STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135133	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Idaho State Veterans Home - Lewiston	821 21st Avenue Lewiston, ID 83501

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, record review, and policy review, the facility failed to ensure one out of 18 sampled residents (Resident (R)32) was treated with dignity. R32's catheter bag, attached to his leg, was observed with urine in it for several hours while the resident was in the common areas with multiple residents and staff, and while attending an activity. Staff failed to intervene to ensure the catheter bag was covered. This created the potential for R32 and other residents to feel undignified.Findings include: Review of the facility's policy titled Dignity dated December 2025 and provided by the facility revealed, Each resident of the [facility name] shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Demeaning practices and standards of care that compromise dignity is prohibited. Staff shall promote dignity and assist residents as needed by: a. Helping the resident to keep urinary catheter bags covered.Review of the undated admission Record in the electronic medical record (EMR) under the Profile tab revealed R32 had diagnoses including Parkinson's Disease, and dementia with agitation, anxiety disorder, and obstructive and reflux uropathy (blockage in the urinary tract and/or urine flows backward from the bladder into the ureters).Review of the quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 06/13/25 in the EMR under the MDS tab revealed the resident was moderately impaired in cognition with a Brief Interview for Mental Status (BIMS) score of nine out of 11 which indicated moderate cognitive impairment). R32 utilized an indwelling catheter. R32 required partial/moderate assistance for toileting hygiene, upper body dressing and required substantial/maximal assistance for lower body dressing. Review of the Order Summary Report dated 06/21/25 in the EMR under the Orders tab revealed R32's physician prescribed a Foley catheter. Review of the Care Plan dated 11/16/23 in the EMR under the Care Plan tab revealed R32 had a focus area of, I need limited to extensive assistance in most care areas r/t [related to] Parkinson's disease with impaired mobility, CHF [congestive heart failure] with activity intolerance, dementia. The goal was, I will be clean and well groomed, without odor and will continue to assist with my care as I am able through the review date. Interventions included in pertinent part, Dressing: extensive assist x [times] 1 [one staff] . Review of the Care Plan dated 05/16/25 in the EMR under the Care Plan tab revealed a focus area of, I . have a foley catheter r/t [related to] impaired mobility, Parkinson's disease, CKD [chronic kidney failure], DM II [diabetes mellitus type 2], CHF [Congestive Heart Failure], dementia, medication effects. The goal was, I will remain free from skin breakdown related to incontinence, foley catheter and brief use through the review date. Interventions in pertinent part included, Resident educated on the possibility of people visualizing the catheter when he is in shorts, he states he does not have an issue with this and will continue to wear shorts as preferred.Observation on 07/16/25 at 8:00 AM revealed R32 was propelling through the common area in front of the nursing station and past three residents to go down the East hall. R32 was wearing shorts and had a visible leg bag attached to his left lower leg which was about half full of urine. The catheter bag was clear. There was no dignity bag/cover in place.Observation on 07/16/25 at 9:52 AM revealed R32 was sitting in his wheelchair in the hallway at the entrance to his room. He continued to wear shorts with the catheter bag attached to his left shin with urine in the bag and fully visible to anyone in the hallway. There were residents and staff coming and going down the hall. Continuous observations were made from this time until 10:42 AM.Observation on 07/16/25 at 10:08 AM revealed R32 was sitting in the common area in his wheelchair facing the atrium directly across from the nurses' station, R32 continued to wear shorts with the leg bag attached to his shin with urine visible. There were several staff sitting at the nurses' station facing R32 and a few residents sitting in recliners in the area as well as staff and residents passing through. R32's catheter bag with urine was visible. Observation on 07/16/25 at 10:13 AM revealed the Recreation Assistant (RA) came over to where he was sitting in his wheelchair and asked him if he wanted to play a game, then left. The RA was not observed to make an inquiry regarding R32's catheter bag. R32's catheter bag with urine was visible. Observation on 07/16/25 at 10:19 AM revealed Certified Nursing Assistant (CNA)1 in the area facing the resident. Several residents wheeled by R32 and a couple were sitting in recliners in the area. R32's catheter bag with urine was visible. Observation on 07/16/25 at 10:22 AM revealed the RA returned to where R32 was sitting and wheeled him into the small sitting area adjacent to the nurses' station. Two more residents arrived at the table where R32 was sitting, and the RA initiated and coordinated a game of Yahtzee with the three residents. R32's catheter bag was visible to anyone in the room, looking in the window into the room or from the doorway. Observation on 07/16/2025 at 10:26 AM revealed all three residents continued to play Yahtzee with the RA. R32's

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. (continued on next page)

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, review of facility procedure and review of the Minimum Data Set (MDS) Resident Assessment Instrument (RAI) procedure, the facility failed to ensure the discharge and/or entry tracking records were complete as required for four (Resident (R)2, R21, R1, R22) of four residents reviewed for hospitalization. This failure had the potential to inaccurately identify a resident as receiving care in the facility after they had been admitted to the hospital, which could affect reimbursement and quality measures. Findings include: 1. Review of R21's admission Record, located in the electronic medical record (EMR) under the Profile tab revealed he was admitted to the facility on [DATE] with diagnoses including stroke, kidney transplant, and vascular dementia. Review of R21's Secure Conversations note dated 06/11/25 and located in the EMR under the Progress Notes tab revealed he was sent to the emergency room (ER). Review of R21's Nursing Note dated 06/13/25 located under the Progress Notes tab of the EMR revealed he was re-admitted to the facility following a hospital stay. Review of R21's MDS tab of the EMR revealed there was a quarterly MDS completed on 04/10/25 and an entry tracking record completed on 06/13/25. There was no evidence of a discharge tracking MDS completed upon his transfer to the hospital. During an interview on 07/17/25 at 10:37 AM, the MDS Coordinator (MDSC) stated her understanding was that a discharge tracking record only needed to be completed for a hospital stay greater than 72 hours. She stated R21 was at the hospital from [DATE] to 06/13/25, so a discharge MDS was not required. She stated she had started to complete the discharge tracking record for R21 as she was not very familiar with the requirements but was told by her preceptor it did not need to be completed. The MDSC was unable to explain why an entry tracking record was completed upon R21's return to the facility. 2. Review of R2's admission Record located under the Profile tab of the EMR, revealed he was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, dementia, diabetes, and bipolar disorder. Review of R2's Secure Conversations note dated 07/11/25 and located under the Progress Notes tab of the EMR, revealed he was sent to the ER. Review of R2's Nursing Note dated 07/14/25 revealed he was re-admitted to the facility following a hospital stay. Review of R2's MDS tab of the EMR revealed there was a quarterly MDS assessment on 05/16/25 and an entry tracking record completed on 07/14/25. There was no evidence of a discharge tracking assessment upon his transfer to the hospital. During an interview on 07/17/25 at 10:37 AM, the MDSC stated since R2 was at the hospital from [DATE] to 07/14/25, a discharge tracking record should have been completed. She stated it was overlooked. 3. Review of R1's admission Record located in the Profile tab of the EMR revealed he was admitted to the facility on [DATE]. Review of the EMR Progress Notes tab revealed a note dated 07/03/25 which documented R1 went out to the hospital. A Progress note dated 07/05/25 documented R1 returned to the facility following a stay at the hospital for aspiration pneumonia. Review of R1's MDS tab of the EMR revealed no entry tracking record nor discharge MDS assessment were completed. 4. Review of R22's admission Record located in the Profile tab of the EMR revealed he was admitted to the facility on [DATE]. Review of the EMR Progress Notes tab revealed a note dated 07/05/25 which stated R22 was transferred to the hospital. A Progress note dated 07/09/25 documented R22 was re-admitted from the hospital to the facility. Review of R22's MDS tab of the EMR revealed no discharge MDS assessment was completed. During an interview on 07/17/25 at 10:37 AM, the MDSC stated that she initiated and completed MDS entry tracking records and discharge assessments when a resident was out of the building for 72 hours or more. If a resident was not out for at least 72 hours, the assessments were not done because it was an interrupted stay and not a discharge. The MDSC was unsure of the timeframe for the completion of entry tracking records and discharge MDS assessments but reported she tried to complete them within 72 hours of the event. R1 was out less than 72 hours. R22 went to the hospital, and she had not initiated a discharge MDS until 07/17/25, eight days after he returned from the hospital. During an interview on 07/17/25 at 1:10 PM, the Director of Nursing (DON) reported the expectation of following the Resident Assessment Instrument (RAI) manual. Review of the facility's procedure MDS Resident Assessment Instrument revised January 2025 revealed, The entry tracking record will be completed by the MDS Coordinator and The MDS Coordinator(s) will provide a schedule as to which residents are due, the type of assessment to be done and when the assessments/RAI components re due to assure the facility is maintaining compliance with timeframes. Review of the RAI dated 10/01/24 and located at https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual revealed entry

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. (continued on next page)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of facility procedure and review of the Resident Assessment Instrument (RAI), the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the restraint status of five (Resident (R)20, R32, R3, R5, and R34) of five residents reviewed for restraint use out of a total sample of 18. These failures created a potential for an incomplete or ineffective plan of care related to bedrail/siderail and restraint use.Findings include: 1. Review of R20's undated admission Record located under the Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses including heart disease, collapsed vertebra, mood disorder, vascular dementia, depression, and anxiety. Review of R20's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/04/25 and located under the MDS tab of the EMR revealed he was dependent on staff for transfers in and out bed and required substantial to maximum assistance with bed mobility. He used bed rails as a restraint daily. Review of R20's Side Rail assessment dated [DATE] and located under the Assessment tab of the EMR revealed he used left and right turn rails for bed mobility and the rails did not restrict his movement or access to his body. During an interview on 07/16/25 at 12:53 PM, Registered Nurse (RN) 1 stated R20 was dependent for transfers out of bed and used a mechanical lift assisted by two staff members with transfers. RN1 stated the resident used his bed rails to assist with mobility and positioning in bed. RN1 stated the bed rails did not restrain the resident in any way. During an interview on 07/17/25 at 10:37 AM, the MDS Coordinator (MDSC) stated she marked side rails under the restraint section whenever side rails were in use, whether they were considered restraints or not. The MDSC stated it was only a yes or no question related to the use of bedrails, and she was not aware of the requirement to only code a bed rail used as a restraint under this section. The MDSC stated R20 did not use any restraints, and the bed rails were used for assistance with mobility. 2. Review of the undated admission Record in the EMR under the Profile tab revealed R32 had diagnoses including Parkinson's Disease, and dementia with agitation, and anxiety disorder. Review of the quarterly MDS with an ARD of 06/13/25 in the EMR under the MDS tab revealed a BIMS score of nine out of 11 which indicated the resident was moderately impaired in cognition. Under the Physical Restraints and Alarms section, physical restraints were defined as, any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. R32 was coded as using two bed rails as restraints. Review of the Order Summary Report dated 07/25/24 under the Orders tab revealed, Bilateral transfer rails on bed to enhance independence with bed mobility. Review of the quarterly Side Rail assessment dated [DATE] in the EMR under the Assessment tab revealed the bed rails did not restrict the resident's freedom of movement or access to his body. The bed rails (right upper and left upper turn rails) were indicated for support and to enable bed mobility. Recommend left and right upper bed rail. Review of the Care Plan dated 12/10/21 revealed a focus area of altered mobility and risk for falls. The goal was for R32 to have no serious injury related to falls. Interventions in pertinent part included, I utilize 1/4 side rail on the right side of my bed to enhance my independent with bed mobility. Assess me for safety with these devices quarterly and PRN [as needed]. During an interview together on 07/16/25 at 3:08 PM, the Infection Preventionist (IP) and RN3 stated R32 utilized one bar on his bed for turning, the provision of care, and for transferring in and out of bed. Both nurses stated the rail was not a restraint and that R32 could get in and out of bed with the rail in place. 3. Review of R3's undated admission Record located in the Profile tab of the EMR revealed she was re-admitted to the facility on [DATE] with diagnoses of stroke and low back pain. Review of a Bed Rails Informed Consent for Use dated 03/22/24 and located in the Misc tab of the EMR revealed R3 was recommended for use of upper bed rails on her bed. Review of R3's Care Plan tab revealed, I have impaired mobility and require use of upper bilateral side rails for bed mobility assistance revised on 03/22/24. Review of R3's Order Summary Report located in the Orders tab of the EMR revealed an order for bilateral bed rails on the bed to enhance independence with bed mobility. Review of a Side Rail Assessment located in the Assessments tab of the EMR and dated 06/12/25 revealed R3 used left and right upper bed rails for positioning/support and/or to enable bed mobility. The rails did not restrict the resident's freedom of movement or access to their body. Review of R3's quarterly MDS with an ARD of 06/13/25 located in the MDS tab of the EMR revealed a BIMS score of 15 out of 15, which indicated intact cognition. Further review revealed R3 was coded as using bed rails on a daily basis as a physical restraint, restricting