STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135132	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Idaho State Veterans Home - Pocatello	1957 Alvin Ricken Drive Pocatello, ID 83201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22411 Based on a facility reported investigation, policy review, and staff interview, the facility failed to ensure an allegation of sexual abuse was reported to the State Agency within two hours. This was true for 1 of 18 residents (Resident #149) reviewed for abuse. This failure resulted in Resident #149's allegation of sexual abuse not being acted on in a timely manner, investigated, and measures implemented to protect residents during the investigation, which placed all residents in the facility at risk of abuse. Findings include: The facility's policy, Abuse Prevention Notification and Reporting Guidelines, states the facility does not condone resident abuse or neglect by anyone. All personnel will promptly report any incident or suspected incident of resident abuse. The first person to suspect abuse, is responsible for notifying the Home Administrator by telephone per the facility's Policy. - Resident #149 was admitted to the facility on [DATE], with multiple diagnoses including post hospitalization care for fracture of her right tibia and fibula (shin bones) Type 2 Diabetes, major depressive disorder, and anxiety disorder. -Resident #22 was admitted to the facility on [DATE], with multiple diagnoses including chronic kidney disease and dementia. A facility investigation report, signed by the facility Administrator on 1/22/24, documented Resident #149 was interviewed by the SW. The SW stated Resident #22 walked in on Resident #149 while she was bathing. The following day Resident #22 approached Resident #149 at the nurse's cart in the hallway, rubbed her shoulder, and said inappropriate things to her. When Resident #19 was asked if she felt threatened, Resident #149 stated she felt very threatened and unsafe in the facility. Review of the facility's investigative documents documented that the SA was notified of the allegation of sexual abuse on 1/16/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/15/24 at 5:02 PM with the Administrator and DON, the Administrator stated that he received a call on 1/15/24 from Resident#149 who reported an incident between her and Resident #22. The Administrator stated Resident#149 stated Resident #22 came into the shower room while she was in the shower. Resident #149 yelled at Resident #22 to get out and he looked around the curtain at her. The Administrator said this happened on 1/14/24 and then on 1/15/24, Resident #22 cornered Resident #149 at the nursing station and said that he liked what he saw, and if she needed help next time, he would help her. The Administrator stated he advised staff they had 24 hours to report the incident, and he would handle it upon coming to the facility on [DATE]. The Administrator stated the allegation of sexual abuse was reported to the State Agency on 1/16/24. The Administrator stated he did not know about the two hour requirement for reporting abuse to the State Agency.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on record review, facility investigation report, and resident and staff interview, it was determined the facility failed to ensure physician orders were followed for pain medication administration and a respiratory treatment. This was true for 1 of 18 residents (Resident #18) reviewed for quality of care. These failures created the potential to adversely affect Resident #18 whose care and services were not delivered according to physician orders. Finding include: Resident #18 was admitted to the facility on [DATE] with multiple diagnosis including Chronic Obstructive Sleep Apnea (when a blockage in the airway keeps air from moving through the windpipe while asleep). A quarterly MDS assessment, dated 5/31/24, documented Resident #18 received oxygen therapy. A physician order, dated 6/29/24 documented Resident #18 was to receive a Norco Oral tablet (narcotic pain medication) 5-325 milligrams (mg), 1 tablet as needed. The order also documented Resident #18 was to receive continuous positive airway pressure (CPAP - a machine that uses mild air pressure to keep breathing airways open while sleeping) with two liters oxygen via mask at bedtime for Obstructive Sleep Apnea. Resident #18's MAR, dated 5/11/24, did not include documentation Resident #18 received the prescribed Norco pain medication on the evening shift. Resident 18's TAR, dated 5/11/24, did not include documentation Resident #18 received the ordered CPAP with two liters oxygen via mask at bedtime. A facility investigation report, dated 5/16/24, included a statement from RN #2 who documented she did not administer Resident #18's pain medication nor his CPAP treatment. RN #2 documented that she assumed another staff member addressed Resident #18's needs/requests. During an interview on 7/17/24 at 9:30 AM, Resident #18 stated there was a problem with RN #2, who was the evening nurse on 5/11/24, not giving him the pain medication and CPAP treatment that the physician ordered for him. Resident #18 stated he had a nightly routine starting at 8:00 PM in which he received pain medication and his CPAP. Resident #18 stated he made several requests for RN #2 to start his treatment. Resident #18 stated he received messages RN #2 was busy with another resident. He stated RN #2 never came to address his needs. Resident #18 stated he felt this nurse intentionally did not respond to his requests. During an interview on 7/19/24 at 10:06 PM, the DON stated on the evening of 5/11/24, RN #2 sent word to Resident #18 that she would be with him as soon as possible. The DON further stated RN #2 assumed another staff member addressed Resident #18's needs so she did not enter his room. The DON stated RN #2 admitted she did not administer Resident #18's pain medication, nor his CPAP treatment. The DON also stated that RN #3, the night nurse, administered Resident #18's pain medication but did not administer his CPAP treatment.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154 Based on observation, policy review, record review, and resident and staff interview, it was determined the facility failed to ensure alternatives to bed rails were attempted or were assessed for use of bed rails prior to placing bed rails on the residents' bed. This was true for 2 of 2 residents (#33 and #34) reviewed for bed rails. This failure created the potential for harm due to the risk of entrapment and injury. Findings include: The facility's policy titled, Proper Use of Bed Rails, dated 10/2023, stated it is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. The policy further stated the facility will attempt to use appropriate alternatives prior to installing or using bed rails. Alternatives that are attempted should be appropriate for the resident, safe and address the medical conditions, symptoms, or behavioral patterns for which a bed rail was considered. The following residents did not have complete assessments that included why alternatives to bed rails failed or why a resident had continued use of bed rails after an assessment documented the resident no longer needed bed rails. a. Resident #34's was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including cervical fractures, hypertension, insomnia, cardiac arrythmia, heart failure, and history of falling. Resident #34's care plan for assistive devices, initiated 2/11/22, documented the goal was to improve independence, promote comfort, assist with positioning, skin integrity, increase ADL [Activities of Daily Living] independence, improve mobility, safety decreased fall risk. Interventions included Resident #34 had transfer rails on both sides of the bed to help improve bed mobility and transfer stability. During an observation and interview on 7/16/24 at 2:49 PM, and on 7/18/24 at 3:48 PM, Resident #34 was observed in his room in bed with raised bilateral upper side rails and an air mattress. Resident #34 stated he used the side rails. A Side Rail assessment dated [DATE], documented alternative interventions attempted for Resident #34 included reminders to use the call light, regular toileting, and use of a urinal/bed pan. The summary of findings documented side rails were indicated for Resident #34 and served as an enabler to promote independence. The assessment documented based on the summary of findings 1/4 bed rails were recommended for Resident #34 on the left and right side of the bed. The assessment did not include how the alternatives attempted failed to work for Resident #34. b. Resident #33 was admitted to the facility on [DATE] with multiple diagnoses including heart disease, hypertension, obstructive sleep apnea, and vertigo. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #33's care plan for assistive devices documented he used assistive devices and the goal was to improve independence, promote comfort, assist with positioning, skin integrity, to increase ADL independence, improve mobility, and for safety/decreased fall risk (initiated 5/11/22). The care plan also documented Resident #33 had 1/4 rails bilaterally for bed mobility, ADL assistance, transfer stability, and had padded side rails for skin integrity and comfort (initiated 2/16/22). Side Rail Assessments, dated 2/1/22 through 4/27/23, stated Resident #33 should have bilateral upper quarter rails. Side Rail Assessments dated 7/27/23, 1/16/24, and 7/27/24 documented Resident #33 did not need bed rails. During an observation on 7/16/24 at 3:10 PM and on 7/19/24 at 12:17 PM, Resident #33 was in his room with raised bilateral upper side rails covered in a sheepskin-like material on his bed. During an interview on 7/19/24 at 4:58 PM, regarding attempted alternatives to side rails and how they failed, the Administrator stated an expectation was to try everything we can before placing side rails and if they are assessed to not need side rails that they do not have them.