



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – 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
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E-mail: fsb@dhw.idaho.gov

May 10, 2019

Mark High, Administrator
Idaho State Veterans Home - Lewiston
821 21st Avenue
Lewiston, ID 83501-6389

Provider #: 135133

Dear Mr. High:

On **April 26, 2019**, a survey was conducted at Idaho State Veterans Home - Lewiston 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 in your facility to be **WIDESPREAD** and to constitute immediate jeopardy to residents' health and safety. You were informed of the immediate jeopardy situation(s) in writing on **April 26, 2019**.

On **April 26, 2019**, the facility submitted a credible allegation that the immediate jeopardy would be removed **May 1, 2019**. After review of your Plan of Correction, and a resvisit conducted on **May 2, 2019** it was determined that the immediate jeopardy to the residents had been removed. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction. The most serious deficiency now constitutes actual harm that is not immediate jeopardy and that is isolated in scope, as evidenced by the Form 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.**

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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 **May 20, 2019**. Failure to submit an acceptable PoC by **May 20, 2019**, may result in the imposition of additional civil monetary penalties by **June 12, 2019**.

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:

- **F610 -- S/S: L -- 483.12(c)(2)-(4) -- Investigate/prevent/correct Alleged Violation**

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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:

- Civil money penalty,
- Denial of Payment for New Admissions effective **July 26, 2019**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **October 26, 2019**, 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.

Your facility's noncompliance with the following:

- **F0607 - S/S: F 483.12(b)(1)-(3) -- Develop/implement Abuse/neglect Policies;**
- **F0609 -- S/S: F -- 483.12(c)(1)(4) -- Reporting Of Alleged Violations;**
- **F0610 -- S/S: L -- 483.12(c)(2)-(4) -- Investigate/prevent/correct Alleged Violation**

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Resident #3 as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

If you believe the deficiencies have been corrected, you may contact Laura Thompson, RN or Belinda Day, RN, LTC 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through

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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:

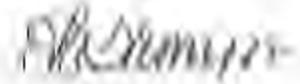
- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **May 20, 2019**. If your request for informal dispute resolution is received after **May 20, 2019**, 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,



Laura Thompson, RN, Chief
Bureau of Facility Standards

lt/lj

c: Chairman, Board of Examiners - Nursing Home Administrators

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

PRINTED: 05/31/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2019
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 821 21ST AVENUE LEWISTON, ID 83501		
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F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from April 22, 2019 through April 26, 2019 The surveyors conducting the survey were: Edith Cecil, RN Team Coordinator Presie Billington, RN Karen George, RN Survey Abbreviations: ADLs - Activities of Daily Living CNA - Certified Nursing Assistant COPD - Chronic Obstructive Pulmonary Disease DON - Director of Nursing LPN - Licensed Practical Nurse LSW - Licensed Social Worker MD - Medical Director/Doctor mg - milligrams MDS - Minimum Data Set RCM - Resident Care Manager RN - Registered Nurse	F 000			
F 607 SS=F	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and	F 607		5/31/19	

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

TITLE

(X6) DATE

Electronically Signed

05/17/2019

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 607	<p>Continued From page 1</p> <p>§483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, record review, policy review, grievance log review, and review of Incident and Accident reports, it was determined the facility failed to ensure its policies were implemented to protect residents from potential physical abuse. This was true for 1 of 15 residents (Resident #3) reviewed for abuse. This deficient practice placed Resident #3, and the other 56 residents residing in the facility, at risk for physical and/or psychosocial harm. Findings include:</p> <p>The facility's Abuse Prevention Program Policy, revised 10/2016, documented the facility was committed to protecting their residents from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion by anyone. The facility had a zero tolerance policy for resident mistreatment, neglect, abuse, or misappropriation of resident property. The policy documented physical abuse included hitting, slapping, pinching, kicking etc.</p> <p>The facility's Abuse Prevention Program Policy documented the individual conducting the investigation should at a minimum:</p> <ul style="list-style-type: none"> *Interview the person(s) reporting the incident. *Interview any witnesses to the incident. *Interview the resident (as medically appropriate). *Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. 	F 607	<p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>A thorough investigation was conducted by the facility Administrator regarding the allegations made by CNA #3 in accordance with facility procedures including the immediate removal of the accused staff member RN #1. Those results were provided to the Bureau of Facility Standards.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>The facility has determined that all residents have the potential to be affected.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>In house review of all residents including interviews with residents and/or representatives to ensure that any further incidents are identified and if needed investigated. An additional review of all allegations of abuse/neglect over the past three (3) months to ensure that proper reporting procedures were followed and proper investigations were conducted. An in-service education program was conducted by the Administrator with all direct care and ancillary staff addressing</p>		

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F 607	<p>Continued From page 2</p> <p>*Interview the resident's roommate, family members, and visitors.</p> <p>*Interview other residents to whom the accused employee provides care or services.</p> <p>*Review all events leading up to the alleged incident.</p> <p>*Employee(s) accused of resident abuse were to be removed from the facility and could not work until the investigation was completed.</p> <p>This policy was not followed.</p> <p>Resident #3 was admitted to the facility on 9/6/12, with multiple diagnoses including dementia with behavioral disturbance, depression, and obstructive uropathy (difficulty urinating).</p> <p>A quarterly MDS assessment, dated 4/16/19, documented Resident #3 had severe cognitive impairment, required the assistance of one or two staff members for his ADLs, and he had an indwelling catheter.</p> <p>An Incident and Accident (I&A) report, dated 9/18/18 at 1:30 AM, documented Resident #3 had an unwitnessed fall with no injury. The I&A report documented Resident #3 was found kneeling on the floor with both hands resting on his bed. Resident #3 was not wearing his non-skid socks and said "Help, help, help me up."</p> <p>On 4/25/19 at 4:21 PM, the DON said CNA #3 told her RN #1 slapped Resident #3's ears and CNA #3 was concerned about Resident #3's safety in the facility. The DON said she clarified to CNA #3 the difference between the words</p>	F 607	<p>the facility policies and procedures regarding alleged violations. A procedure change to include home administrator and abuse coordinators personal contact information to include that information on each employee's abuse/neglect procedures card. Oversight of these actions are to be conducted by a contracted recognized long term care expert.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur: Social Services, or designee, will conduct a random audit of five (5) staff members, including management staff, weekly for four (4) consecutive weeks, then monthly for three (3) months to ensure that staff members have on their person or readily available their abuse/neglect procedures card and that they know what those procedures entail.</p> <p>This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.</p>		

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F 607	<p>Continued From page 3</p> <p>"slapping the ears" and "cupping the ears." The DON said she explained and demonstrated to CNA #3 the difference between cupping the ears and slapping the ears. The DON said Resident #3 was hard of hearing and it could be RN #1 was trying to get his attention because he was not wearing his hearing aid the night he fell. The DON said she interviewed RN #1, and RN #1 told her she put her hands on Resident #3's ears to get his attention. The DON said she was not sure if she kept the written report from CNA #3.</p> <p>On 4/25/19 at 4:46 PM, LSW #2 who was the Abuse Coordinator, said there was no investigation done into the alleged abuse because the DON clarified to CNA #3 the difference between the words "slapping" and "cupping." LSW #2 said RN #1 did not slap Resident #3's ears, instead RN #1 cupped her hands against Resident #3' ears to get his attention. LSW #2 said there was no abuse to Resident #3, it was instead a misuse of words.</p> <p>On 4/25/19 at 5:28 PM, during a telephone interview, RN #1 said during her shift on 9/18/18, she heard Resident #3 calling for help and saying, "help me, help me." RN #1 said she found Resident #3 kneeling on the floor with his hands resting on his bed. RN #1 said she asked CNA #3 to get the Hoyer lift (a mechanical lift) while she assessed Resident #3 for injury. RN #1 said Resident #3 was still yelling for help even though she was already in his room, and it became louder and louder. RN #1 said she "tapped" Resident #3's ears to let him know she was already there and trying to help him but Resident #3 kept yelling. RN #1 said she then used her foot to "tickle" Resident #3's feet to get</p>	F 607			

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F 607	<p>Continued From page 4</p> <p>his attention, but Resident #3 kept yelling for help.</p> <p>On 4/25/19 at 6:00 PM, CNA #3 said on 9/18/18, she heard Resident #3 yell for help and found Resident #3 kneeling on the floor next to his bed. CNA #3 said she called RN #1 for help. CNA #3 said Resident #3 kept on yelling for help even though they were already in his room trying to assist him. CNA #3 said RN #1 stood behind Resident #3 to support him and every time Resident #3 yelled for help RN #1 kicked his feet. CNA #3 said Resident #3's catheter tubing was caught between one of his legs and the floor and when RN #1 pulled him back to a sitting position Resident #3 yelled "stop you are hurting me." CNA #3 said she then saw RN #1's hands about 12 inches away from Resident #3's ears and she then slapped his ears. CNA #3 said her command of the English language was not good, so she described it in her report as a "clapping" sound. CNA #3 said it was really loud and it mimicked the sound of clapping your hands. CNA #3 said she reported the incident to the Unit Manager the following morning and she was asked to provide a written report of the incident. CNA #3 said the DON talked with her and explained to her the difference between "cupping of the ears" and "slapping of the ears." CNA #3 said she described what she saw and heard that night in her written report.</p> <p>CNA #3 then provided a copy of her written report to the surveyor. CNA #3's unedited written report documented the following:</p> <p>*RN #1 kicked Resident #3 in the feet each time he screamed "help me."</p>	F 607			

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F 607	<p>Continued From page 5</p> <p>*RN #1 told Resident #3 to stop screaming as they were there to help him and that he made her headache more and she did not feel well.</p> <p>*When Resident #3 screamed again RN #1 kicked him on his left side between the lower back.</p> <p>*RN #1 pulled back on Resident #3 to get him from a kneeling to a sitting position and Resident #3 said stop it you are hurting me.</p> <p>*Resident #3 screamed for help again and RN #1 slapped both of his ears. Resident #3 told RN #1 to stop because it was hurting him.</p> <p>On 4/26/19 at 9:44 AM, the Administrator, with the DON present, said when the words "cupping the ears" and "slapping the ears" were clarified with CNA #3 it should have been documented and included in the incident report. The Administrator said it was unfortunate they could not provide that document. The Administrator said he was not notified of CNA #3's report. The DON said she did not notify the Administrator of the incident because it was concluded there was no abuse to Resident #3. The DON said there was a language barrier between CNA #3 and RN #1.</p> <p>On 4/26/19 at 11:02 AM, during the follow-up interview with the Administrator, DON, RCM, and LSW #2, the surveyor provided a copy of CNA #3's report for review. The DON and the RCM both said this was the first time they had seen the report. LSW #2 said CNA #3's report was not in his Grievance log. LSW #2 said if CNA #3's report was submitted to him it would be in his Grievance log. The DON said when CNA #3 came to her she had a written report on a piece of paper taken from a notebook and she was</p>	F 607			

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F 607	Continued From page 6 unable to find it. The Administrator then read CNA #3's report and after reading the report, the surveyor asked the Administrator what he would have done if he had the report earlier. The Administrator said, "without a doubt it will be reported to the State portal and an investigation initiated." The facility failed to follow its policies and procedures when it did not retain the written allegation of abuse, conduct a thorough investigation, and protect Resident #3 and the other 56 residents residing in the facility by removing the accused staff member from the facility until the investigation was completed. * Refer to F609 as it relates to the failure of the facility to report allegations of abuse to the administrator and State Survey Agency within 2 hours, as specified in its policy. * Refer to F610 for futher details related to the failure of the facility to thoroughly investigate allegations of abuse, as specified in its policy.	F 607			
F 610 SS=L	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		5/31/19	

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F 610	<p>Continued From page 7</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, record review, facility policy review, Incident and Accident Report review, Grievance Log review, and State Survey Agency Reportable Incidents Database review, it was determined the facility failed to ensure allegations of abuse were investigated and written allegations of abuse were not altered to minimize the severity of the allegations. This was true for 1 of 15 residents (Resident #3) reviewed for abuse. The health and safety of all residents residing in the facility were placed in immediate jeopardy when a) Resident #3 was at risk of ongoing abuse by facility staff and b) the other 56 residents residing in the facility were at risk of being subjected to abuse without detection and intervention. Findings include:</p> <p>The facility's Abuse Prevention Program Policy, revised 10/2016, documented all reports of resident abuse, neglect, and injuries of unknown origin, were to be investigated. All employees, facility consultants, attending physicians, family members, and visitors were to promptly report any incident or suspected incident of neglect or abuse, including injuries of unknown source, to facility management. The policy documented physical abuse included hitting, slapping, pinching, kicking, etc.</p>	F 610	<p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>Resident #3 was reassessed by the Nursing Services on April 26, 2019 along with review of Resident #3 medical record to verify any signs/symptoms of abuse. The physician and the resident's family were notified promptly upon completion of the assessment. Immediate suspension of DNS and RN#1 was enacted as a thorough investigation was initiated by the facility Administrator.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>The facility has determined that all residents have the potential to be affected.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>In house review of all residents including interviews with residents and/or representatives to ensure that any further incidents are identified and if needed investigated. An additional review of all</p>		

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F 610	<p>Continued From page 8</p> <p>The facility's Abuse Prevention Program Policy documented the individual conducting the investigation should at a minimum:</p> <ul style="list-style-type: none"> *Interview the person(s) reporting the incident. *Interview any witnesses to the incident. *Interview the resident (as medically appropriate). *Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. *Interview the resident's roommate, family members, and visitors. *Interview other residents to whom the accused employee provides care or services. *Review all events leading up to the alleged incident. *Employee(s) accused of resident abuse were to be removed from the facility and could not work until the investigation was completed. <p>This policy was not followed.</p> <p>Resident #3 was admitted to the facility on 9/6/12, with multiple diagnoses including dementia with behavioral disturbance, depression and obstructive uropathy (difficulty urinating).</p> <p>A quarterly MDS assessment, dated 4/16/19, documented Resident #3 had severe cognitive impairment and he required the assistance of one to two staff members for his ADLs, and he had an indwelling catheter.</p> <p>A care plan, revised 3/25/19, documented Resident #3 was at risk for falls related to impaired balance, confusion, and impulsive</p>	F 610	<p>allegations of abuse/neglect over the past three (3) months to ensure that proper reporting procedures were followed and proper investigations were conducted. An in-service education program was conducted by the Director of Nursing Services and the Administrator with all direct care staff addressing circumstances that require reporting including appropriate timeframes. Oversight of these actions are to be conducted by a contracted recognized long term care expert.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur: The Social Services team, or designee, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks and monthly for three (3) months. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated and reported to the appropriate people. In addition, Social Services, or designee, will conduct a random audit of five (5) staff members, including management staff, weekly for four (4) consecutive weeks, then monthly for three (3) months to ensure that staff members have on their person or readily available their abuse/neglect procedures card and that they know what those procedures entail.</p> <p>This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial</p>		

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F 610	<p>Continued From page 9 behaviors. The care plan interventions included encouraging Resident #3 to wear non-skid socks, keep his pathways clear and free from clutter, keep his room well lit, keep his call light within reach, and to provide him with supportive care.</p> <p>An Incident and Accident (I&A) report, dated 9/18/18 at 1:30 AM, documented Resident #3 had an unwitnessed fall with no injury. The I&A report documented Resident #3 was found kneeling on the floor with both hands resting on his bed. Resident #3 was not wearing his non-skid socks and said "Help, help, help me up."</p> <p>On 4/25/19 at 4:05 PM, the Resident Care Manager (RCM) said she remembered a conversation with CNA #3 where she reported RN #1 yelled at Resident #3. The RCM said she did not remember exactly what CNA #3 told her, but she remembered talking to the DON about her conversation with CNA #3. The RCM said she and the DON spoke to Resident #3 and asked him if he felt safe in the facility. RCM said Resident #3 said "yes."</p> <p>On 4/25/19 at 4:21 PM, the DON said CNA #3 told her RN #1 slapped Resident #3's ears and CNA #3 was concerned about Resident #3's safety in the facility. The DON said she clarified to CNA #3 the difference between the words "slapping the ears" and "cupping the ears." The DON said she explained and demonstrated to CNA #3 the difference between cupping the ears and slapping the ears. The DON said Resident #3 was hard of hearing and it could be RN #1 was trying to get his attention because he was not wearing his hearing aid the night he fell. The</p>	F 610	compliance has been met.		

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F 610	<p>Continued From page 10</p> <p>DON said she interviewed RN #1, and RN #1 told her she put her hands on Resident #3's ears to get his attention. The DON said she was not sure if she kept the written report from CNA #3.</p> <p>On 4/25/19 at 4:46 PM, LSW #2 who was the Abuse Coordinator, said there was no investigation done into the alleged abuse because the DON clarified to CNA #3 the difference between the words "slapping" and "cupping." LSW #2 said RN #1 did not slap Resident #3's ears, instead RN #1 cupped her hands against Resident #3' ears to get his attention. LSW #2 said there was no abuse to Resident #3, it was instead a misuse of words.</p> <p>On 4/25/19 at 5:28 PM, during a telephone interview, RN #1 said during her shift on 9/18/18, she heard Resident #3 calling for help and saying, "help me, help me." RN #1 said she found Resident #3 kneeling on the floor with his hands resting on his bed. RN #1 said she asked CNA #3 to get the Hoyer lift (a mechanical lift) while she assessed Resident #3 for injury. RN #1 said Resident #3 was still yelling for help even though she was already in his room, and it became louder and louder. RN #1 said she "tapped" Resident #3's ears to let him know she was already there and trying to help him but Resident #3 kept yelling. RN #1 said she then used her feet to "tickle" Resident #3's feet to get his attention, but Resident #3 kept yelling for help.</p> <p>On 4/25/19 at 6:00 PM, CNA #3 said on 9/18/18 she heard Resident #3 yell for help and found Resident #3 kneeling on the floor next to his bed. CNA #3 said she called RN #1 for help. CNA #3</p>	F 610			

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F 610	<p>Continued From page 11</p> <p>said Resident #3 kept on yelling for help even though they were already in his room trying to assist him. CNA #3 said RN #1 stood behind Resident #3 to support him and every time Resident #3 yelled for help RN #1 kicked his feet. CNA #3 said Resident #3's catheter tubing was caught between one of his legs and the floor and when RN #1 pulled him back to a sitting position Resident #3 yelled "stop you are hurting me." CNA #3 said she then saw RN #1's hands about 12 inches away from Resident #3's ears and she then slapped his ears. CNA #3 said her command of the English language was not good, so she described it in her report as a "clapping" sound. CNA #3 said it was really loud and it mimicked the sound of clapping your hands. CNA #3 said she reported the incident to the Unit Manager the following morning and she was asked to provide a written report of the incident. CNA #3 said the DON talked with her and explained to her the difference between "cupping of the ears" and "slapping of the ears." CNA #3 said she described what she saw and heard that night in her written report.</p> <p>CNA #3 then provided a copy of her written report to the surveyor. The words in the report were changed as follows:</p> <ul style="list-style-type: none"> * "kick" was changed to "tap" * "hit him" was changed to "tap his" * "lower back" was changed to "[lower] flank" * "slap" was changed to "cupp" <p>The changes were not initialed or dated.</p> <p>Unedited, CNA #3's written report documented the following:</p>	F 610			

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F 610	<p>Continued From page 12</p> <ul style="list-style-type: none"> * RN #1 kicked Resident #3 in the feet each time he screamed "help me." * RN #1 told Resident #3 to stop screaming as they were there to help him and that he made her headache more and she did not feel well. * When Resident #3 screamed again RN #1 kicked him on his left side between the lower back. * RN #1 pulled back on Resident #3 to get him from a kneeling to a sitting position and Resident #3 said stop it you are hurting me. * Resident #3 screamed for help again and RN #1 slapped both of his ears. Resident #3 told RN #1 to stop because it was hurting him. <p>On 4/26/19 at 9:44 AM, the Administrator, with the DON present, said when the words "cupping the ears" and "slapping the ears" were clarified with CNA #3 it should have been documented and included in the incident report. The Administrator said it was unfortunate they could not provide that document. The Administrator said he was not notified of CNA #3's report. The DON said she did not notify the Administrator of the incident because it was concluded there was no abuse to Resident #3. The DON said there was a language barrier between CNA #3 and RN #1.</p> <p>On 4/26/19 at 11:02 AM, during the follow-up interview with the Administrator, DON, RCM, and LSW #2, the surveyor provided a copy of CNA #3's report for review. The DON and the RCM both said this was the first time they had seen the report. LSW #2 said CNA #3's report was not in his Grievance log. LSW #2 said if CNA #3's report was submitted to him it would be in his Grievance log. The DON said when CNA #3</p>	F 610			

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F 610	Continued From page 13 came to her she had a written report on a piece of paper taken from a notebook and she was unable to find it. The Administrator then read CNA #3's report and after reading the report, the surveyor asked the Administrator what he would have done if he had the report earlier. The Administrator said, "without a doubt it will be reported to the State portal and an investigation initiated." The facility failed to investigate the allegation of abuse to Resident #3 and protect him further abuse, as documented in its Abuse Prevention Program Policy. Additionally, the original written allegation of abuse was altered and neither the original or altered written allegation was retained by the facility. On 4/26/19 at 1:10 PM, the Administrator was notified verbally and in writing of the Immediate Jeopardy to residents' health and safety.	F 610			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		5/31/19	

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F 657	<p>Continued From page 14</p> <p>the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, staff interview, and policy review, it was determined the facility failed to ensure residents' care plans were revised as care needs changed. This was true for 1 of 2 residents (#108) reviewed for care plan revision and had the potential for harm if cares and/or services were not provided due to inaccurate information. Findings include:</p> <p>The facility's comfort care policy, dated 1/2015, documented:</p> <p>* Terminal comfort care provides supportive care for residents and their families during the end stage of life by enabling them to participate in interactions of their choice, in a supportive environment, with assistance of compassionate caregivers.</p> <p>* Nursing will coordinate the plan of care and will collaborate closely with other disciplines as necessary including hospice care if ordered by the physician.</p>	F 657	<p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>Resident #108 has expired. MDS coordinator conducted facility audit of resident care plans for those residents identified as having a significant change to ensure updating of the care plans were completed.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>All residents of the facility have the potential to be affected by this practice.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>An in-service education program was conducted for the facility's MDS team and Interdisciplinary Team specific to care plan updates and when they are required</p>		

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F 657	Continued From page 15 * The resident care plan will be initiated/updated to define appropriate goals and interventions. Resident #108 was admitted to the facility on 7/13/15 with multiple diagnoses including Alzheimer's Dementia. A significant change in condition MDS assessment, dated 3/27/18, documented Resident #108 declined in cognition, ADLs, continence of bowel, and had weight loss. Resident #108's medical record documented the election of comfort care on 5/7/18. Resident #108's care plan was last reviewed and updated on 4/27/18. The care plan did not reflect the election of comfort care or interventions to meet the needs of Resident #108's end of life care. On 4/29/19, at 5:30 PM, the MDS Coordinator said it had been her responsibility to update the care plan. She said she had not updated the care plan prior to 5/19/18, when Resident #108 expired.	F 657	including when comfort care situations. How the corrective action(s) will be monitored to ensure the practice will not recur: Unit manager will review care plans daily (M-F) for (2) weeks for those residents experiencing a change in status and identified by the interdisciplinary team during morning clinicals to ensure new or modified interventions have been addressed and documented regarding the resident's care. The interim Director of Nursing Services or designee will review a five (5) random sample of care plans one (1) time per week for one (1) month and every other week for (1) month to assure the review and revision of care plans. Results will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and policy review, it was	F 677	Immediate action(s) taken for the resident(s) found to have been affected	5/31/19	

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F 677	<p>Continued From page 16</p> <p>determined the facility failed to ensure residents were provided with bathing consistent with their needs. This was true for 1 of 15 (#7) residents reviewed for bathing. This failure created the potential for residents to experience embarrassment, a decreased sense of self-worth, skin impairment and compromised physical and psychosocial well-being. Findings include:</p> <p>The facility's policy for bathing, dated 1/2015, documented the facility will provide quality resident grooming and hygiene to include bathing/showering of residents at a minimum of once weekly and/or resident preference. If a resident is unable or unwilling to shower as scheduled, the shower will be referred to the next shift until the shower is completed.</p> <p>Resident #7 was admitted to the facility on 5/3/18, with multiple diagnoses which included a stroke, impaired balance, and weakness.</p> <p>A quarterly MDS assessment, dated 4/16/19, documented Resident #7 was cognitively intact, did not reject care, and bathing activity did not occur.</p> <p>A quarterly MDS assessment, dated 1/22/19, documented Resident #7 was cognitively intact, did not reject care, and required the physical assistance of one person for bathing.</p> <p>A care plan, dated 5/12/18, documented Resident #7 required extensive assistance with bathing and liked her hair shampooed with showers twice weekly. If Resident #7 refused her shower, the care plan directed staff to</p>	F 677	<p>include:</p> <p>Resident #7 was offered and accepted a shower on 4/25/2019. Care plan has been updated to include interventions for refusals of showers and resident bathing preferences have also been updated.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>All residents of the facility have the potential to be affected by this practice.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>An in-service education program was conducted for the facility bath aides and licensed nursing staff on care plan updates, approach, interventions and documentation for refusal of showers. A facility wide audit of resident bathing records completed to identify any other possible instances of this deficient practice.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The interim Director of Nursing, or designee, will review shower/refusal documentation weekly for four (4) weeks and then every other week for two (2) months to identify missing showers and/or refusals to identify residents who may need additional interventions and/or care plan updates for their bathing preferences.</p>		

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F 677	<p>Continued From page 17</p> <p>reapproach her at a later time. If she refused the second offer, staff were to notify the licensed nurse.</p> <p>On 3/12/19 at 6:29 PM, a nursing note documented Resident #7's "HAIR VERY OILY, NEEDS BETTER HYGIENE."</p> <p>Resident #7's January 2019 ADL record documented she received a shower or bath on 1/1/19, 1/8/19, and 1/22/19. The record documented she refused bathing on 1/10/19 and 1/15/19.</p> <p>Resident #7's February 2019 ADL record documented she received a bath on 2/11/19. There were no documented refusals. Resident #7 did not receive a bath or shower for 19 days (1/23/19 through 2/10/19).</p> <p>Resident #7's March 2019 ADL record documented she received a shower or bath on 3/2/19, 3/14/19, and 3/26/19. There were no documented refusals. Resident #7 did not receive a bath or shower for 11 days (3/3/19 through 3/13/19) and another 11 days (3/15/19 through 3/25/19).</p> <p>Resident #7's April 2019 ADL record documented she received a shower or bath on 4/2/19. There were no documented refusals.</p> <p>Resident #7 received 8 out of 32 scheduled showers over 4 months.</p> <p>On 4/23/19 at 9:39 AM, Resident #7 was observed in her room, her hair appeared oily and uncombed. She took her hair in her hand and</p>	F 677	<p>Results will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2019
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 821 21ST AVENUE LEWISTON, ID 83501		
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F 677	Continued From page 18 said, "I would like to have more showers. Look at how dirty my hair is." Resident #7 stated the last shower she received was 3 weeks ago, on 4/2/19. Resident #7 stated the CNAs offer her showers at 10:00 AM and 3:00 PM but those are not the best times for her. She stated she had refused showers a few times when she did not feel good, but the CNAs did not offer the shower a second time. On 4/24/19 at 10:00 AM, Resident #7 was in her room, sitting on her bed. Her hair was oily. She stated she had not received a shower. On 4/24/19 at 1:49 PM, the DON stated Resident # 7 often refused her showers and the ADL record should have reflected those refusals. The DON was unable to provide documentation Resident #7 was offered a shower on the shift following her refusals. The DON agreed Resident #7 should have had more than 8 showers in 4 months. When the DON was informed Resident #7 said her showers were only offered to her at 10:00 AM or 3:00 PM, the DON stated that maybe she did not like those times. The DON said perhaps Resident #7 should be asked about when she would like to receive showers. On 4/25/19 at 1:05 PM, Resident #7's ADL record documented a shower was provided with staff assistance. Resident #7 did not receive a bath or shower for 22 days (4/2/19 through 4/24/19).	F 677			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		5/31/19	

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F 684	<p>Continued From page 19</p> <p>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure professional standards of care were followed for 2 of 2 residents (#38 and #57) reviewed for transfers and respiratory care. These failed practices placed residents at risk of falls and adverse effects from inhaled medications. Findings include:</p> <p>1. Resident #38 was admitted to the facility on 2/2/18, and readmitted on 2/27/19, with multiple diagnoses including congestive heart failure (progressive lung diseases characterized by increasing breathlessness) and diabetes.</p> <p>An admission MDS assessment, dated 3/16/19, documented Resident #38 required extensive assistance from 2 staff for transfers.</p> <p>On 4/24/19, at 2:05 PM, the facility's beautician was observed as she assisted Resident #38 from the stylist chair in the beauty shop to her wheelchair. The beautician pulled a wheelchair in front of Resident #38, leaving very little room between the front of the wheelchair and the resident's knees as she sat in the stylist chair. The beautician placed her right forearm under Resident 38's left armpit and her left hand on</p>	F 684	<p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>Contracted beautician was verbally reminded, re-trained regarding resident transfers and the facility procedures that no resident transfers by non-certified personnel was permitted in the facility. Licensed nursing staff were in-serviced on proper delivery of Symbicort inhalers including the requirement of having the resident's mouth being rinsed out following usage.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>All residents of the facility have the potential to be affected by this practice.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>An in-service education program was conducted for the contracted beautician in regard to certified personnel only assisting with resident transfers and this training has been added to the facility</p>		

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F 684	<p>Continued From page 20</p> <p>Resident #38's left forearm. The beautician began to lift and pull on Resident 38's arm to encourage her to a standing position. Resident #38 stood and grabbed onto the arm of the wheelchair and was able to pivot and sit in the wheelchair. She did not stand erect and required multiple attempts to reach a standing position. The beautician did not use a gait belt and did not use proper and safe transfer techniques while moving Resident #38's into her wheelchair.</p> <p>Resident #38's plan of care documented she required the assistance of 2 people for all transfers.</p> <p>On 4/24/19 at 2:10 PM, the beautician said she was balancing Resident #39 while she transferred to the wheelchair. She said she did not know how to determine if residents were to receive staff assistance for transfers while in the beauty shop. She then asked if she had done something wrong. The beautician said she had assisted other residents into and out of the stylist chair. The beautician stated she had not received training on the transfer of residents. CNA #1 entered the salon to assist with another resident and confirmed Resident #38 required staff assistance with transfers.</p> <p>On 4/24/19, at 2:40 PM, the DON said the facility did not have a method of training people like the beautician regarding transfers of residents, and the facility did not have a policy to address this.</p> <p>2. The facility's undated policy for Medication Administration and Medication Orders, directed staff to instruct the resident to gargle or rinse their mouth with water and spit after using a</p>	F 684	<p>orientation program for future non-certified contracted personnel. In-servicing education was provided for all licensed nursing staff in regard to inhaler usage and this training has been added to the annual skill's fair curriculum for continuing education of licensed nursing personnel.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur: The interim Director of Nursing, or designee, will audit five (5) inhaler med passes weekly for four (4) weeks and then every other week for two (2) months to ensure proper procedures are met. Administrator will audit two (2) contracted staff weekly for four (4) weeks and then every other week for two (2) months to ensure knowledge and adherence to not performing resident transfers from non-certified personnel.</p> <p>Results will be reviewed by the Quality Assurance Committee until such time consistent</p>		

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F 684	Continued From page 21 steroid metered dose inhaler and to caution the resident not to swallow the water. This policy was not followed: Resident #57 was admitted to the facility on 4/23/18, with multiple diagnoses including chronic obstructive pulmonary disease (progressive lung diseases characterized by increasing breathlessness). On 4/24/19 at 4:15 PM, RN #3 was observed as she gave Symbicort inhaler (combination of steroid and a bronchodilator) to Resident #57. Resident #57 took two puffs of Symbicort and gave it back to RN #3. Resident #57 was not observed rinsing his mouth after taking the puff of Symbicort. On 4/24/19 at 4:54 PM, RN #3 said she should have asked Resident #57 to rinse his mouth with water and spit it out after taking two puffs of Symbicort.	F 684			
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of	F 700		5/31/19	

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F 700	<p>Continued From page 22</p> <p>bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.</p> <p>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation, and staff interview, it was determined the facility failed to ensure bed rail consents were in place prior to the use of bed rails. This was true for 3 of 3 residents (#3, #36, and #55) reviewed for bed rail use. This failure created the potential for harm as it prevented the resident and/or resident representative's ability to make informed decisions related to the risk and benefits for bed rails. Findings include:</p> <p>1. Resident #55 was admitted to the facility on 3/28/19 with multiple diagnoses including chronic obstructive pulmonary disease (a progressive lung disease that restricts breathing) and vascular dementia.</p> <p>An Admission MDS assessment, dated 4/4/19, documented Resident #55 had moderately impaired cognition and required extensive assistance from 2 people for bed mobility and transfers.</p> <p>A bed rail assessment, dated 3/28/19, documented bilateral 1/2 bed rails were utilized to aid Resident #55 with bed mobility.</p>	F 700	<p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>Residents #3, #36 and #55 and/or their representatives were provided with a consent which informed them of the risks and/or benefits of bed rail use and these are included in the medical record.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>All residents of the facility have the potential to be affected by this practice.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>A facility wide sweep of all residents who are currently utilizing bed/transfer rails has been completed with every resident and/or family member receiving education on the risks and/or benefits of their use. In-service education provided by Administrator to Interdisciplinary Team on the procedure of providing education and</p>		

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F 700	<p>Continued From page 23</p> <p>Resident #55's medical record did not include a consent that informed him or his representative of the risks or benefits of bed rail use.</p> <p>On 4/22/19 at 2:00 PM and 4/23/19 at 11:53 AM, a 1/2 bed rail was observed in the up position on the upper right and left side of Resident #55's bed.</p> <p>On 4/25/19 at 3:20 PM, the DON stated the facility did not obtain a consent for the use of bed rails and the risks and benefits were not reviewed with Resident #55 or his representative prior to the use of the bed rails.</p> <p>2. Resident #3 was admitted to the facility on 9/6/12, with multiple diagnoses including dementia with behavioral disturbance, depression and obstructive uropathy (difficulty urinating).</p> <p>Resident #3's care plan documented he had a transfer bar (a form of bed rail attached to the bed to assist people with bed positioning and transfers) on the left side of his bed to aid him with bed mobility.</p> <p>Resident #3's bed rail assessment, dated 1/17/19, documented bed rails were indicated and served as an enabler to promote independence.</p> <p>Resident #3's medical record did not include a consent that informed him or his representative of the risks and benefits of bed rail use.</p> <p>On 4/24/19 at 9:26 AM and on 4/25/19 at 10:30</p>	F 700	<p>obtaining signed consent to the resident and/or representatives prior to initiation of transfer/bed rail usage and their inclusion in the care plan.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur: The interim Director of Nursing, or designee, will perform five (5) random medical record audits of residents who are utilizing transfer/bed rails for presence of signed consent forms weekly for four (4) weeks and then every month for two (2) months to ensure proper procedures are met.</p> <p>Results will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.</p>		

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

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F 700	<p>Continued From page 24</p> <p>AM, Resident #3 was in bed and transfer bar was present on the left side of his bed.</p> <p>On 4/25/19 at 2:10 PM, RN #4 said she explained to the residents and their families the risk and benefits of using bed rails. RN #4 said she told the residents and their families bed rails could cause bruising, skin tears, and possible death due to entrapment. RN #4 said she asked for the residents' and their families for verbal consent, but it was not documented.</p> <p>3. Resident #36 was admitted to the facility on 8/11/15, with multiple diagnoses including anxiety disorder, altered mental status, and paraplegia (paralysis of the lower half of the body with involvement of both legs).</p> <p>Resident #36's care plan documented he had bilateral 1/4 bed rails to aid him with bed mobility.</p> <p>Resident #36's bed rail, dated 3/12/19, documented bed rails were indicated and served as an enabler to promote independence.</p> <p>Resident #36's medical record did not include a consent that informed him or his representative of the risks and benefits of bed rail use.</p> <p>On 4/23/19 at 11:16 AM, 4/24/19 at 1:44 PM, and 4/25/19 at 9:58 AM, Resident #36 was observed in bed and bed rails were present to both sides of his bed.</p> <p>On 4/25/19 at 2:10 PM, RN #4 said she told the residents and their families bed rails could cause bruising, skin tears, and possible death due to entrapment. RN #4 said she asked for the</p>	F 700			

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F 700	Continued From page 25 residents' and their families for verbal consent, but it was not documented.	F 700			
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758		5/31/19	

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F 758	<p>Continued From page 26</p> <p>are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation, staff interview, and policy review, it was determined the facility failed to ensure specific target behaviors were identified and monitored for residents receiving psychotropic medications. This was true for 4 of 4 residents (#10, #36, #37, and #53) reviewed for psychotropic medications. This failed practice created the potential for harm should residents receive psychotropic medications that were unnecessary or ineffective. Findings include:</p> <p>The facility's policy for the use of psychotropic medications, dated 1/2015, did not address the monitoring of specific target behaviors.</p> <p>The facility's policy for the mood/behavior review, dated 11/2017, did not address the monitoring of specific target behaviors.</p> <p>The facility's Behavior Monitoring flowsheet provided CNAs with 13 standardized choices to select exhibited behaviors from, which included</p>	F 758	<p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>Residents found to be affected by this practice have been assessed and a new behavior specific flowsheets has been initiated for each of those residents assigned to the licensed nursing staff for completion.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>The facility has determined that all residents have the potential to be affected. A review of all medication orders and indications for use and appropriate behavior monitoring flow sheets have been assigned.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p>		

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F 758	<p>Continued From page 27</p> <p>pushing, biting, and abusive language. Resident behaviors were monitored each shift and if a behavior listed on the monitor was exhibited, the CNA checked that box. The flowsheet did not provide resident-specific behaviors related to depression or anxiety. The Behavior Monitoring flowsheet also offered CNAs the option to select from the following choices:</p> <ul style="list-style-type: none"> * None of the above observed * Resident not available * Resident refused * Not applicable <p>a. Resident #36 was admitted to the facility on 8/11/15, with multiple diagnoses including anxiety and depression.</p> <p>A quarterly MDS assessment, dated 3/5/19, documented Resident #36 was cognitively intact and he received anti-anxiety and anti-depressant medication daily.</p> <p>Resident #36's April 2019 physician's orders included the following:</p> <ul style="list-style-type: none"> *Buspirone HCL (anti-anxiety medication) 10 mg twice a day for anxiety disorder. *Buspirone HCl 5 mg once a day in the morning for anxiety disorder. *Paroxetine HCl (anti-depressant medication) 20 mg once a day in the morning for other recurrent depressive disorders. <p>Resident #36's care plan documented he had ineffective coping related to depressive disorder and anxiety, and he received anti-depressant and anti-anxiety medications. The care plan directed</p>	F 758	<p>A new monthly behavior flow sheet was developed by Social Services. All Licensed Nursing staff were in serviced regarding the facility monthly behavior flow sheet and the proper usage to accurately document targeted behaviors which will be resident specific.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>Social Services, or designee, will complete five (5) random weekly audits for four (4) consecutive weeks of the monthly behavior flow sheet, then monthly for three (3) months to ensure that resident specific behavior monitors are completed.</p> <p>Audit records will be reviewed by the /Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.</p>		

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F 758	<p>Continued From page 28</p> <p>staff to monitor/record per facility protocol the occurrence of target behaviors including violence/aggression towards staff/others, continual/repetitive yelling/calling out, repetitive voiced anxiety, and worries/fears.</p> <p>Resident #36's Behavior Monitoring flowsheet, dated 3/27/19 to 4/24/19, documented "repeats movement" one time, "yelling and screaming" 2 times, "none of the above" 65 times, and "not applicable" 21 times out of 89 opportunities.</p> <p>Resident #36's progress notes did not correlate with his Behavior Monitoring flowsheet dated 3/27/19 to 4/24/19. Examples include:</p> <ul style="list-style-type: none"> - A Nurse's Progress Note, dated 4/3/19 at 9:57 AM, documented Resident #36 had yelled for help and when staff asked him what he needed, Resident #36 said he did not need help. Resident #36 continued to yell for help and said he did not need help whenever the staff approached him. This was not documented in the Behavior Monitoring flowsheet. - A Recreation Assistant Progress Note, dated 4/11/19 at 3:59 PM, documented Resident #36 started calling for help when he arrived in the Activity room. Resident #36 left the Activity room, came back later and called for help again and left the Activity room. Resident #36 went back to the Activity room for the third time and stated, "I want to lie down, Help me." Nursing was notified, but Resident #36 went back again into the Activity room and was given ice-cream. Resident #36 said he did not know what he needed and he was escorted out of the Activity room. This was not documented in the Behavior Monitoring 	F 758			

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F 758	<p>Continued From page 29 flowsheet.</p> <p>On 4/22/19 at 4:15 PM, Resident #36 was heard yelling "Help me, help me, help me." When the surveyor entered Resident #36's room and asked what he needed, Resident #36 said he was afraid something might happen to him and he did not know what it was. Resident #36's yelling for help was not documented in the Behavior Monitoring flowsheet or in the Nurse's Progress Notes.</p> <p>b. Resident #10 was admitted to the facility on 8/29/16, with multiple diagnoses including anxiety disorder.</p> <p>A quarterly MDS assessment, dated 1/29/19, documented Resident #10 was cognitively intact, had no behaviors, and received antidepressant medication daily.</p> <p>A physician's order, dated 10/31/18, directed staff to provide sertraline (anti-depressant medication) 150 mg daily related to anxiety disorder.</p> <p>A care plan, dated 1/10/18, documented Resident #10 had depression and an anxiety disorder. The care plan interventions directed staff to monitor Resident #10 for and record feelings of sadness, loss of pleasure and interest in activities, feelings of worthlessness or guilt, change in appetite/eating habits, change in sleep patterns, diminished ability to concentrate, and change in psychomotor skills.</p> <p>Resident #10's Behavior Monitoring flowsheet, dated 3/27/19 through 4/24/19, documented choices of "none of the above observed" 73 times and "not applicable" 15 times out of 88</p>	F 758			

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F 758	<p>Continued From page 30 opportunities.</p> <p>c. Resident #37 was admitted to the facility on 8/14/17, with multiple diagnoses including depression and anxiety.</p> <p>A quarterly MDS assessment, dated 3/5/19, documented Resident #37 had severe cognitive impairment and exhibited wandering behavior 1-3 days out of the last 7 days.</p> <p>A physician's order, dated 2/27/19, directed staff to provide Resident #37 with divalproex (anti-seizure/mood stabilizer) 500 mg 3 times daily for dementia with Lewy Bodies (dementia accompanied by changes in behavior, cognition, and movement).</p> <p>A care plan, dated 1/9/19, documented Resident #37 had dementia with Lewy Bodies and interventions directed staff to monitor and record target behaviors of verbal/physical aggression, threats, and refusing cares and medications.</p> <p>Resident #37's Behavior Monitoring flowsheet, dated 3/27/19 through 4/25/19, documented wandering 1 time, "none of the above observed" 81 times and "not applicable" 5 times out of 87 opportunities.</p> <p>d. Resident #53 was admitted to the facility on 1/4/19, with multiple diagnoses including anxiety disorder, depression, and Post-Traumatic Stress Disorder (PTSD) (a mental disorder that can develop after a person is exposed to a traumatic event).</p> <p>A quarterly MDS assessment, dated 3/26/19,</p>	F 758			

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F 758	<p>Continued From page 31</p> <p>documented Resident #53 was cognitively intact, had verbal behavioral symptoms (threatening, screaming at, cursing at others) directed at others 1-3 days out of the last 7 days, and received an antidepressant daily.</p> <p>A physician's order, dated 3/15/19, directed staff to provide Resident #53 with mirtazapine (anti-depressant medication) 7.5 mg at bedtime daily related to depression.</p> <p>A care plan, dated 3/6/19, documented Resident #53 had depression, anxiety, and PTSD. The care plan interventions did not include specific behaviors for staff to monitor.</p> <p>A quarterly Mood/Behavior Medication Review, dated 3/13/19, documented Resident #53 was monitored for hopelessness, insomnia, verbalizing negative statements, tearfulness, and flashbacks.</p> <p>Resident #53's Behavior Monitoring flowsheet, dated 3/27/19 through 4/24/19, documented "none of the above observed" 69 times and "not applicable" 19 times out of 87 opportunities.</p> <p>On 4/24/19 at 10:46 AM, LPN #1 stated he monitored residents' behaviors daily, however, he did not chart them every day. LPN #1 stated residents who started a new psychotropic medication were placed on alert charting for 30 days and those residents were monitored and documented on daily. LPN #1 said after the 30-day alert charting was completed, residents were monitored daily but only documented on if they exhibited a behavior.</p>	F 758			

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F 758	Continued From page 32 On 4/24/19 at 2:48 PM, LSW #1 stated CNAs documented resident behaviors on the Behavior Monitoring flowsheet and nurses documented resident behaviors in their nursing notes. LSW #1 stated the Behavior Monitoring flowsheet was not specific for each resident and there were no specific target behaviors monitored for individual residents. On 4/25/19 at 9:52 AM, LPN #2 stated if a resident exhibited a behavior, she documented it in the resident's progress notes and informed the Social Worker and the physician. She stated she did not chart if there were no behaviors exhibited. On 4/25/19 at 1:59 PM, CNA #2 stated she documented a resident's behavior in their medical record. CNA #2 said if the exhibited behavior was not an offered choice, she wrote a note about the behavior. The facility failed to ensure resident specific behaviors were identified, documented, and monitored.	F 758			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		5/31/19	

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F 761	<p>Continued From page 33</p> <p>Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure expired medications were removed from the medication cart and not available for administration to residents. This was true for 1 of 2 medication carts. This failed practice created the potential for adverse effects if residents received expired medications with decreased efficacy. Findings include:</p> <p>On 4/25/19 at 11:05 AM, during the inspection of the West Medication Cart with LPN #2, a medication card containing 14 tablets of Oxycodone 5 mg had two stickers, one on the front and one on the back with different expiration dates. The sticker on the front of the medication card read "use by 8/7/18" and the sticker on the back of the medication card read "2/19." LPN #2 said 8/7/18, the date on the front, was the date the medication order was placed. LPN #2 then called the RCM and the RCM said she was told by the pharmacist the date on the back, 2/19,</p>	F 761	<p>Immediate action(s) taken for the resident(s) found to have been affected include: On 4/25/2019 all expired medications were destroyed.</p> <p>Identification of other residents having the potential to be affected was accomplished by: All residents of the facility have the potential to be affected by this practice.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include: A facility wide sweep of all medication carts, pixis and pharmacy were conducted to ensure that there were no expired medications. In-service education given to all licensed personnel by pharmacist regarding expired medications and facility procedures to</p>		

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F 761	Continued From page 34 was the expiration date. On 4/25/19 at 11:27 AM, the pharmacist said the 14 tablets of Oxycodone 5 mg were expired and were going to be destroyed.	F 761	eliminate them were provided. How the corrective action(s) will be monitored to ensure the practice will not recur: The interim Director of Nursing, or designee, will perform two (2) random medication cart audits for expired medications weekly for four (4) weeks and then every other week for two (2) months to ensure proper procedures are met. Results will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable	F 880		5/31/19	

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F 880	<p>Continued From page 35</p> <p>diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the</p>	F 880			

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F 880	<p>Continued From page 36</p> <p>corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure infection control measures were consistently implemented and followed. This was true for 2 of 15 residents (#34 and #36) observed for infection prevention practices. This failure created the potential for harm by potentially exposing residents to the risk of infection and cross contamination. Findings include:</p> <p>1. The facility's policy for Handwashing, revised 1/2015, directed staff to wash their hands before and after resident contact, before and after performing any procedure, after sneezing or blowing their nose, after using the toilet, before handling food, and when hands become obviously soiled.</p> <p>The facility's policy for Using Gloves, dated 1/2015, directed staff to wash their hands after removing gloves.</p> <p>These policies were not followed.</p> <p>Resident #36 was admitted to the facility on 8/11/15, with multiple diagnoses including</p>	F 880	<p>Immediate action(s) taken for the resident(s) found to have been affected include: The licensed Practical Nurse (LPN #1) was immediately in-serviced on proper hand hygiene procedures. The Registered Nurse (RN#3) was in-serviced on proper washing and drying of the nebulizer cup and nebulizer mouthpiece after each use.</p> <p>Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include: All personnel will be in-serviced on the facility's policy for hand hygiene. In-service training includes random observation of personnel performing hand</p>		

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F 880	<p>Continued From page 37 peripheral vascular disease.</p> <p>On 4/24/19 at 1:47 PM, LPN #1 was observed while performing wound care to wounds on Resident #36's feet. LPN #1 performed hand hygiene, applied clean gloves, and then used scissors to cut the old dressing from Resident #36's right foot. LPN #1 unwrapped the dressing from Resident #36's right foot and then cut the old dressing on Resident #36's left foot and unwrapped the dressing from his left foot.</p> <p>LPN #1 washed Resident #36's right foot with normal saline and applied Silvasorb gel (a medication used to aid wound healing) wearing the same gloves he used to remove Resident #36's old dressings. LPN #1 then removed his gloves and applied new gloves without performing hand hygiene. LPN #2 next applied Aquacel AG (a type of wound dressing) and wrapped Resident #36's right foot with Kerlix (a bandage roll). LPN #1 then washed Resident #36's left foot with normal saline and wrapped it with Kerlix wearing the same gloves.</p> <p>LPN #1 placed the scissors he used to cut the old wound dressings back into a pouch and put the pouch in his pocket without cleaning the dirty scissors. LPN #1 then put away the wound dressing material and placed them back inside a zip lock plastic wearing the same gloves.</p> <p>On 4/24/19 at 2:07 PM, LPN #1 said hand hygiene should be performed in between residents' care and before entering and leaving a resident's room. LPN #1 said he did not perform hand hygiene after removing his gloves when he performed wound care to Resident #36. LPN #1</p>	F 880	<p>hygiene procedures according to facility policy including licensed nursing staff performing treatments and procedures with all findings reviewed with personnel and corrective action and or education being provided as needed. All licensed nursing staff provided with in-service education on the proper washing/drying procedures for nebulizer cups and nebulizer mouthpieces following each use.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The interim Director of Nursing Services (DNS), or designee, will complete three (3) random audits of licensed nursing personnel and the timing and technique of hand hygiene procedure while performing treatments and procedures weekly for four (4) weeks and then monthly for two (2) months. DNS or designee will complete three (3) random audits of licensed nursing personnel regarding proper washing and drying of nebulizer cups and mouthpieces following each use for four (4) weeks and then monthly for two (2) months.</p> <p>This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.</p>		

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F 880	<p>Continued From page 38</p> <p>said he did not clean the scissors before or after using them.</p> <p>On 4/24/19 at 2:17 PM, RCM said hand hygiene should be performed before and after each resident contact and anytime gloves were removed.</p> <p>2. The facility's policy for Equipment/Supplies Cleaning/Disposal Schedule, revised 1/2015, directed staff to soak and rinse nebulizer tubing and the attachment with water, then set on a paper towel to air dry after each use.</p> <p>This policy was not followed.</p> <p>Resident #34 was admitted to the facility on 9/25/17, with multiple diagnoses including COPD.</p> <p>A physician's order, dated 9/26/18, included Duoneb (a medication used to treat airway narrowing), inhale orally 4 times a day related to chronic obstructive pulmonary disease (progressive lung diseases characterized by increasing breathlessness).</p> <p>On 4/24/19 at 4:08 PM, RN #3 entered Resident #34's room with a Duoneb vial in her hand. Resident #34's nebulizer cup was connected to the nebulizer mouthpiece and was on top of his bed. RN #3 took the nebulizer cup and poured the Duoneb into it and connected the cup to the nebulizer mouthpiece and gave it to Resident #34. RN #3 then turned on the nebulizer machine and left Resident #34's room.</p> <p>On 4/24/19 at 5:02 PM, RN #3 said Resident #34 preferred to turn off his machine once he was</p>	F 880			

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

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OMB NO. 0938-0391

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F 880	Continued From page 39 done with his nebulization treatment and leave the nebulizer cup and the nebulizer mouthpiece on top of his bed. RN #3 said Resident #34 had one more nebulization treatment before he went to sleep. RN #3 said the nebulizer cup and nebulizer mouthpiece were cleaned once a day by the night shift staff. On 4/25/19 at 5:00 PM, the RCM said the nebulizer cup and the nebulizer mouthpiece should be washed after each use and placed on top of a paper towel to air dry.	F 880			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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June 19, 2019

Mark High, Administrator
Idaho State Veterans Home - Lewiston
821 21st Avenue
Lewiston, ID 83501-6389

Provider #: 135133

Dear Mr. High:

On **April 22, 2019** through **April 26, 2019**, two surveyors conducted an unannounced federal recertification survey and on-site complaint investigation at Idaho State Veterans Home - Lewiston. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007911

ALLEGATION #1:

The facility failed to ensure residents received cares in a timely manner related to activities of daily living (ADLs).

FINDINGS #1:

Observations were made of resident care. Residents or their representatives were interviewed. Records were reviewed for ADL tasks and provision of care by facility staff. During an interview, the Ombudsman expressed no concerns related to the care of residents.

Call light audits were conducted with no excessive delays in response time. Dining observations were conducted, and resident cares were observed throughout the survey. Review of one resident's record did not include documentation the resident was being provided consistent showers/baths.

Based on the investigative findings, the allegation was substantiated. The facility was cited for a Federal deficiency at F677 due to failure to provide sufficient care related to ADLs.

Mark High, Administrator
June 19, 2019
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CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

Facility failed to ensure sufficient nursing staff to meet resident needs.

FINDINGS #2:

Review of the residents' clinical records included documentation the residents' pain levels were monitored consistently and medication administered on an as needed basis. Pain medications were later ordered to be given on a scheduled basis. Observations were made of resident care, and residents or their representatives were interviewed. Records were reviewed for adverse outcomes and the appropriate provision of resident care. The Ombudsman was interviewed and had no concerns.

Comfort Care measures were reviewed for a resident receiving Comfort Care during the survey with no complaints of unmanaged pain verbalized during an interview with the resident. There were no concerns voiced or documented in interviews and record reviews of 15 residents related to unmanaged pain.

Based on the investigation findings, the allegation could not be substantiated, and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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 any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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The facility failed to ensure residents received cares in a timely manner related to activities of daily living (ADLs).

FINDINGS #1:

Observations were made of resident care. Residents or their representatives were interviewed. Records were reviewed for ADL tasks and provision of care by facility staff. During an interview, the Ombudsman expressed no concerns related to the care of residents.

Call light audits were conducted with no excessive delays in response time. Dining observations were conducted, and resident cares were observed throughout the survey.

Review of one resident's record did not include documentation the resident was being provided consistent showers/baths.

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Based on the investigative findings, the allegation was substantiated. The facility was cited for a Federal deficiency at F677 due to failure to provide sufficient care related to ADLs.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

Facility failed to ensure sufficient nursing staff to meet resident needs.

FINDINGS #2:

Review of the residents' clinical records included documentation the residents' pain levels were monitored consistently and medication administered on an as needed basis. Pain medications were later ordered to be given on a scheduled basis. Observations were made of resident care, and residents or their representatives were interviewed. Records were reviewed for adverse outcomes and the appropriate provision of resident care. The Ombudsman was interviewed and had no concerns.

Comfort Care measures were reviewed for a resident receiving Comfort Care during the survey with no complaints of unmanaged pain verbalized during an interview with the resident. There were no concerns voiced or documented in interviews and record reviews of 15 residents related to unmanaged pain.

Based on the investigation findings, the allegation could not be substantiated, and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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 any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

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BD/lj