



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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December 15, 2016

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

Provider #: 135132

Dear Mr. Dahlstrom:

On **December 1, 2016**, a survey was conducted at Idaho State Veterans Home - Pocatello by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

Josiah Dahlstrom, Administrator
December 15, 2016
Page 2 of 4

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 **December 27, 2106**. Failure to submit an acceptable PoC by **December 27, 2106**, may result in the imposition of penalties by **December 30, 2016**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **January 5, 2017 (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 **March 1, 2017**. A change in the seriousness of the deficiencies on **January 15, 2017**, may result in a change in the remedy.

Josiah Dahlstrom, Administrator
December 15, 2016
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **March 1, 2017** includes the following:

Denial of payment for new admissions effective **March 1, 2017**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 30, 2017**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **March 1, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Josiah Dahlstrom, Administrator
December 15, 2016
Page 4 of 4

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 **December 27, 2106**. If your request for informal dispute resolution is received after **December 27, 2106**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

A handwritten signature in black ink, appearing to read "David Scott for". The signature is written in a cursive style.

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

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

PRINTED: 01/03/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2016
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility from November 28, 2016 to December 1, 2016. The surveyors conducting the survey were: Presie C. Billington, RN, Team Coordinator Jenny Walker, RN Sheila Sizemore, RN Abbreviations: ICN - Infection Control Nurse QAPI - Quality Assurance Performance Improvement	F 000			
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in	F 371		12/23/16	

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

TITLE

(X6) DATE

Electronically Signed

12/21/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 371	<p>Continued From page 1 accordance with professional standards for food service safety.</p> <p>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of in-service records and the facility's Weekly Cleaning Schedule, it was determined the facility failed to ensure food was stored, distributed, and served under sanitary conditions. This had the potential to affect 49 of 51 residents residing in the facility who consumed food prepared in the facility kitchen. The deficient practice resulted in the storage of wet bowls, plate covers and food trays; uncovered foods stored in a walk-in cooler, and foods stored beside meat in the walk-in cooler; a steamer which included food debris; and a silverware holder in need of cleaning. Findings include:</p> <p>During the initial kitchen tour, beginning on 11/28/16 at 1:45 pm, with the Dietary Manager, the following was observed within the facility kitchen:</p> <p>a. 2 of 7 mixing bowls on a metal rack used to store ready to use mixing bowls, had been stored while wet with water.</p> <p>b. 19 of 22 the plate covers on a cart which contained plate covers, had been stored while wet with water.</p> <p>c. 15 of 22 food trays on cart which contained</p>	F 371	<p>F371 Corrective Actions: Immediately upon notification of the wet storage of bowls, plate covers and food trays; uncovered foods stored in the walk-in cooler, and foods stored beside meat in the walk-in cooler; a steamer which included food debris; and a silverware holder in need of cleaning, the concerns were remedied as staff were in-serviced and made aware of the concerns. Drying racks were ordered and received during the survey to allow for dishes to dry effectively, the silverware holder and steamer were cleaned immediately, the food item in the walk-in was covered and the mandarin oranges were discarded. Identification of others affected and corrective actions: Forty-nine of the residents in the home had the potential to be affected as they are served meals directly from the kitchen. Measures to ensure the deficient practice does not reoccur: Further in-service training has occurred to be specific to the findings in this statement of deficiencies. The silverware</p>		

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F 371	<p>Continued From page 2</p> <p>stored and ready to use food trays, had been stored while wet.</p> <p>During an interview on 11/28/16 at the above time, the Dietary Manger stated the bowls, plate covers, and the food trays, should not be stored wet. A Dietary Aide said she had nowhere to place the items for them to air dry and asked if she was to use a paper towel to dry the above items.</p> <p>d. The silverware holder containing butter knives had dried food crumbs in the bottom, including a dried green bean. The Dietary Manager indicated the container needed to be cleaned.</p> <p>e. 1 of 5 steamers in the steam table had bits of corn and other debris floating in the hot water. The Dietary Manager indicated to her staff the steam table needed to be cleaned.</p> <p>f. In the walk-in cooler there was a food tray containing slices of pepperoni. The plastic cover had come off the pepperoni, which had left the meat open to air. The Dietary Manager pulled the plastic cover back over the pepperoni.</p> <p>g. There was a food tray which contained 9 bowls of mandarin oranges sitting on the meat rack in the walk-in cooler next to beef and beef broth. There was also other types of uncooked meat on the rack. The Dietary Manager said the bowls of mandarin oranges would need to be thrown away.</p> <p>During an interview on 12/1/16 at 1:35 pm, the Dietary Manager stated she had started to in-service the kitchen staff on the above findings.</p>	F 371	<p>holder is cleaned daily and the steamers are cleaned after each meal. The food items in the walk-in cooler are monitored daily during each shift. The weekly cleaning schedule was updated to include the items listed above and the "Weekly Cleaning Schedule" sign off sheet is reviewed by the CDM weekly. The contract RD also provides monthly audits to ensure these items and others are reviewed to ensure sanitary storage, handling and consumption of food.</p> <p>Monitor corrective actions: The CDM reviews the weekly cleaning sign off sheets every week (which has listed daily and weekly duties to be performed) the RD provides added oversight with weekly visits and audits to review compliance with state and federal regulations. The CDM/designee addresses concerns as they arise and reports findings to the home's monthly QA committee for further monitoring and discussion as deemed necessary to maintain compliance.</p>		

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F 371	Continued From page 3 She said she had ordered more drying racks for the plate covers and food trays. The Dietary Manager stated she did not know the kitchen staff had been storing the bowls, plate covers, and food trays wet.	F 371			
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the	F 520		12/23/16	

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F 520	<p>Continued From page 4</p> <p>records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure the Medical Director, or his/her designee, participated in the facility's QAPI meetings. The lack of input from the Medical Director had the potential to negatively affect all residents, staff, and visitors in the facility. Findings include:</p> <p>On 12/1/16 at 1:35 pm, the Administrator said the facility held its QAPI meetings on a monthly basis. The sign-in sheets for the monthly meetings held during last 4 quarters (October 2015 to October 2016), did not include evidence the Medical Director attended the monthly meetings held during the third quarter (April - June, 2016). The Administrator said the Medical Director was unable to attend the monthly meetings held during the third quarter.</p>	F 520	<p>F520</p> <p>Corrective Actions:</p> <p>Immediately following the findings of the survey on 12/01/2016, the administrator met with the Medical Director's Nurse Practitioner to discuss said findings. A request to meet with the Medical Director was also instigated and a meeting was set up for 12/20/16.</p> <p>Identification of others affected and corrective actions:</p> <p>The lack of input from the Medical Director in the QA meetings had the potential to affect all residents.</p> <p>Measures to ensure the deficient practice does not reoccur:</p> <p>A meeting was held with the Medical Director on 12/20/16 to go over specific details of the findings and the regulations. The Medical Director is in agreement to meet quarterly with the QA team to provide feedback and oversight of items that are brought to the meeting. An annual calendar has been provided to give the Medical Director advanced notice to ensure his attendance at the quarterly meetings and the Medical Director has</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520	Continued From page 5	F 520	<p>agreed to this method. The next scheduled quarterly meeting, to review the last quarter (October, November, December) of 2016 will be held on January 18, 2017.</p> <p>Monitor corrective actions: The home administrator/designee will remind all attendees 2 weeks in advance of the meeting to ensure all required attendees are in attendance and prepared. The QA committee will address concerns and make changes as necessary to maintain compliance.</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001312	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2016
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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - POCATELL	STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following were cited during the state licensure survey conducted at the facility from November 28, 2016 to December 1, 2016.</p> <p>The surveyors conducting the survey were:</p> <p>Presie C. Billington, RN, Team Coordinator Jenny Walker, RN Sheila Sizemore, RN</p> <p>Abbreviations:</p> <p>ICN - Infection Control Nurse</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on review of Quality Assurance Performance Improvement meeting minutes and staff interview, it was determined the facility failed to ensure the Medical Director and pharmacist participated in the facility's Infection Control Meetings. This failure had the potential affect all residents, staff and visitors to the facility. Findings include:</p> <p>On 11/30/16 at 10:00 am, the ICN said the facility held its Quality Assurance Performance Improvement meetings on a monthly basis and infection control was a component of those meetings. Review of the sign-in sheets for the last 13 months, from October 2015 to October</p>	C 664	<p>C664</p> <p>Corrective Actions: Immediately following the findings of the survey, the administrator met with the Medical Director's Nurse Practitioner to discuss said findings. A request to meet with the Medical Director was also instigated and a meeting was set up for 12/20/16. The administrator also met with the home's Pharmacist as her attendance was not verified with her signature on the sign-in sheet. She agreed to attend and sign in for her attendance. Identification of others affected and corrective actions:</p>	12/23/16

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 12/21/16
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Bureau of Facility Standards

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C 664	<p>Continued From page 1</p> <p>2016, covering the last 4 quarters, showed the Medical Director did not attend the monthly meetings held during the third quarter (April - June 2016), and the Pharmacist attended only one of the monthly meetings.</p> <p>The ICN said the Pharmacist attended all of the monthly meetings but did not sign the sign-in sheets.</p> <p>On 12/1/16 at 1:35 pm, the Administrator said the Medical Director was not able to attend the monthly meetings during the third quarter.</p>	C 664	<p>The lack of input from the Medical Director and pharmacist in the Infection Control meetings had the potential to affect all residents.</p> <p>Measures to ensure the deficient practice does not reoccur:</p> <p>A meeting was held with the Medical Director on 12/20/16 to go over specific details of the findings and the regulations. The Medical Director is in agreement to meet quarterly with the Infection Control team to provide feedback and oversight of items that are brought to the meeting. An annual calendar has been provided to give the Medical Director advanced notice to ensure his attendance at the quarterly meetings and the Medical Director has agreed to this method. The pharmacist is employed daily in the home and is available to attend this meeting as often as it is held. The next scheduled quarterly meeting, to review the last quarter (October, November and December) of 2016 will be held on January 18, 2017.</p> <p>Monitor corrective actions:</p> <p>The home administrator/designee will remind all attendees 2 weeks in advance of the quarterly Infection Control meetings to ensure all required attendees are in attendance and prepared. Any findings or concerns from the Infection Control meeting will be taken to the QA committee for review. The QA committee will address concerns and make changes as necessary to maintain compliance.</p>	