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



April 12, 2016

Oni Kinberg, Administrator
Idaho State Veterans Home - Boise
PO Box 7765
Boise, ID 83707-1765

Provider #: 135131

Dear Mr. Kinberg:

On **March 31, 2016**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **February 29, 2016**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

**F0309 -- S/S: E -- 483.25 -- Provide Care/services For Highest Well Being**

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 copy of the Form CMS-2567B, Post-Certification Revisit Report listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 25, 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*.

As noted in the Bureau of Facility Standards' letter of **February 8, 2016**, following the survey of **January 22, 2016**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **July 22, 2016**, if substantial compliance is not achieved by that time. The findings of non-compliance on **March 31, 2016**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **March 23, 2016**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **April 22, 2016**

- A 'per instance' civil money penalty of $**Federal Civil Money Penalty of $5,000.00 per instance for the instance on January 22, 2016 described at deficiency F0226 (S/S: L)**

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

If you believe 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 **April 25, 2016**. If your request for informal dispute resolution is received after **April 25, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

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

NS/pmt
Enclosures

State of Idaho
DIVISION OF VETERANS SERVICES
*"Caring for America's Heroes"*

C.L. "BUTCH" OTTER
*Governor*

DAVID E. BRASUELL
*Division Administrator*

Idaho State Veterans Home - Boise
320 Collins Road - P.O. Box 1765
Boise, ID 83707-1765
(208) 780-1688

April 15, 2016

RECEIVED
APR 15 2016
FACILITY STANDARDS

Nina Sanderson, L.S.W.
Supervisor, Long Term Care
Department of Health & Welfare
Bureau of Facility Standards
3232 Elder Street
PO Box 83720
Boise ID 83720-0009

Dear Ms. Sanderson:

On March 31, 2016 the Department of Health and Welfare, Bureau of Facility Standards conducted an on-site revisit for our Recertification and State Licensure Survey that was conducted on January 22, 2016 at this facility. Our plan of correction for the deficiencies noted during that survey is enclosed.

Please let this letter and the plan of correction serve as a credible allegation of compliance with applicable State and Federal standards on April 14, 2016. Please note that this facility admits to no intentional wrongdoing with regard to the deficiencies noted during the survey.

We appreciate the professionalism the survey team displayed during the complaint investigation.

We are "Caring for America's Heroes."

Oni Kinberg, LCSW, MSSW
Interim Administrator Designee

OK:rjw

Enclosure

| 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 _____ | R 03/31/2016 |

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

| (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<br><br>The following deficiencies were cited during the revisit survey conducted from March 30, 2016 to March 31, 2016.<br><br>The surveyors conducting the survey were:<br>Evelyn Floyd, JD, MS, RN<br>Ann Monhollen, MS, RN<br><br>Definitions:<br><br>DON= Director of Nursing<br>UM=Unit Manager | {F 000} | *This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.* | FACILITY STANDARDS APR 15 2016 RECEIVED |
| {F 309} SS=E | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, it was determined the facility failed to ensure that timely, and complete neurological assessments were completed for 7 of 9 residents (#s 9, 30, 33, 34, 40, 41 and 42) reviewed for falls. This deficient practice resulted in the potential for neurological changes to be unnoticed. Findings include:<br><br>The facility's nursing procedure manual, "Neurological Assessment," documented, "When a resident experiences a change in the level of | {F 309} | **SPECIFIC RESIDENT**<br><br>Resident #9, 30, 33, 34, 40, 41 and 42 experienced no signs or symptoms of new neuro damage. Neuro checks will be completed following falls that are unwitnessed or where a head injury is suspected. This includes; nurse initials, readable times, timely complete assessments, and no holes in documentation.<br><br>**OTHER RESIDENTS**<br><br>Residents who have unwitnessed falls or suspected head injuries will have neuro checks completed as indicated. This includes; nurse initials, readable times, timely complete assessments, and no holes in documentation. | 4/14/16 ok. |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| LCSW, A.D. | Administrative Designee | 4/15/16 |

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 309} | Continued From page 1<br>consciousness, an unwitnessed fall and/or a fall involving a possible injury to the head the following procedure will be implemented ... "Institute neurological assessments using the Neurological Assessment Flow sheet per the following schedule: a. Assessments q 15 minutes x 4, then; b. Assessments q 30 minutes x 4, then; c. Assessments q 1 hour x 2, then; d. Assessments q 2 hours x 2, then; e. Assessments q 4 hours x 2, then; f. Assessments q 8 hours x 8 ... "<br><br>1. Resident #9 was admitted to the facility on 4/7/15 with diagnoses that included dementia.<br><br>On 2/29/16 at 3:45 pm, Resident #9 experienced an unwitnessed fall. The neurological assessment that was initiated did not document a nurse's signature for the neurological checks scheduled for every 30 minute (times 4), the one hour checks (times one) and the two hour checks (times one).<br><br>2. Resident #30 was admitted to the facility on 1/7/16 with diagnoses that included dementia.<br><br>On 3/7/17 at 6:00 pm, Resident #30 experienced an unwitnessed fall. The neurological assessment that was initiated documented the 2 two-hour assessments were not completed in a timely manner and one of the 8-hour assessments was not completed.<br><br>3. Resident #33 was admitted to the facility on 2/22/16 with diagnoses that included acute respiratory failure.<br><br>On 3/4/16 at 6:30 pm, Resident #33 experienced an unwitnessed fall. The neurological | {F 309} | Residents who are not available (eating, participating in activity, out of facility, etc.) at the exact time neuro checks are due will have assessment completed when available. Sleeping residents will be woken and assessed as scheduled.<br><br>**SYSTEMIC CHANGES**<br><br>License nurses have been in-serviced on how to complete the neuro check assessment form and on the neuro assessment process.<br><br>Our neuro policy has been reviewed and updated to be more in line with standard of practice as identified by Primaris which is contracted by the Centers for Medicare & Medicaid Services.<br><br>A new more user friendly neuro check form is now being utilized.<br><br>**MONITOR**<br><br>DON, Unit Managers or designee, will complete neuro check audits following each fall where neuro checks are indicated for 3 months and PRN.<br><br>Results of audits will be taken to monthly Quality Assurance Meetings for review and adjustment to POC made as indicated. | |

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| {F 309} | Continued From page 2 | {F 309} | | |

assessment that was initiated documented the 2 two-hour assessments and two of the 8-hour assessments were not completed.

4. Resident #34 was admitted to the facility on 1/7/16 with diagnoses that included Alzheimer's disease and fractured left hip.

On 3/18/16 at 11:15 pm, Resident #34 experienced an unwitnessed fall. That portion of the neurological assessment performed on 3/20/16 at 12:00 am documented the resident's pupil response as "N/A [not applicable]" and the last assessment due on 3/22/16 at 8:00 am was incomplete.

On 3/30/16 at 3:00 pm, in regards to Resident #34's assessment, the DON stated, "These blank assessments are just documentation with the nurse and needs some re-education."

5. Resident #40 was admitted to the facility on 7/29/14 with diagnoses that included Parkinson's disease and dementia.

On 3/6/16 at 5:30 am, Resident #40 experienced an unwitnessed fall. The neurological assessment that was initiated documented the resident's pupil response for those assessments performed on 3/6/16 from 5:45 am through 9:15 am was documented as "N/A" and the assessments were not completed in a timely manner.

6. Resident #41 was admitted to the facility on 9/15/15 with diagnoses that included Alzheimer's disease and diabetes.

a. On 2/29/16 at 2:00 pm, Resident #41

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| {F 309} | Continued From page 3<br>experienced an unwitnessed fall. The neurological assessment that was initiated documented the assessment due at 2/29/16 at 2:45 pm was not completed when "... activities took resident ..." and the assessments due at an illegible time for 2/29/16 and again at another illegible time on 3/1/16 were also not completed.<br><br>b. On 3/6/16 at 12:00 am, Resident #41 experienced an unwitnessed fall. The neurological assessment that was initiated was not completed as outlined in the facility's policy.<br><br>c. On 3/27/16 at 12:30 pm, Resident #41 experienced an unwitnessed fall. The neurological assessment that was initiated documented the assessments due at 3/27/16 from 1:45 pm to 2:45 pm, and the assessments due from 4:15 pm to 9:15 pm, were not signed by the nurse.<br><br>7. Resident #42 was admitted to the facility on 2/25/16 with diagnoses that included dementia.<br><br>On 3/8/16 at 1:50 pm, Resident #42 experienced an unwitnessed fall. The neurological assessment that was initiated documented the second 15-minute assessment was not completed and the assessment due 4:50 pm also was not completed as the resident was documented as being "at dinner." Subsequent assessments also were not completed as outlined in the facility policy.<br><br>On 3/31/16 at 11:30 am, UM #1 stated checks on the assessment without a nurse's signature meant the assessment had not been completed, noting, "Not signed, not done ..." | {F 309} | | |

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| {F 309} | Continued From page 4<br>On 3/31/16 at 11:45 am, when asked what staff should do when a resident leaves the unit, and a neurological assessment is being completed, UM #2 stated "I would expect staff to get them and complete the assessment." She stated residents should be woken at night for a neurological assessment as "that's why you're doing an assessment, to see if they wake up or not." UM #2 stated the neurological assessment is reviewed at its conclusion by the unit manager for accuracy. Once the unit manager has reviewed the completed assessment, it is then given to Medical Records, she noted.<br><br>On 3/31/16 at 12:30 pm, the DON stated she does not review completed neurological assessments before they are sent to Medical Records as the unit manager is responsible for the final review. | {F 309} | | |