STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135148	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Idaho State Veterans Home - Post Falls	590 S Pleasant View Rd Post Falls, ID 83854

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on interview, record review and policy review, the facility failed to ensure the needs of 1 out of 23 sampled residents (Resident (R)16) were accommodated. R16's call light was not placed within R16's reach. This created the potential for R16's physical, emotional and safety needs to be compromised. Findings include: Review of the facility's policy titled, Resident Safety Policy, dated February 2023 and provided by the facility revealed, Call lights should be placed and attached in easy reach of resident at all times . Review of the undated Admission Record provided by the facility revealed R16 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke), hemiplegia (paralysis to one side of the body) and hemiparesis (weakness on one side of the body). Review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/22/24 in the electronic medical record (EMR) under the MDS tab showed R16's cognition was intact. Review of the Care Plan, dated 04/03/23 and provided by the facility, showed R16 was at risk for falls due to poor mobility, left sided hemiparesis from a stroke, and dementia. Interventions included: -Important: Be aware that I am unable to use left arm/leg due to stroke . -Encourage to utilize my call light to seek staff assist with all transfers and ambulation. Review of the Facility Reported Incident (FRI) investigation, dated 10/04/23 and provided by the facility, showed Registered Nurse (RN)2 received a text message on 09/27/23 at approximately 11:00 PM from Certified Nursing Assistant (CNA) 10 that CNA10 had forgotten to give R16 her call light back when CNA10 left the facility at the end of her shift. The investigation revealed, RN2 then reported to the resident's room to find the door closed. When she entered, she found R10 maladjusted in the bed at a sideways angle in an attempt to reach her nightstand. R16 made a verbal statement to RN2 she was attempting to reach her call light in her nightstand, but CNA10 had hidden it from her . at 2100 [11:00 PM]. (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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/12/24 at 3:02 PM, the surveyor attempted to interview R16 about the incident that occurred on 09/27/23; however, R16 stated she did not want to talk to the surveyor. During an interview on 08/13/24 at 3:53 PM, the Administrator and Director of Nursing Services (DNS) stated an investigation had been conducted into the incident in which R16's call light had been placed out of her reach. The Administrator and DNS stated neither of them had been employed by the facility at the time the investigation was conducted (both were hired after the investigation). The Administrator stated the investigation verified that R16's call light had been placed outside of R16's reach by CNA10. During an interview on 08/14/24 at 12:15 PM, RN2 stated she was the charge nurse on 09/27/23 when the call light incident occurred with R16. RN2 stated CNA10 had worked until around 10:00 PM and at around 10:30 PM, CNA10 had texted her to inform her that R16's call light had been placed in the dresser drawer and was not within R16's reach. RN2 stated she did not see the text message until midnight at which time she immediately went to R16's room. RN2 stated when she arrived R16 was lying in the bed cross ways, shouting Help, help, help. RN2 stated R16 told her CNA10 had hidden her call light. RN2 stated she found the call light in a dresser drawer outside of R16's reach. RN2 stated she called the previous DON and he came to the facility at 2:00 AM to conduct an investigation into the incident. RN2 stated call lights should always be placed within reach of residents. During an interview on 08/15/24 at 11:06 AM, the Social Worker (SW) stated it was the facility's policy for the call light to always be placed within reach of the resident. The SW stated it was a potential safety issue if the light was not placed within the resident's reach. During an interview on 08/15/24 at 12:00 PM, the Registered Nurse (RN) Manager stated R16 required staff assistance with activities of daily living (ADLS) such as with repositioning and with transfers. The RN Manager stated R16 required a Hoyer lift (mechanical lift) be used for transferring her. During an interview on 08/16/24 at 12:19 PM, the DNS stated she had not been employed when the call light incident for R16 occurred. The DNS stated staff should not remove the call light out of a resident's reach due to it being a residents' rights and safety issue.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15013 15406 39411 Based on record review, interview, and facility policy review, the facility failed to ensure that two (Residents (R)36 and R39) reviewed for abuse out of 23 sampled residents were free from resident to resident abuse. Findings include: 1.Review of R39's Profile tab of the EMR revealed he was admitted to the facility on [DATE] with diagnosis that included vascular dementia and cerebrovascular disease. Review of R39's quarterly MDS with an assessment reference date (ARD) of 06/12/24 located in the MDS tab of the EMR, revealed a BIMS score of 14 out of 15, indicating intact cognition. Review of R55's Profile tab of the EMR revealed he was admitted to the facility on [DATE] with a diagnosis that included Alzheimer's, dementia, and delirium. R55 was discharged to the hospital on 04/18/24 and did not return to the facility. Review of R55's MDS with an ARD of 04/18/24 and located in the MDS tab of the EMR, revealed a BIMS score of zero out of 15, indicating severely impaired cognition. Review of the facility investigation summary titled, Investigation into Allegations of Resident Abuse dated 03/08/24 provided by the Administrator, revealed a resident-to-resident allegation of physical abuse was reported on 03/04/24 involving R39 and R55. R39 reported that R55 had entered his room, accused R39 of stealing his truck and caused skin abrasions to his arm. During an interview on 08/13/24 at 8:44 AM R39 stated he didn't remember much about the incident between him and R55 other than R55 came into his room and tried to bother him. R39 stated that staff took care of everything, and nobody bothered him anymore. R39 stated that he was not hurt. During an interview on 08/13/24 at 10:00 AM Certified Nursing Assistant (CNA) 4 stated that he went in R39's room on 03/08/24 and R39 was laying on his back and holding R55 away from him, yelling to get R55 off him. CNA4 stated that he immediately calmed R55 down and escorted him out of the room. CNA4 stated the incident was immediately reported to the Administrator. CNA4 stated that R55 was known to wander, however was never aggressive before this incident. CNA4 stated that 15-minute checks were initiated on R55. There were no other incidents of resident to resident altercations from R55 until a month later (04/08/24). During an interview on 08/16/24 at 2:38 PM the Director of Nursing Services (DNS) confirmed the above incident with R55 and R39. She further stated that they have zero tolerance for abuse and they want all staff to protect the residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the undated Admission Record provided by the facility revealed R36 was admitted to the facility on [DATE] with diagnoses including aphasia (language disorder affecting the ability to communicate) cerebral infarction (stroke) with hemiplegia (paralysis to one side of the body) and hemiparesis (weakness on one side of the body). Review of the quarterly MDS with an ARD of 06/23/23 in the EMR under the MDS tab showed R36 was moderately impaired in cognition. Review of the Investigation into Allegation of Resident Abuse initiated on 04/18/24, provided by the facility showed a resident-to-resident incident of abuse occurred on 04/18/24 at approximately 11:30 AM between R55 (aggressor) and R36 (victim). R36 was in the hallway on 04/18/24 when R55 grabbed R36's left arm and pulled it down and would not let go. R36 vocalized pain. The incident was witnessed and was documented as being unprovoked on the part of R36. R55 was redirected to his room to calm down. A police report was filed and R55's family member was notified. R55 was then emergently discharged from the facility to the hospital and did not return. X-rays were taken of R36's arm and were negative for physical injury. During an interview on 08/12/24 at 2:05 PM, R36 was interviewed by asking yes/no questions to which he responded by shaking his head yes or no. R36 shook his head up and down showing yes as the answer to the question of whether he had negative interactions with other residents. During a subsequent interview on 08/15/24 at 11:46 AM, R36 shook his head yes when asked if his previous negative resident interaction involved R55 grabbing and pulling his arm on 04/18/24. R36 shook his head yes when asked if it caused pain at the time the incident occurred, however denied any lasting injury by shaking his head no. During an interview on 08/14/24 at 8:28 AM, CNA7 revealed on 04/18/24 around lunch time she witnessed R55 grab R36's arm in the hallway. R55 was removed from the area and staff called 911 (emergency services). During an interview on 08/14/24 at 11:19 AM, the DNS stated R55's family had not been forthcoming when she screened R55 for admission to the facility. The DNS stated the family denied any aggression or assaultive behavior then later she found out R55's family had been dealing with it for a couple of years. The DNS stated, He [R55] hurt [R36]. The DNS stated there was only one previous incident of physical aggression by R55 towards another resident (R39) that occurred a month prior. Review of the facility policy tilted Freedom from Resident Abuse, Neglect, Mistreatment and Exploitation revised 06/2021 revealed, Each resident has a right to be free from verbal, sexual, physical, and mental abuse; neglect; exploitation; mistreatment, including injuries of unknown source, misappropriation of resident property, involuntary seclusion, and crime against a resident. Further, each resident at the [Name of Facility] will be treated with dignity and respect.