisting when needed.

The identified resident's record and nine other residents' records regarding mechanical lift transfers documented the therapy department provided mechanical lift education and training to nursing staff prior to staff transferring residents. Additionally, the therapy department sized all mechanical lift slings prior to use by nursing staff. The residents' records documented the residents were adequately medicated for pain and did not document the residents verbalized pain and/or discomfort during mechanical lift transfers.

The identifed resident's and the nine sampled residents' physician orders, nurses notes, and therapy notes did not include an order for staff not to touch residents.

The Rehabilitation Director stated restorative aides are responsible for measuring and sizing mechanical lift slings on resident admission. Additionally, the restorative aides provide four hours of orientation prior to the Certified Nursing Aides first shift on the floor. The Director stated Certified Nursing Aides are required to attend yearly skills fairs and complete a check-off regarding mechanical lift transfers. The Director stated residents' mechanical lift transfer status are reviewed quarterly and as needed.

Five direct care staff were interviewed and stated the restorative aides measure and size the slings upon admission and deliver the slings to the residents rooms. The direct care staff stated the therapy department provides the initial training on positioning, proper placement, and training on mechanical lift transfers.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The facility was always short-staffed on weekends.

Findings #2: During the survey process from January 19, 2016 to January 22, 2016, staff were observed answering call lights within five minutes and respond within ten minutes.

Staffing hours for the weeks of December 21, 2015, December 28, 2015, January 4, 2016, and January 11, 2016 documented the facility had exceeded federal staffing requirements.

Residents in the Group Interview stated they had no problems receiving assistance from staff.

The residents stated they were content with the care and services they received in the facility.

Grievances and Incident/Accident reports from July 2015 to January 2016 did not document concerns related to staffing.

Five individual interviews and two family interviews were conducted and there were no concerns related to staffing.

A nursing staff manager stated the facility "does its best" to ensure consistency of staff on all halls to maintain continuity of care. She stated it was "challenging at times" when staff called in and/or did not show up for work.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

N. Scott for N.S.

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt

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Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

March 21, 2016

Randal Barnes, Administrator
Idaho State Veterans Home - Boise
PO Box 7765
Boise, ID 83707-1765

Provider #: 135131

Dear Mr. Barnes:

On **January 22, 2016**, an unannounced on-site complaint survey was conducted at Idaho State Veterans Home - Boise. The complaint allegation, findings and conclusion are as follows:

Complaint #ID00007187

Allegation: Residents are "neglected" by staff as evidenced by long wait times for staff to respond to call lights, meals, and other services.

Findings: Observations in the facility from January 19, 2016 to January 22, 2016 in all areas of the facility did not reveal any concerns with wait times related to call lights, using the restroom or arriving at the dining room on time.

Several individual residents were interviewed and none of those residents stated they had experienced any excessive wait times either with call light times, or related to waiting for nurses and or Certified Nursing Aides for assistance or cares.

During a group resident interview on January 20, 2016, one resident stated that residents had to "sometimes" wait longer for the "midnight shift" Certified Nursing Aides to respond to call lights, but no one in the group stated the longer wait had caused problems for them. The residents in the group meeting further stated that they had not heard of other residents with concerns.

The Social Worker stated she had not received any complaints from residents on the2-West unit during the time period of concern and that complaints from residents about care-related issues result in her completing a grievance form, which is then submitted to the administrator.

Review of the facility's grievance book revealed no grievances filed from October 2015 to January 2016.

Based on observations and interviews at the facility, the complaint is unsubstantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

D. L. Scott for N. S.

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt