| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135148 | A. Building<br>B. Wing | 08/01/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Idaho State Veterans Home - Post Falls | 590 S Pleasant View Rd<br>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 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>(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 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on observation, record review, and interview, the facility failed to honor one of one resident's (Resident (R) 43's) right to self-administer medications when clinically appropriate of 20 sample residents. Specifically, the facility did not conduct a comprehensive assessment of R43's ability to safely self-administer medications and failed to include all prescribed medications in the evaluation. When R43 did not take medications immediately upon staff offering, the medications were withheld, rather than allowing R43 to take them independently and without feeling rushed. This failure compromised R43's dignity and right to participate in decisions regarding their care. Findings include:Review of R43's admission Record (Face Sheet) located under the Profile tab in the electronic medical record (EMR) revealed the facility initially admitted R43 on 05/31/24. R43's pertinent diagnoses included depression and intervertebral disc degeneration.Review of R43's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/30/25 revealed R43 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident did not have any cognitive impairment. During the review period, R43 did not display any physical, verbal, or other behavioral symptoms directed toward others. R43 did not have any functional limitation in range of motion and was independent with eating, dressing their upper and lower body, and required substantial/maximal assistance with personal hygiene. R43's pertinent diagnoses included depression and schizophrenia. R43 did not receive any antidepressant or antipsychotic medication during the review period [per the resident's choice].Review of R43's care plan, last revised on 04/23/25 and located under the Care Plan tab of the EMR, revealed R43 was approved to self-administer specific medications. The interventions directed staff to continue to reassess R43's ability and safety with their approved self-administration medication each quarter and as needed, and to provide R43 with their Zinc cream to self-administer as approved. The care plan did not identify any other medications for self-administration. During an observation on 07/30/25 at 10:46 AM, Registered Nurse (RN) 10 administered medications to R43 as ordered. During the observation, R43 made multiple comments voicing his frustration with staff having to watch him take his medication. R43 stated that some nurses left his medication at the bedside for him to take at his leisure, while others would not. If he did not take the medication on the nurse's schedule, the nurse would take the medication and leave the room.Review of the facility's Investigation into Abuse Allegation, dated 07/01/25, revealed R43 told the Director of Nursing (DON) that on 06/26/25, RN8 came into his room at 12:07 PM with his medications, which he took without difficulty. She set his psyllium fiber on his table. When he was done with his pills, she wanted him to take the psyllium fiber right then. R43 stated, Doesn't she know that you can't take psyllium fiber with your routine medication? Why can't she just put it in the bathroom near the sink, and I will take it later? R43 stated that he has been taking psyllium fiber for well over 30 years, and that he is perfectly capable and responsible to take it at the right time. He stated that RN8 refused to leave the psyllium fiber in his bathroom, grabbed the cup, and started to leave. R43 stated, I feel like she has the power, and she has to have other people come in here with her because I'm just a big bad ogre. Reading from a notebook, a second entry he read was on 06/20/24 at 16:30; this time it was RN8 and Certified Nursing Assistant (CNA) 1, she did the knock and walk and again did not wait and come in my room, stating that he again was on his phone with a friend and when he asked her [RN8] to come back later, she huffed out of my room with the medications. Although the facility did not verify the allegation of abuse, the facility determined that RN8 occasionally administered R43's medications late and in instances in which RN8 falls behind on scheduled medication passes later in the afternoon. To support resident-centered care and honor the resident's rights, staff indicated that they updated R43's care plan to reflect the administration of Torsemide and Gabapentin at 10:30 AM per the residents request and that if he is participating in an outline or activity, he will communicate with the licensed nurse to inform them that they can be dispensed upon his report, updated R43's care plan, and educated staff. Still, the facility did not address the resident's wish to self-administer his psyllium fiber.Review of R43's Self-Administration of Medications Assessment, dated 09/01/24, located under the Assessments tab in the EMR, revealed an incomplete assessment. Staff completed Section AA for nebulizer treatments and answered some questions in Section A, confirming that R43 could hold the nebulizer and notify staff of any issues. However, they left key questions blank, including those related to monitoring needs, comments, and care plan updates. Staff also failed to complete Sections B and C, which address other medications and the final decision regarding self-administration. In subsequent assessments dated 10/21/24, 10/25/24, 11/30/24, 02/27/25, and 06/01/25, staff evaluated R43 for |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, facility investigation, and policy review, the facility failed to ensure one of four residents (Resident (R) 4) was free from neglect when staff failed to provide timely and competent care in response to complaints of pain and decreased urinary output of 20 sample residents. As a result, R4, who had a neurogenic bladder and an indwelling catheter, experienced severe pain, and improper placement of an indwelling catheter. Findings include:Review of the facility's policy titled, Freedom From Resident Abuse, Neglect, Mistreatment & Exploitation, dated 06/24 documented, Each resident at the [Facility Name], Idaho State Veterans Homes (ISVHs) has the 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.NEGLECT means failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect may be the result of a [NAME] of failures or may be the result of one or more failures involving a covered individual and a resident(s).Review of R4's significant change in condition Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/15/25, located under the MDS tab in the electronic medical record (EMR), revealed the facility admitted R4 on 05/03/24. R4 had a Brief Interview for Mental Status (BIMS) score of nine out of 15 which indicated R4 was moderately cognitively impaired. R4 required total dependence on toileting and personal hygiene and had an indwelling catheter. R4's pertinent diagnosis included neurogenic bladder.Review of R4's care plan, last revised on 04/15/25, located under the Care Plan tab in the EMR, revealed R4 had an indwelling catheter related to a diagnosis of neurogenic bladder. The care plan interventions indicated R4 had a 16 French catheter with a 10-millimeter (ml) [balloon] and directed staff to change and care for the indwelling catheter per the physician's orders. The care plan also directed staff to assess R4 for signs and symptoms of urinary tract infections, such as changes in urine color, consistency, and odor; behavioral changes, altered vital signs, pain/flank pain, burning, chills, and altered mental status.Review of the Medication Administration Audit Report, dated 10/25/24, provided by the facility, revealed the following pertinent orders:-Lidocaine (local anesthetics) external patch 4 %. Apply to [R4's] back topically one time a day for pain and remove per schedule.-Acetaminophen (pain reliever/fever reducer) oral tablet. Give 1000 milligrams (mg) by mouth three times a day for pain.-Buprenorphine HCl (opioid medication) sublingual tablet 2mg. Give one tablet sublingually three times a day for pain every eight hours.-Methocarbamol (muscle relaxant) oral tablet 1000mg. Give 1000 mg by mouth three times a day for muscle spasms for two Days (10/23/24 - 10/24/24). -Methocarbamol (muscle relaxant) oral tablet 750mg. Give 750 mg by mouth three times a day for muscle spasms (start 12/25/24).-Indwelling Foley catheter [size of the catheter and balloon was not noted]. -Monitor catheter anchor point and tubing to ensure no kinking, blockage, or pain at the insertion site.-Indwelling Foley catheter, change every three months on the first of the month, and PRN (as needed) for malfunction.Review of the provider's Skilled Nursing Follow Up Note, dated 10/22/24 at 8:15 AM, located under the Miscellaneous tab in the EMR, revealed R4 seen for routine follow-up on chronic conditions. R4 reports worsening pain to mid/low back, ongoing for the last 1-2 weeks. Pain seems to grab him. No radiculopathy or other pain in the legs today. He is lying down in bed this morning due to the pain. No recent falls or other injury.Exam: Elderly. Well nourished. Lying down in bed. Abdomen: positive bowel sounds. Soft, hernia is noted. Protuberant. GU: catheter in place, straw-colored urine. Assessment and Plan: Chronic pain syndrome, low back pain, peripheral neuropathy. On gabapentin, Robaxin, Buprenorphine, Tylenol, and a lidocaine patch. Son does not want the pt [patient] to take further opioid medications, given prior history. Today, pain seems to stem from low back grabs/muscle spasms. Will increase Robaxin to 1g three times a day for two days, then reduce to 750mg three times a day routine. Also, referring to pain management, will also ask about heat packs by physical therapy. Continue to monitor.Review of R4's Alert Charting Progress Note, dated 10/22/24 at 9:58 PM, located under the Progress Notes tab in the EMR, revealed Licensed Practical Nurse (LPN) 5 noted Methocarbamol l000mg three times a day for two days for back pain. Action taken: Will monitor.Review of R4's Alert Charting Progress Note, dated 10/23/24 at 3:50 PM, located under the Progress Notes tab in the EMR, revealed Registered Nurse (RN) 9 noted an increase in Robaxin (Methocarbamol). Resident complains of severe pain to [his] lower back this morning, requested to get back in bed, did receive new dose of Robaxin, has not alleviated pain as of this time. Action Taken: Continue to |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure one of one resident reviewed for restraints (Resident (R) 2) was free of restraints of 20 sample residents. The therapy department failed to assess R2's wheelchair with seat belts in accordance with a physician's order, the facility failed to attempt less restrictive measures prior to restraint use, failed to assess and identify the belts as restraints, and failed to implement a plan to release the restraint having the potential for the resident to be at risk for negative outcomes (skin deterioration, discomfort, decreased quality of life etc.).Findings include:Review of the facility's policy titled, Physical Restraint Use/Evaluation, dated 02/25 revealed the purpose was, To ensure this facility utilizes physical restraints only when alternative interventions to protect the resident's safety have been exhausted, or when the resident has been determined to have the presence of a specific medical symptom that requires the use of a restraint to protect the resident's safety . The use of physical restraints will be evaluated on a continual basis . in conjunction with the residents' MDS [Minimum Data Set] schedule. Physical restraint is 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. physician's order for the restraint. Obtain physician order to include Type of restraint. Reasons for restraint . Times restraint is to be applied/ released. Establish care plan for use of the restraint. Restraint elimination. Each quarter . the RN [Registered Nurse] Manager shall complete the physical Restraint Elimination Assessment and resident will be evaluated by the Physical Restraint /Reduction Review Committee for a physical restraint reduction program implementation.Review of the undated admission Record in the electronic medical record (EMR) under the Profile tab revealed R2 was admitted to the facility on [DATE]. Diagnoses included history of cerebral infarction (ischemic stroke when blood flow to the brain is disrupted), paraplegia (paralysis of the legs and lower body), dementia, above the knee amputation, and Parkinson's disease. Review of the quarterly MDS with an Assessment Reference Date (ARD) of 06/08/25 in the EMR under the MDS tab revealed R2 was severely impaired in cognition with a Brief Interview for Mental Status (BIMS) score of four out of 15 which indicated R2 was severely cognitively impaired. R2 was impaired in range of motion (ROM) on one side to his lower extremities. R2 was dependent on staff for shower/baths and required substantial assistance with personal hygiene, upper body dressing, toileting hygiene, and lower body dressing. R2 required set up assistance with eating and oral hygiene. R2 had not received physical or occupational therapy and had not been on a restorative nursing program during the assessment period. R2 was not identified as using any restraints. A request for an assessment of R2's wheelchair with the seat belt and chest belt was made on 07/30/25. A Consultation Request, dated 02/26/24, was provided by the facility to the surveyor. The document read, Evaluate for seat belt use in wheelchair to aid in positioning. Under Findings and Recommended Treatment, Physical Therapy Aid (PTA) 1 documented, Referred to VA [Veteran's Administration]. The assessment was not provided.Review of the Order Summary Report current on 07/27/25 and provided by the facility revealed there was a Physician's Order, dated 08/06/24, that read, Okay to wear double seat belt while in wheelchair for safety and chair positioning. The orders did not address when the belt was to be released.Review of the Care Plan, dated 09/30/23 in the EMR under the Care Plan tab, revealed a focus area of, Mobility/Fall Risk: I am at risk for falls. I am paraplegic. I have a left AKA [above the knee amputation] amputation. I am taking high risk medication that may increase my fall risk. Fall History, Weakness, Unsafe Behaviors, Poor Safety Awareness, Impulsive Decision Maker. Balance impaired due to CVA [cerebrovascular accident] and Parkinson's. The goal was for R2 to, have no serious injury related to falls through the next review period. Interventions in pertinent part included, Resident has double seat belts while in wheelchair that I can release on command. Initiated on 07/26/24. The Care Plan did not identify physical restraint use.Observations revealed R2 had a seat belt and a chest strap in place when he was up in his wheelchair:-On 07/28/25 at 11:53 AM, R2 was observed with both belts in place sitting in his wheelchair near the nurse's station in front of the large screen TV. He was leaning slightly to the left and the chest belt was tight across his chest.-On 07/28/25 at 2:53 PM, R2 was observed sitting in his wheelchair with the waist and chest belts in place with the chest belt tight across his chest. He was sitting near the nurse's station in front of the large screen TV. -On 07/29/25 at 8:38 AM, R2 was sitting in his wheelchair with the seat belt and chest belt in place in the TV area -On 07/30/25 at 12:27 PM, R2 was eating lunch in the dining room in his wheelchair with both the seat |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and procedure review, the facility failed to provide assistance with baths and shaving for one of one sample residents (Resident (R) 2) requiring substantial assistance from staff, reviewed for activities of daily living (ADLs) of 20 sample residents. This created the potential for discomfort and/or feeling unkempt. Findings include: Review of the facility's undated procedure titled, Nursing Procedure Manual Bathing Procedure, revealed This facility will provide quality resident grooming and hygiene to include bathing/showering of residents at a minimum of once weekly and/or resident preference . Bathing/showering of a resident will be recorded on the specific resident in POC [Point of Care]. If a resident refuses a bath/shower, then the CNA [Certified Nursing Assistant] will document the ADL's [activities of daily living] bathing task in POC as resident refused. The CNA is responsible for the grooming and hygiene of the resident during the bathing/showering process including shampooing hair, shaving facial hair, etc . Review of the facility's undated guideline titled, Nursing Procedure Manual Resident Care Guidelines, revealed In the event a resident either refuses or resists any of the cares offered, then the aide assigned the resident shall indicate this refusal. The information as to the specific refused or resisted is to be documented in POC in the Behavioral Symptoms 3.0 Resists/Rejects Evaluation of Care.Reapproach the resident after a short time to attempt to provide care. If possible, have another staff attempt to engage the resident in participation. Up to three (3) attempts should be made. The resident's refusal or resistance to care(s) shall be communicated per above and to the licensed nurse assigned the resident at the time of the occurrence. The licensed nurse shall assess situation and determine appropriate course for further interventions. Review of the undated admission Record in the electronic medical record (EMR) under the Profile tab revealed R2 was admitted to the facility on [DATE]. Diagnoses included history of cerebral infarction (ischemic stroke when blood flow to the brain is disrupted), paraplegia (paralysis of the legs and lower body), dementia, above the knee amputation, and Parkinson's disease. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/08/25 in the EMR under the MDS tab revealed R2 had a Brief Interview for Mental Status (BIMS) score of four out of 15 which indicated R2 was severely cognitively impaired. R2 was impaired in range of motion (ROM) on one side to his lower extremities. R2 was dependent on staff for shower/baths and required substantial assistance with personal hygiene. Review of R2's Care Plan, dated 09/30/23 in the EMR under the Care Plan tab, identified a focus area of Self-care deficit: I require assistance in order to complete my ADLs . The goal was, I will have a neat, clean, tidy appearance, and be dressed appropriately through review period. Interventions included in pertinent part, Personal hygiene: I need max [maximum] assistance of 1 staff, set up items and allow me to do as much as possible for myself.Shower/bathing: I need maximum assistance of 1 - 2 staff for bathing 1 - 2 X [times] a week and as needed. It is difficult to obtain my cooperation with bathing. Re-approach with different staff member as needed and vary the timing. A request for bath/shower records for R2 was made and the Point of Care Documentation Survey Report for the month of June 2025 was provided by the facility, which revealed R2 received baths/showers on 06/07/25, 06/14/25, 06/17/25, 06/25/25, and on 06/28/25. Review of the CNA POC Documentation Survey Report for the month of July 2025 and provided by the facility, revealed R2 received baths/showers on 07/09/25 (there was a 11day gap from his prior shower), 07/16/25, and on 07/23/25. Review of the CNA POC Response History report for the task of Monitor for refusal of agitation, and/or confusion during cares. Resident may show anxiety in times of confusion through agitation for the month of July 2025 under the POC tab revealed one instance on 07/24/25. Review of the Behavior Progress Notes from 06/01/25 - 08/01/25 in the EMR under the Progress Notes tab, revealed no instances of refusals of baths/showers or shaving. Observations during the survey (on 07/28/25 at 10:54 AM, at 11:53 AM, and at 2:53 PM; on 07/29/25 at 8:38 AM, and at 3:53 PM; on 07/30/25 at 12:27 PM and at 1:39 PM) revealed R2 was observed with long stubble/facial hair 1/4 to 1/2 inch long. During an interview on 07/28/25 at 12:34 PM, Family Member (F) 1 stated R2 should have been shaved twice a week when he was given showers. F1 stated R2's facial hair was long, and he needed to be shaved. F1 stated she had brought in an electric shaver and R2 used to be able to shave but now needed staff assistance. During an interview on 07/30/25 at 1:15 PM, Registered Nurse (RN) 3 stated R2 should have been showered twice a week on Wednesdays and Saturdays. During an interview on 07/30/25 at 1:13 PM, CNA7 stated R2 was dependent on staff to shave him. CNA7 stated R2 should have been shaved on shower days and stated he was given a |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>(continued on next page) |

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|---|---|
| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a restorative nursing program recommended by physical therapy was implemented for one of two residents (Resident (R) 2) reviewed for range of motion of 20 sample residents. This created the potential that R2 would experience a decline in his abilities to perform activities of daily living (ADLs). Findings include: Review of R2's undated admission Record in the electronic medical record (EMR) under the Profile tab revealed R2 was admitted to the facility on [DATE]. Diagnoses included history of cerebral infarction (ischemic stroke when blood flow to the brain is disrupted), paraplegia (paralysis of the legs and lower body), dementia, above the knee amputation, and Parkinson's disease. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/08/25 in the EMR under the MDS tab revealed R2 had a Brief Interview for Mental Status (BIMS) score of four out of 15 which indicated R2 was severely cognitively impaired. R2 was impaired in range of motion (ROM) on one side to his lower extremities. R2 was dependent on staff for shower/baths and required substantial assistance with personal hygiene, upper body dressing, toileting hygiene, and lower body dressing. R2 required set up assistance with eating and oral hygiene. R2 had not received physical or occupational therapy and had not been on a restorative nursing program during the assessment period. Review of the PT [Physical Therapy] Evaluation & Plan of Treatment, dated 04/15/25 and provided by the facility, revealed R2 would not be picked up by therapy following readmission from the hospital; however, the plan of treatment indicated R2 was to continue with restorative program. The document read, On evaluation it was found he was at his prior level of function and would not be followed by PT, but a RA [Restorative Aid] program would be generated to prevent physical decline. Review of the Care Plan, dated 04/04/25 in the EMR under the Care Plan tab, revealed a focus area of Self-care deficit: I require assistance in order to complete my ADLs, altered mobility, dementia, paraplegia, pain. The goal was to have a neat, clean, tidy appearance and be dressed appropriately. Interventions documented how much assistance R2 required with specific ADLs. The Care Plan did not include the provision of a restorative nursing program to prevent a physical decline. Observation during the survey revealed R2 was able to slowly feed himself lunch on 07/28/25 at 11:53 AM. R2 was leaning slightly to the left in his wheelchair. R2's food was cut into bite sized pieces. R2 was also observed feeding himself breakfast on 07/29/25 at 8:38 AM using built up silverware. He had eaten less than 25% of pancakes cut into bite sized pieces and sausage links cut into pieces. R2 was not observed to complete any other ADLs during the survey except for eating. During an interview on 07/28/25 at 12:31 PM, Family Member (F) 1 stated R2 was not receiving restorative nursing services. F1 stated R2 was paralyzed from the waist down and she thought he would benefit from a restorative program. F1 stated R2 used to shave himself and now he did not. During an interview on 07/30/25 at 1:13 PM Certified Nursing Assistant (CNA) 7 stated R2 was dependent for most ADLs. She stated the staff combed his hair and shaved him but R2 was still able to feed himself. CNA7 stated R2 could still wheel himself in his wheelchair but no longer got himself coffee. CNA7 stated there were two RAs who implemented restorative programs; the CNAs did not do ROM exercises, etc. with residents. During an interview on 07/30/25 at 1:48 PM, Certified Occupational Therapy Aid (COTA) 1 stated the last time R2 was evaluated for PT or Occupational Therapy (OT) was on 04/15/25 after he returned from the hospital. COTA1 stated R2 was not picked up by either PT or OT at that time as he was at his prior level of functioning. COTA1 stated restorative programs were intended to prevent a resident from experiencing a decline. He stated a therapist would generate a restorative program that would be implemented by nursing. During an interview on 07/30/25 at 2:47 PM, Registered Nurse (RN) 3 stated she oversaw the restorative nursing program and would check to see if R2 was on a restorative program. During a joint interview on 07/30/25 at 3:00 PM, RA1 and RA2 stated R2 was not on a restorative program and had not been on one for over a year. RA1 and RA2 stated the PT or OT developed the restorative programs, the Restorative Nurse put the program into the computer system and told them what the program entailed, and they implemented the restorative programs. During an interview on 07/31/25 at 11:47 AM, RN3 stated Physical Therapy Aid (PTA) 1 (Director of Therapy) had missed the PT referral for R2's restorative program. RN3 stated the program was not implemented because she had not received the referral. RN3 stated the typical process was for her to receive a referral from therapy, she entered it into the computer under the task list for the RAs, then she updated the care plan. RN3 stated she then talked to the RAs about the new program. During an interview on 07/31/25 at 2:39 PM |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure fall interventions were in place for one out of three residents (Resident (R) 2) reviewed for falls of 20 sample residents. Fall interventions such as mats on the floor, bed alarm, low bed, and a wedge were not consistently in place when R2 was in bed. This created the potential for significant injury from falls.Findings include:Review of the facility's policy titled, Interdisciplinary Team, dated 02/25, revealed the purpose was, To provide a process to assess and review results of findings and investigation of resident and employee incidences; determine appropriate interventions to decrease/eliminate incidence(s). A multi-disciplinary workgroup shall be established. The workgroup shall meet on regularly scheduled intervals to review Incident Report(s). The purpose of the workgroup is to further investigate incidents, as necessary, and to determine further interventions and plans to decrease/eliminate the potential for recurrence.Review of the undated admission Record in the electronic medical record (EMR) under the Profile tab revealed R2 was admitted to the facility on [DATE]. Diagnoses included history of cerebral infarction (ischemic stroke when blood flow to the brain is disrupted), paraplegia (paralysis of the legs and lower body), dementia, above the knee amputation, and Parkinson's disease.Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/08/25 in the EMR under the MDS tab, revealed R2 had a Brief Interview for Mental Status (BIMS) score of four out of 15 which indicated R2 was severely cognitively impaired. R2 was impaired in range of motion (ROM) on one side to his lower extremities. R2 was dependent on staff for shower/baths and required substantial assistance with personal hygiene, upper body dressing, toileting hygiene, and lower body dressing. R2 had not received physical or occupational therapy and had not been on a restorative nursing program during the assessment period. R2 had not experienced any falls since the prior MDS assessment.During an interview on 07/28/25 at 12:26 PM, Family Member (F) 1 stated R2 fell and that R2 had fallen lots recently. F1 stated R2 had fallen out of bed and was found on the floor the previous Wednesday. F1 stated R2 had some injuries such as bruises from the fall and had been transferred to the emergency room for evaluation. F1 stated R2 had an amputated leg and was paralyzed from the waist down. F1 stated all of R2's recent falls had been out of bed, and she thought more needed to be done to keep R2 safe.Review of R2's Care Plan, dated 09/30/23 in the EMR under the Care Plan tab, revealed a focus area of I am at risk for falls. I am paraplegic. I have a left AKA [above the knee] amputation. I am taking high risk medication that may increase my fall risk. Fall History, Weakness, Unsafe Behaviors, Poor Safety Awareness, Impulsive Decision Maker. Balance impaired due to CVA [cerebral vascular disease] and Parkinsons. The goal was, I will have no serious injury related to falls through the next review period. Interventions in place prior to the falls beginning in June 2025 included:-Bed is in a lower position with bilateral floor mats initiated on 04/27/24. -Perimeter mattress overlay initiated on 07/05/24.-Double seat belt in wheelchair initiated on 07/26/24; and-Bed alarm initiated on 09/09/24.Observations revealed R2 had a seat belt and a chest strap in place when he was up in his wheelchair on 07/28/25 at 11:53 AM and 2:53 PM; on 07/29/25 at 8:38 AM; and on 07/30/25 at 12:27 PM and 1:39 PM. On 07/29/25 at 3:35 PM, R2 was lying in the bed in a low position with mats on the floor on both sides of the bed, with a perimeter mattress, two positioning bars in place near the head of the bed, and with pillows between his torso and the grab bars on each side.Review of the facility's incident reports revealed R2 fell three times between 06/23/25 and 07/23/25:1. Review of the Un-witnessed Fall report, dated 06/23/25, provided by the facility revealed R2 experienced an unwitnessed fall at 11:00 AM. R2 was found on the floor mat on the left side of the bed; the bedside table was over his bed. The Certified Nursing Assistant (CNA) had checked on him at 10:45 AM. R2 stated he was reaching for something and fell out of his bed. R2 denied hitting his head. Neuro checks were initiated. The physician and family were notified. Factors contributing to the fall included clutter, poor lighting, confusion, recent illness, weakness, gait imbalance, and impaired memory. Interdisciplinary Team (IDT) follow up included ensuring further training of staff to assure all assistive devices were being used. The report did not indicate whether the bed alarm was sounding and/or what assistive devices were not in place. Lab work was requested to rule out infection on encephalopathy.Review of R2's Care Plan for fall risk, dated 09/30/23 in the EMR under the Care Plan tab, revealed a new intervention was added one day after the fall on 06/23/25. A wedge cushion to the left side of the bed was added to the care plan on 06/24/25. 2. Review of the Un-witnessed Fall report completed by Licensed Practical Nurse (LPN) 3, dated 06/28/24 at 2:15 PM |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, interviews, and policy review, the facility failed to ensure expired medications were not available for use in one of one medication room reviewed for medication storage and labeling. Failure to ensure expired medications were not available for use had the potential to result in residents receiving expired medications, which may be ineffective or harmful, leading to adverse drug reactions, diminished therapeutic outcomes, and increased risk of complications or hospitalization.Findings include:Review of the facility's policy titled, Pharmacy Services, last reviewed on 02/25, revealed that the Pharmacist shall be responsible for reviewing all medications in the facility for expiration dates. Removal of discontinued or expired drugs from use as indicated at least every thirty (30) days.Review of the facility's policy titled, Floor Stock Medication, last reviewed on 02/25, revealed certain medications shall be available within the facility for occasional use where the pharmacy source was not immediately available. The Pharmacist will be responsible for the replacement and disposal of expired medications.Observations on 07/29/25 at 8:24 AM in the presence of Registered Nurse (RN) 1 revealed the following expired medications were available for use in the medication storage room:-Six urinary pain relief 95 milligram (mg) tabs that expired on 06/25.-Three fleet laxative enemas that expired on 05/25.-One fleet laxative enema that expired on 02/25.-Three bottles of 3% hydrogen peroxide that expired on 09/24.During an interview on 07/26/25 at 8:30 AM, RN1 acknowledged that the expired medications were available for use. RN1 stated that the pharmacy consultant regularly checked for expired medications and that central supply staff were in the medication room this morning; however, she could not say how often central supply staff checked for expired medications. RN1 stated that expired medications should not be available for use.During an interview on 07/29/25 at 8:55 AM, the Pharmacist acknowledged the expired medications and stated that she manually tracked any medication with a pharmacy label and that central supply staff reviewed all other medications.During an interview on 07/29/25 at 9:01 AM, the Director of Nursing (DON), in the presence of the Administrator, stated that expired medications should not be available for use. She said that she was not sure who was responsible for monitoring the medications and would need to follow up. At 11:15 AM, the DON returned and stated that all nurses were responsible for checking the medication rooms for expired medications. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure food temperatures were palatable for two out of 20 sample residents (Resident (R) 9 and R43) reviewed for palatability. This created the potential for meal dissatisfaction, decreased intake, and weight loss.Findings include:Review of the facility's policy titled, Dining/Meal Service, dated 2023, revealed Food will be at the proper temperature. to meet each individual's needs and desires.1. Review of R9's admission Record (Face Sheet) located under the Profile tab in the electronic medical record (EMR) revealed R9 admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/17/25, located under the MDS tab in the EMR, revealed R9 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R9 was cognitively intact.During an interview on 07/28/25 at 12:05 PM, R9 stated that the food arrived from the kitchen lukewarm at best, or it was cold. R9 stated he was so tired of it. R9 stated the facility told the residents that they were working on it, but it was not getting any better. R9 reported the staff said that they do not have the right equipment to keep the types of plates they have warm and in the meantime their answer was to get your food reheated. R9 stated if he got the food reheated it could be a long wait to get it and by the time they got it back to him, it was cold again. R9 stated he bought his own microwave so he could reheat his food, but the staff did not allow him to have a microwave in his room.2. Review of R43's admission Record, located under the Profile tab in the EMR, revealed R43 admitted to the facility on [DATE]. Review of the annual MDS with an ARD of 06/03/25, located under the MDS tab in the EMR, revealed R43 had a BIMS score of 15 out of 15 which indicated R43 was cognitively intact. During an interview on 07/28/25 at 4:30 PM, R43 stated that the food arrived cold a lot of the time.3. Review of the Week Three Spring/Summer Menu, provided by the facility, revealed lunch on 07/30/25 consisted of orange chicken, fried rice, stir fry vegetables, a fortune cookie, and ice cream. The alternate was crispy shrimp Caesar salad, garlic bread, fruit, and ice cream.On 07/30/25 at 11:17 AM, food temperatures were taken immediately prior to meal service. The steamtable pans of hot foods had been placed into a hot box (heated compartment to keep food warm); the steamtable was not being used to hold food during meal service. The Food Service Manager (FSM) stated there were not that many residents and it took too much time to set up the steam table. The hot box was initially at a temperature of 173 degrees per external thermometer. The FSM verified serving temperatures for hot foods should be a minimum of 135 degrees Fahrenheit (F). Observation revealed food temperatures prior to meal service were:-Orange chicken 168 degrees F-Shrimp 147 degrees F-Fried rice 168 degrees F-Stir fried vegetables 166 degrees F-Mashed potatoes 165 degrees F-Mechanical chicken 181 degrees [NAME] 07/30/25, residents' meals for the 2100 hall (for approximately 15 residents who ate in their rooms) were dished up and placed into the uninsulated stainless steel food cart. Meal service for the 2100 hall cart began at 11:26 AM and continued to 11:40 AM. The temperature of the hot box had dropped to 166 degrees F per the external thermometer at 11:26 AM. The door had been left open when placing pans into the hot box and during the measurement of food temperatures. The FSM stated he had gotten approval for purchase of induction plates which would ensure food temperatures were hot when residents received their meals; however, they had not been purchased yet. On 07/30/25 at 11:30 AM, the external temperature of the hot box had dropped to 152 degrees; the door had been open and the pans with food were uncovered. The FSM stated he tried to keep the hot box as hot as possible with a goal of around 180 degrees F. The FSM stated he would like residents' hot foods to be between 140 - 145 degrees F when they received their meals and cold food should be 35 degrees F. Foods were dished up from the steam table pans, in the hot box, onto trays for the residents. There was no plate warmer utilized to keep plates hot. There were no insulated bases or lids for keeping the plates hot after meals were dished up. A thin clear plastic lid with a hole in the top of it (the size of a quarter) was placed on top of resident's plates. Residents' trays were placed into an uninsulated stainless-steel cart for transportation to the 2100 hall.On 07/30/25 at 11:40 AM, the cart for the 2100 hall was full and two test trays (main selection and alternate selection) were placed onto the cart after all the residents' meals had been dished up. The cart was wheeled out of the kitchen and taken to the 2100 hall. Observation revealed all residents' meal trays were served on the 2100 hall at 11:50 AM and the test trays were evaluated by the FSM and the surveyor at this time. Temperatures of the main selection (orange chicken, rice, and stir-fried vegetables were:-Orange chicken 112 degrees F. It was lukewarm -Stir fried rice 113 degrees F. It was lukewarm Temperature of the alternate |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on observation, record review, interview, and policy review, the facility failed to ensure staff followed Enhanced Barrier Precautions (EBPs) for one of four residents (Resident (R) 8) reviewed for Transmission-Based Precautions of 20 sample residents. Failure to follow EBPs increases the potential for cross-contamination and transmission of infections to both staff and residents.Findings include: Review of the facility's policy titled, Enhanced Barrier Precautions last reviewed on 03/24, revealed It is the procedure of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms [MDROs]. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown, and gloves use during high contact resident care activities. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ ventilator tubes) even if the resident is not known to be infected or colonized with an MDRO. ii. Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply. High-contact resident care activities include a. Dressing; b. Bathing; c. Transferring; d. Providing hygiene; e. Changing linens; f. Changing briefs or assisting with toileting; g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ ventilator tubes; and Wound care: any skin opening requiring a dressing.Findings include:Review of the facility's admission Record (Face Sheet), located under the Profile tab in the electronic medical record (EMR), revealed that the facility initially admitted R8 on 05/08/24. His pertinent diagnoses included urinary retention and benign prostatic hyperplasia (BPH) with lower urinary tract symptoms. Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/13/25, located under the MDS tab in the EMR, revealed R8 had a Brief Interview for Status (BIMS) score of seven out of 15, which indicated R8 had severe cognitive impairment. R8 required total dependence of staff for activities of daily living and had an indwelling catheter related to a diagnosis of BPH. Further review revealed R8 had a urinary tract infection within the last 30 days from the ARD.Review of R8's care plan, last revised on 02/26/25, located under the Care Plan tab in the EMR, revealed R8 was at risk for infection with multidrug-resistant organisms. R8 was placed on EPB to decrease the risk of active infection due to his indwelling catheter. The care plan directed staff to use gloves and a gown for any high contact care activities, such as, but not limited to, dressing, bathing, transfers, hygiene, linens changes, toileting, device care, wound care, etc.During an observation on 07/29/25 at 12:27 PM Certified Nursing Assistant (CNA) 10 assisted R8 back to their room from the dining room. At which time, CNA10 closed the door to the room. At 12:30 PM, CNA10 exited R8's room carrying a clear plastic garbage bag with a white blanket inside. Upon entering R8's room, observations revealed R8 lying in bed with no shirt on. CNA10 properly secured R8's catheter tubing, and the catheter bag was hanging on the side of the bed, below the level of the bladder, and placed in a privacy bag. Observations revealed no evidence that CNA10 disposed of an isolation gown in R8's room.Observation of R8's room on 07/30/25 at 12:40 PM with CNA10 revealed the resident had personal protective equipment (PPE) located inside the closet located in the bathroom, along with a sign indicating EBP. During an interview on 07/29/25 at 2:55 PM, CNA10 reported that she had worked at the facility as an agency CNA for the past three weeks and had cared for R8 for one week. She explained that R8 required one-person assistance with activities of daily living. She stated that day, she helped R8 return to his room after lunch, assisted him into bed, and covered him with a blanket. She stated she then placed the blanket R8 had used during lunch into a bag and took it to the dirty utility room. CNA10 acknowledged that she did not wear PPE while assisting R8 because she did not perform catheter care or empty his catheter bag.During a follow-up interview on 07/30/25 at 1:33 PM, CNA10 reviewed R8's care plan and she confirmed that staff were required to wear gowns and gloves during all high-contact care, including dressing, transfers, and bathing; essentially any care provided in the resident's room, except when delivering a tray without resident contact. She admitted that she should have worn a gown and gloves while assisting R8 on 07/29/25.During an interview on 08/01/25 at 9:21 AM, the Infection Preventionist (IP) for a sister facility, who was assisting the facility because they did not currently have a qualified IP (cross-referenceF882), stated that for residents on EBP, the facility required staff to don (put on) gloves and a gown when they provide any high contact care. She said that the staff kept PPE supplies in the closet located in the bathrooms of residents on EBPs. She |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.<br><br>Based on record review and interview, the facility failed to designate one or more qualified individuals as Infection Preventionists (IPs) who are responsible for the Infection Prevention and Control Program (IPCP) and who physically work onsite at the facility at least part-time. Failure to designate one or more qualified onsite IPs to oversee the implementation and monitoring of infection prevention practices has the potential to result in the inadequate identification, prevention, and control of infections within the facility, placing all 58 residents at increased risk for the transmission of communicable diseases and healthcare-associated infections.Findings include:Review of the facility's undated [Name of Facility] Employee Listing revealed the facility did not have a designated IP who worked on-site at least part-time.During an interview on 08/01/25 at 9:21 AM, the IP who worked at the facility stated that she worked remotely and assisted the facility with its infection control and prevention program and did not spend any time on-site at the facility. She said that she had been assisting the facility since 04/25. She indicated the facility hired an IP, but they quit a few weeks ago, and that no one in the facility was certified or qualified as an IP.During an interview on 08/01/25 at 1:15 PM, the Administrator stated that Registered Nurse (RN) 7 was the facility's previous IP who started in 08/24; however, she was in the process of completing the training, and that the previous Director of Nursing (PDON) oversaw the IPCP. She indicated that RN7 quit on 07/11/25, that the PDON quit on 05/23/25, and that the facility had been actively recruiting for an IP since 07/11/25. At 1:24 PM, the Administrator provided a copy of the PDON's infection preventionist's training certificate. The Administrator stated that RN7 sent her an email dated 06/26/25 indicating that she had completed the infection prevention modules through the Centers for Disease Control; however, she did not have a copy of RN7's completion certificate. |