



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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March 16, 2018

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

Provider #: 135132

Dear Mr. Dahlstrom:

On **March 8, 2018**, 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 an isolated 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.

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 26, 2018**. Failure to submit an acceptable PoC by **March 26, 2018**, may result in the imposition of penalties by **April 20, 2018**.

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 **April 12, 2018 (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 **June 6, 2018**. A change in the seriousness of the deficiencies on **April 22, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by

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June 6, 2018 includes the following:

Denial of payment for new admissions effective **June 6, 2018**. [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 **September 4, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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 **June 6, 2018** 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>

Go to the middle of the page to **Information Letters** section and click on **State** and select the following:

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- 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 **March 26, 2018**. If your request for informal dispute resolution is received after **March 26, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby Ranson, RN, RHIT, Chief
Bureau of Facility Standards

dr/lj
Enclosures

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 03/08/2018
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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201
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(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
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F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility from March 5, 2018 through March 8, 2018. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Jenny Walker, RN Edith Cecil, RN Survey Abbreviations: CNA = Certified Nurse Assistant DNS = Director of Nursing Services LPN = Licensed Practical Nurse	F 000		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure staff received direction regarding Resident #155's dialysis care. This affected 1 of 1 (#155) sampled residents. This failure created the potential for harm if Resident #155 experienced complications and/or compromised medical status. Findings include: 1. Resident #155 was admitted to the facility on 2/15/18 with multiple diagnoses, including	F 698	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. a. An order has been obtained for resident #155 to receive dialysis treatments and includes the name of the dialysis provider, frequency and location. b. The resident assessment form related to dialysis treatments was revised to include pre- and post-dialysis	3/26/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/23/2018
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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 698	Continued From page 1 epilepsy with seizures and stage 4 chronic kidney disease. Resident #155's clinical record did not document orders for dialysis, including the dialysis provider's name, frequency, location, or post dialysis assessments. On 3/8/18 9:48 AM, the DNS and the Nursing Consultant stated Resident #155's clinical record should have included physician orders for dialysis. The licensed staff should have monitored and documented Resident #155's central line port assessment and vital signs upon return from dialysis.	F 698	assessments to include vital signs, dialysis port/site assessment and general health status. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. a. There are no other residents in the facility who receive dialysis. b. All residents and future residents have the potential to be affected by the deficient practice when dialysis treatments are ordered. If/when this occurs the following shall be initiated (See # 3 below). 3. What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. a. A nursing procedure was developed which guides staff to ensure dialysis order(s) is present and that the Resident Assessment Dialysis form is to be completed with each dialysis treatment. b. Clinical meetings (which includes the DNS, RN Manager, Staff Development Coordinator, MDS Coordinator, Social Service Director, Activities Director, and other interested staff members) will be conducted each business day and includes review of all new admissions and all new physician orders to ensure if a resident is admitted with anticipated dialysis treatments, an order is present and includes the name of the provider, frequency and location. c. A Clinical Meeting checklist will be utilized to ensure/verify the review of		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/02/2018
FORM APPROVED
OMB NO. 0938-0391

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F 698	Continued From page 2	F 698	physician orders/new admissions to ensure appropriate orders are present. d. Licensed nursing staff were educated 3/23/18 related to the need to ensure a resident who receives dialysis treatments are assessed, according to the criteria on the Resident Assessment Dialysis form, and this assessment is documented pre- and post-dialysis. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. An audit of the completed Resident Assessment Dialysis forms will be conducted weekly by the DNS/designee to ensure that these assessments are complete and that the dialysis treatments are done in accordance with the physician order(s). This audit will be conduct by the DNS/designee 1x a week x 4 weeks, then monthly x 3 months. Results of the audit will be presented to the monthly QA/PI committee.		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.	F 849		3/26/18	

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F 849	Continued From page 3 §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate	F 849			

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F 849	Continued From page 4 course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.	F 849			

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F 849	<p>Continued From page 5</p> <p>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.</p> <p>§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.</p> <p>The designated interdisciplinary team member is responsible for the following:</p> <ul style="list-style-type: none"> (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: <ul style="list-style-type: none"> (A) The most recent hospice plan of care specific to each patient. 	F 849			

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F 849	<p>Continued From page 6</p> <p>(B) Hospice election form.</p> <p>(C) Physician certification and recertification of the terminal illness specific to each patient.</p> <p>(D) Names and contact information for hospice personnel involved in hospice care of each patient.</p> <p>(E) Instructions on how to access the hospice's 24-hour on-call system.</p> <p>(F) Hospice medication information specific to each patient.</p> <p>(G) Hospice physician and attending physician (if any) orders specific to each patient.</p> <p>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.</p> <p>§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, hospice staff and facility staff interview, it was determined the facility failed to ensure care was coordinated to ensure residents were met. This was true for 1 of 3 residents (#49) sampled for hospice care. This failure had the potential for harm if the residents received inadequate care from the facility and/or hospice agency due to a lack of care coordination. Findings include:</p>	F 849	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. 1 of 3 residents on hospice services were affected by the deficient practice. The Clinical Team met with the director of the hospice company to develop a collaborative plan of care for resident # 49. This plan of care was incorporated</p>		

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F 849	<p>Continued From page 7</p> <p>Resident #49's hospice agency and facility contract, dated 2/16/17, documented the hospice agency and the facility would develop a joint care plan and coordinate care and services.</p> <p>Resident #49 was admitted to the facility on 2/2/18 with multiple diagnoses, including dementia and diabetes with foot ulcers.</p> <p>Resident #49's physician orders, dated 2/8/18, documented an order for hospice services.</p> <p>Resident #49's Admission Minimum Data Set assessment, dated 2/9/18, documented the resident was severely cognitively impaired, required extensive assistance from staff for all cares, and received hospice services.</p> <p>Resident #49's current care plan, dated 2/12/18, directed facility staff to work with the hospice staff to ensure the resident's needs were met and hospice staff was to provide bathing two times a week, unless they were unable to and then the facility would provide bathing.</p> <p>Resident #49's Skin Integrity care plan, dated 2/12/18, directed facility staff to administer treatments and dressing changes.</p> <p>Resident #49's record did not contain comprehensive, integrated plan of care that reflected the services needed and who was to provide those services.</p> <p>On 3/5/18 at 11:11 AM, Resident #49 was observed in his wheelchair in his room while Hospice Nurse #1 performed a dressing change to the resident's left toes. Hospice Nurse #1 said</p>	F 849	<p>into the resident's current plan of care.</p> <p>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>a. One of three (3) sampled residents who currently receive hospice services were identified as being affected by the deficient practice. An audit was performed on 3/22/18 to review all hospice files on all current hospice residents and all active hospice files have a collaborative plan of care between the home and the hospice agency. For future residents who are admitted with or receive hospice services the Clinical Team (DNS, SDC, RN Mgr, etc.) will utilize the following (#3) systemic processes to ensure compliance.</p> <p>3. What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>a. The facility has designated the MDS coordinator as the member of the IDT who is responsible for working with hospice representatives to coordinate care to the resident provided by the home staff and hospice staff. Clinical meetings (which includes the DNS, RN Manager, Staff Development Coordinator, MDS Coordinator, Social Service Director, Activities Director, and other interested staff members) are also conducted each business day and includes review of all new admissions and all new physician orders to ensure if a resident is admitted with or has orders for hospice that a</p>		

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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201		
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F 849	<p>Continued From page 8</p> <p>the hospice agency provided wound care for Resident #49's diabetic foot ulcers.</p> <p>On 3/7/18 at 9:32 AM, the Clinical Hospice Director for Resident #49's hospice agency said she could not find the hospice plan of care in the clinical record and asked the facility Ward Clerk where it was and the Ward Clerk said she could not find it. The Clinical Hospice Director said the hospice agency and the facility staff were to coordinate the resident's care.</p> <p>On 3/7/18 at 9:44 AM and 11:45 AM, LPN #2 said she was not sure where Resident #49's coordinated plan of care was and if she had any questions, she could call the hospice nurse. She said the facility care plan should be more specific on who was responsible for the resident's care. LPN #2 said all of Resident #49's medications were ordered by the hospice and provided by an outside pharmacy, rather than the facility's internal pharmacy and said that was not documented in the resident's clinical record.</p> <p>On 3/7/18 at 10:05 AM, Hospice CNA #1 said the hospice staff provided all of the bathing for Resident #49 and would verbally communicate with facility staff when something changed.</p> <p>On 3/7/18 at 10:09 AM, CNA #1 said the hospice provided all the bathing, unless hospice staff needed the facility to bathe Resident #49. CNA #1 said the facility provided toileting needs for the resident.</p> <p>On 3/7/18 at 3:03 PM, the facility's wound nurse said hospice nurses generally provided all of Resident #49's wound care with facility staff</p>	F 849	<p>collaborative plan of care is developed. The Clinical Team also reviews progress notes from the prior period to ensure completeness/accuracy e.g. documentation of the actions/communication with hospice staff. The Clinical Team will also compare the notes against the plan of care to ensure services were provided as planned and the MDS coordinator or DNS will follow-up as indicated.</p> <p>b. A nursing procedure was developed to outline the expectations of the collaborative plan of care.</p> <p>c. The facility's IDT stand-up meeting each business day includes the review of resident payer source and/or changes in payer source which will help identify new hospice orders.</p> <p>d. The Admissions Coordinator and MDS Coordinator have been provided a copy of the nursing procedure related to hospice/facility collaboration of care to assist with this process prior to a resident being admitted.</p> <p>e. A summary meeting of these findings was held with the hospice on 3/22/18 and discussed what the collaboration of care should look like. The Licensed Nursing staff were educated 3/23/18 related to the need to document in the progress notes all actions/communication with the hospice staff to help ensure continuity of care. The hospice staff were also instructed to document their actions/communication with facility staff in their progress notes.</p> <p>4. How the corrective action(s) will be</p>		

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

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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 03/08/2018
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201		
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F 849	Continued From page 9 oversight and said the Skin care plan should have documented that. On 3/7/18 at 3:22 PM, the DNS and Nursing Consultant said there was not an integrated plan of care developed for Resident #49. They said the facility's care plan should have directed staff on what services the facility provided versus what the hospice provided. They said all of Resident #49's medications were provided by the hospice agency. The DNS said that both the facility and the hospice staff provided wound care, but was not documented in the care plan.	F 849	monitored to ensure the deficient practice will not recur. An audit will be conducted by the MDS Coordinator/designee on random residents who receive hospice services to ensure the plan of care is accurate and complete and is being provided as agreed upon and that documentation related to these services is present. This audit will be done weekly x 4, then monthly x 3. The results of this audit will be discussed/acted upon on the monthly QA/PI Committee meeting.		