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	08/05/2021

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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 37963 Based on policy review, staff and resident interview, review of the State Survey Agency's Long-Term Care Reporting Portal, and review of facility documents, it was determined the facility failed to ensure residents were free from verbal abuse, mental abuse, and neglect. This was true for 2 of 15 residents (#4 and #7) who were reviewed for abuse. Resident #7 was subjected to mental and verbal abuse and neglect, when an RN refused to administer her pain and anti-nausea medication until she said please and thank you for the medications. Resident #4 was verbally abused by the same RN when he stated he felt stupid after a verbal interaction with her. These deficient practices placed the health and safety of Resident #4 and Resident #7, and the other 38 residents residing in the facility, in immediate jeopardy of serious harm, impairment, or death. Findings include: The facility's abuse policy, dated June 2021, stated Each resident at Idaho Division of Veterans Services, Idaho State Veterans Home (ISVHs) has the right to be free from exploitation, verbal .and mental abuse . against each resident .and the responsibility of all employees, agents, students, and contractors of the facility (also referenced herein after as to 'covered individuals') to immediately protect the resident(s) and report any and all alleged violations related to abuse, (physical, mental, sexual and verbal) .against a resident .The ISVHs will take all allegations seriously by conducting proper, impartial, and thorough investigations into each alleged violation .Any covered individual who witnesses or suspects abuse (physical, mental, sexual and verbal), neglect, mistreatment .against a resident must ensure the resident(s) is safe and protected from harm . The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This policy was not followed. The Social Services Procedure Manual, undated, included a section on abuse and neglect which documented examples of the signs and symptoms of neglect and abuse which included the following: - Improper use/administration of medication - Caregiver indifference to resident's personal care and needs (continued on next page)

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

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	135133	A. Building B. Wing	08/05/2021

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- New or more frequent expressions of low self-esteem or self-worth - Anger The procedure manual documented other signs and symptoms of abuse/neglect may be apparent and When in doubt, report it. The procedure manual defined mental abuse was the use of verbal or nonverbal conduct that causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. This procedure manual was not followed. 1. Resident #7 was admitted to the facility on [DATE], with diagnoses which included Parkinson's disease (a progressive disease of the nervous system that affects movement), Type 2 diabetes mellitus, and high blood pressure. A quarterly MDS assessment, dated 5/19/21, documented Resident #7 was cognitively intact. During an interview on 8/3/21 beginning at 9:37 AM, Resident #7 stated RN #4 told her she had to say please and thank you before RN #4 would administer her medications. Resident #7 stated RN #4 then refused to give her medications and told her she would come back later and walked out of her room. Resident #7 stated RN #4 would not come back to her room and she had to ask another nurse for her medications. When asked what type of medications, Resident #7 stated her pain and anti-nausea medications. Resident #7 stated it happened a couple times and she reported it to a CNA. Resident #7 stated she had talked to the Social Worker about RN #4. Resident #7 stated she had not seen RN #4 for a while and she did not have an issue with the other nurses. The State Survey Agency's Long-Term Care Reporting Portal, from 4/26/21 to 8/2/21, did not include reports for Resident #7. The State Agency's Reporting Portal did include an investigation and documentation of an incident involving a different resident, Resident #4. The documentation from the facility included interviews conducted with staff and residents, including Resident #7, which stated she had filed a grievance about RN #4. There was also documentation from the staff interviews RN #5 had noted a grievance she reported for Resident #7. There was no further information related to Resident #7's concerns about RN #4. The facility's grievances were reviewed from May 2021 to July 2021. Resident #7 had grievances in May 2021 and July 2021. There were no grievances about Resident #7's concerns with RN #4. An interview was conducted with the Social Worker on 8/4/21 at 3:11 PM. The Social Worker stated he reviewed and investigated grievances and he was the abuse investigation coordinator. He stated while he had the title of coordinator allegations were discussed as a group with him, the Administrator, and the DNS. The Social Worker stated while investigating a different allegation of abuse for another resident he learned of the incident between Resident #7 and RN #4. The Social Worker stated after talking to Resident #7, he determined the incident was not reportable therefore, it was not reported to the State Agency, and no investigation was conducted. When asked if the follow up interview was documented, the Social Worker stated yes, and he would gather the information. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/4/21 at 10:20 AM, the Administrator provided information related to Resident #7 which was attached to a document titled, Investigation Process Checklist for an allegation which involved Resident #4. The document included emails and witness interviews, as follows: - A typed document had the Social Worker's name at the top and was dated 7/20/21. The document stated while working on an investigation of a complaint for a different resident, Resident #7 stated a while back a nurse had refused to give her medications. Resident #7 stated it was RN #4 when asked which nurse it was. Resident #7 also stated she had reported this to another social worker (who was no longer employed at the time of survey) and they had fixed things and there were no problems since them. The Social Worker documented he spoke with the social worker, who spoke with Resident #7, and she provided him information pertaining to Resident #7's grievance, including a resolution. The document stated the situation was non-reportable to the State Survey Agency. - A typed document had Interview with [Resident #7] at the top and was dated 7/21/21. The document did not include who conducted the interview. The document stated Met with [Resident # 7] for follow-up questions. Resident #7 stated she was speaking with a night shift nurse when she reported a past incident with RN #4 who told Resident #7 she needed to say please and thank you when receiving her medications. Resident #7 stated RN #4 walked out of her room and refused to give Resident #7 her medications. - An email, dated 7/21/21 at 8:04 PM, from RN #5 to the Administrator, DNS, and the Social Worker, stated RN #5 was administering medication to Resident #7 that evening and she shared the Social Worker had come to see her yesterday about RN #4. RN #5 documented Resident #7 told her how RN #4 would come into her room with scheduled medications and said to Resident #7 you will get your medicine when you learn to say please and thank you and walked out of room with my medicine. RN #5 documented she called the Administrator that evening to report this incident and went back to Resident #7's room to write down exactly what was told to her by Resident #7. RN #5 stated Resident #7 was tearful when she went back in to write down what was said by RN #4 to Resident #7. - An email, dated 7/21/21 at 9:34 PM, from RN #1 to the Administrator, DNS, and Social Worker, stated Resident #7 told her yesterday the Social Worker had visited with her about incidents regarding a nurse. The email documented Resident #7 told her how the same nurse, RN #4, had held her medications until she said please and thank you. RN #1 documented after talking with another nurse that day the incident was not reported to the Social Worker like she had thought. During an interview on 8/4/21 at 4:40 PM, the Administrator, with the DNS present, stated residents should not have medication withheld from them. The facility failed to ensure that Resident #7 was free from abuse and neglect. 2. Resident #4 was readmitted to the facility on [DATE], with diagnoses which included throat cancer, atrial fibrillation (an irregular and often fast heart rate), high blood pressure, and benign prostatic hyperplasia (an enlarged prostate gland, which can obstruct the outflow of urine). An admission MDS assessment, dated 6/29/21, documented Resident #4 had moderate cognitive impairment. (continued on next page)

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	135133	A. Building B. Wing	08/05/2021

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility entered a report of an allegation of abuse on 7/19/21 at 12:15 PM, to the State Survey Agency's Long-Term Care Reporting Portal. The report documented the incident occurred on 7/18/21 at 2:00 PM, and Resident #4 reported RN #4 was belittling and short with him during cares. The report in the portal documented the staff was removed from the facility pending an investigation. An investigation report completed by the Social Worker, undated, submitted to the State Survey Agency's Long-Term Care Reporting Portal documented Resident #4 made a report on 7/18/21 at 2:00 PM stating He and his nurse [RN #4] had a disagreement with the way he takes his medications and felt the nurse to be rather short with him and made him feel stupid during cares. The investigation included typed witness statements, which documented the following: - A witness statement by CNA #5, dated 7/18/21, stated Resident #10 asked her if nurses were allowed to yell at the residents and belittle them. CNA #5 asked what happened and Resident #10 stated, The .lady nurse yelled at [Resident #4] about his meds. CNA #5 then asked Resident #4 what happened. He explained he's told the nurse numerous times that he only wants milk with his medication. He was then told by the RN that she's new here and can't know everyone. Resident #4 stated he felt like she was talking down to him and made him feel stupid. - A witness statement by CNA #6, dated 7/18/21, stated she heard Resident #10 ask CNA #5 if nurses were allowed to yell at the residents and belittle them. CNA #6 stated [Resident #4] seem [sic] a bit rattled over this. - A witness statement by Resident #10 (Resident #4's significant other), dated 7/19/21, stated, [Resident #4] . reminded the nurse he likes milk with his medication when the nurse sharply told him she's new and can't remember everybody .When asked about [Resident #4's] reaction to this [Resident #10] said he just cowed down with tears in his eyes and didn't say anything. She noted it was very belittling to [Resident #4]. The investigation documented in the conclusion section that Both residents were found to be alert and oriented and to have given a nearly identical account of the exchange during this med [medication] pass. Both have noted RN [RN #4] to be very nice the following day though her actions at the time were found to be sharp, belittling and inappropriate for her profession. During an interview on 8/4/21 at 4:40 PM, the Administrator, with the DNS present, stated the report did not include information whether the allegation was substantiated or unsubstantiated. On 8/4/21 at 10:10 AM, the Administrator provided a letter, dated 7/29/21, which the facility had sent to RN #4. The letter stated RN #4 was involved in an incident concerning abuse/neglect and The Division has conducted an investigation concerning these accusations and found evidence to reflect that this allegation was substantiated. The facility failed to ensure Resident #4 was protected from abuse. On 8/4/21 at 5:04 PM, the Administrator and DNS were notified verbally and in writing of an Immediate Jeopardy (IJ) determination at F600 related to the facility's failure to ensure residents were free from abuse and neglect. This failure placed Resident #7 and Resident #4 at increased likelihood for serious harm, injury, or death, as well as the other 51 residents in the facility. (continued on next page)

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	135133	A. Building B. Wing	08/05/2021

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/5/21 at 9:30 AM, the facility Administrator presented a removal plan for the immediacy which was accepted. The removal plan stated the identified staff were immediately placed on leave and staff education regarding abuse, neglect, and facility policy related to reporting began immediately. The removal plan alleged compliance as of 8/4/21 at 5:44 PM. On 8/5/21 at 10:45 AM, the Administrator was notified the immediacy was removed based on onsite verification the IJ removal plan was implemented. Following the removal of the immediacy, noncompliance remained at actual harm which was isolated.

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	135133	A. Building B. Wing	08/05/2021

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 37963 Based on policy review, review of investigation reports, and staff and resident interview, it was determined the facility failed to ensure its policies were implemented by staff to immediately report allegations of abuse and to protect residents from abuse. This was true for 3 of 15 residents (#3, #4 and #7) who were reviewed for abuse allegations. This had the potential to place all residents residing in the facility at increased risk for abuse. Findings include: The facility's abuse policy, dated June 2021, included a section Investigation which documented the following: - Any employee under investigation for violation of this policy will be removed from the facility .until the investigation is completed. - Regardless of whether an allegation requires federal or state reporting .all allegation related to abuse (physical, mental, sexual and verbal), neglect, mistreatment .whether oral or in writing, must be thoroughly investigated by the facility . The policy stated The following steps will be utilized to assist in ensuring a proper, thorough, and impartial investigation . - The investigation includes a conclusion and what preventative measure, or corrective action was taken. The policy's reporting requirements section stated, Any covered individual who witnesses or suspects abuse (physical, mental, sexual and verbal), neglect, mistreatment .against a resident must ensure the resident(s) is safe and protected from harm, if applicable, and then immediately ** notify the Home Administrator via telephone or text message. The policy defined immediately as .the covered individual must not wait until the end of a shift before reporting the matter. This notification must be done as soon as the covered individual is made aware of the alleged violation or has reasonable suspicion of an alleged violation. The covered individual must, however, first ensure the resident(s) is safe and protected from harm . The policy stated, This facility reporting requirement must be completed immediately but no later than 2 hours after the allegation is made if the allegation involves actual harm or serious bodily injury, or no later than 24 hours if the events that cause the allegation did not involve abuse and does not result in serious bodily injury . This policy was not implemented. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The State Survey Agency's Long-Term Care Reporting Portal reports, dated 4/26/21 - 8/2/21, included 2 reports of allegations of abuse on 7/19/21. One of the reports alleged RN #4 made Resident #4 feel stupid when providing cares and the other report alleged LPN #1 was verbally abusive with Resident #3. In the investigation report for Resident #4, interviews with staff and residents identified another allegation of abuse with RN #4 towards Resident #7, by both Resident #7 and RN #5. Both reports to the State Survey Agency Long-Term Care Reporting Portal documented the Staff removed from facility pending investigation. The subsequent investigation reports, for both incidents, did not include information as to when staff were removed from the facility. The facility conducted in-service education for staff on Freedom from Abuse and Neglect from 7/20/21 through 7/22/21. Staff also signed a form acknowledging the facility's policy for abuse, neglect, mistreatment, and exploitation (IDVS-PO-21-01), which stated when a staff signed the form they had received the training on the policy, understood the policy and procedure, and agreed to abide by the policy and procedure. There was no documentation either RN #4 and LPN #1 did not attend the in-service education and did not have a signed acknowledgement form. Staff were interviewed regarding the facility's policy and procedure for allegations of abuse. Staff interviews were as follows: - On 8/3/21 at 3:27 PM, CNA #1 stated if she witnessed abuse she would report it to the Administrator or the DNS. CNA #1 stated she received training on recognizing and reporting of abuse and neglect recently through in-services. - On 8/3/21 at 4:11 PM, CNA #2 stated if she witnessed or heard of abuse she reported it to the nurse. She stated there was a recent incident with Resident #3 and LPN #1 recently and LPN #1 was placed on leave. CNA #2 stated she was working the night the allegation occurred and she reported to the nurses Resident #3 told her RN #3 had thrown a urinal at him. CNA #2 stated she informed the nurses on shift and LPN #1 was working and went to Resident #3's and told him do not treat the nurse's that way. - On 8/3/21 at 4:21 PM, RN #1 stated if she witnessed or heard of abuse she reported it. She stated she recently turned in a report about RN #4. She stated Resident #7 told her RN #4 withheld her medications until Resident #7 said please and thank you. RN #1 stated she was supposed to fill out a form but since she had written it up in email and so had RN #5, she did not fill out the form. RN #1 stated RN #5 told her she emailed her concern to the Administrator, so she did not think she needed to. - On 8/3/21 at 4:47 PM, RN #2 stated if she witnessed or heard of abuse she first made sure the resident was safe then would report to the Administrator, DNS, or Social Worker. (continued on next page)

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	135133	A. Building B. Wing	08/05/2021

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 8/4/21 at 9:56 AM, RN #3 stated if she witnessed or heard of abuse she would notify the Administrator. When asked if anything had happened recently she stated Resident #3 had accused her of throwing a urinal at him on 7/17/21. RN #3 stated she told LPN #1 who was working with her that night also and he went and investigated the situation. She stated LPN #1 told her Resident #3 had altered his story, so the decision was made for her, RN #3, to continue her shift but on a different hall. RN #3 stated she did not fill out form or notify the Administrator that day. She stated she was scheduled to be off the following day and when she came back to work she spoke with the Administrator who stated he was investigating a separate issue with LPN #1. RN #3 stated she has not worked with Resident #3 since 7/17/21. - On 8/4/21 at 10:45 AM, RN #4 stated if she witnessed or heard of abuse she would first speak with the staff accused and then the resident. She stated she would try to address the situation by assessing the resident and talking with them and then speaking with the nurse involved. During an interview on 8/4/21 beginning at 3:11 PM, the Social Worker was asked what the procedure and policy were for allegations of abuse. He stated staff were to immediately report these to the Administrator and fill out the facility's form for abuse reporting, he said it could be verbal but should fill out the form also. When asked why the incident with Resident #7 was not reported and investigated, the Social Worker stated he determined the incident was not reportable according to policy; therefore, it was not reported, and no investigation was conducted. When asked if staff should be interviewing residents prior to reporting to the Administrator, he stated no. When asked why staff identified to be involved with allegations of abuse were not immediately placed on suspension or Administrative Leave he stated he did not know that was the Administrator's responsibility. During an interview with the Administrator and DNS on 8/4/21 beginning at 4:40 PM, the procedure and policy for allegations of abuse was discussed. The Administrator stated staff were to report any allegations to him immediately and fill out a form related to the allegation prior to the end of their shift. He stated each of the staff had a small card near their ID badge with instructions on the procedure. When asked about the allegations of abuse against RN #4 and LPN #1, the Administrator stated they were placed on Administrative Leave as soon as he had found out. He confirmed this was not the same day as the allegation occurred. During the same interview, the Administrator stated they had recently conducted an in-service for staff on abuse and neglect reporting and all staff should be aware of and follow the policy. The Administrator was informed RN #4 and LPN #1 were not able to verbalize the correct policy and procedure for reporting abuse during their interview. He stated they were required to attend the in-service and training prior to returning to work from their Administrative Leave. The Administrator reviewed the training and in-service documentation and confirmed neither RN #4 and LPN #1 had documentation of completed training prior to returning to work.

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	135133	A. Building B. Wing	08/05/2021

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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** 37963 Based on policy review, review of the State Survey Agency's Long-Term Care Reporting Portal, review of facility grievances, review of facility investigation reports, and staff and resident interview, it was determined the facility failed to ensure allegations of resident abuse were reported within 2 hours to the State Survey Agency and the investigation was submitted within 5 working days to the State Agency. This was true for 2 of 15 residents (#3, #4, and #7) reviewed for abuse. This failure resulted in delayed investigation of Resident #7's allegation of abuse placing her and other residents in the facility at risk of neglect. Findings include: The facility's abuse policy, dated June 2021, stated Each resident at Idaho Division of Veterans Services, Idaho State Veterans Home (ISVHs) has the right to be free from verbal, sexual, physical, and mental abuse; neglect; exploitation; mistreatment .and the responsibility of all employees, agents, students, and contractors of the facility (also referenced herein after as to 'covered individuals') to immediately protect the resident(s) and report any and all alleged violations related to abuse . The policy's reporting requirements section stated, Any covered individual who witnesses or suspects abuse (physical, mental, sexual and verbal), neglect, mistreatment .against a resident must ensure the resident(s) is safe and protected from harm, if applicable, and then immediately ** notify the Home Administrator via telephone or text message. The policy defined immediately as .the covered individual must not wait until the end of a shift before reporting the matter. This notification must be done as soon as the covered individual is made aware of the alleged violation or has reasonable suspicion of an alleged violation. The covered individual must, however, first ensure the resident(s) is safe and protected from harm . The policy stated, This facility reporting requirement must be completed immediately but no later than 2 hours after the allegation is made if the allegation involves actual harm or serious bodily injury, or no later than 24 hours if the events that cause the allegation did not involve abuse and do not result in serious bodily injury . This policy was not followed. Allegations of abuse and neglect were not reported within 2 hours of occurrence to the State Survey Agency and investigation reports were not submitted within 5 days of occurrence to the State Survey Agency. Examples include: a. Resident #7 was admitted to the facility on [DATE], with diagnoses which included Parkinson's disease (a progressive disease of the nervous system that affects movement), Type 2 diabetes mellitus, and high blood pressure. A quarterly MDS assessment, dated 5/19/21, documented Resident #7 was cognitively intact. (continued on next page)

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	135133	A. Building B. Wing	08/05/2021

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/3/21 beginning at 9:37 AM, Resident #7 stated RN #4 told her she had to say please and thank you before RN #4 would administer her medications. Resident #7 stated RN #4 then refused to give her medications and told her she would come back later and walked out of her room. Resident #7 stated RN #4 would not come back to her room and she had to ask another nurse for her medications. When asked what type of medications, Resident #7 stated her pain and anti-nausea medications. Resident #7 stated it happened a couple times and she reported it to a CNA. Resident #7 stated she had talked to the Social Worker about RN #4. Resident #7 stated she had not seen RN #4 for a while and she did not have an issue with the other nurses. The facility's grievances were reviewed from May 2021 to July 2021. Resident #7 had grievances in May 2021 and July 2021. There were no grievances about Resident #7's concerns with RN #4. An interview was conducted with the Social Worker on 8/4/21 at 3:11 PM. The Social Worker stated he reviewed and investigated grievances and he was the abuse investigation coordinator. He stated while he had the title of coordinator, allegations were discussed as a group with him, the Administrator, and the DNS. The Social Worker stated while investigating a different allegation of abuse for another resident he learned of the incident between Resident #7 and RN #4. The Social Worker stated after talking to Resident #7, he determined the incident was not reportable therefore, it was not reported to the State Agency, and no investigation was conducted. When asked if the follow up interview was documented, the Social Worker stated yes, and he would gather the information. On 8/4/21 at 10:20 AM, the Administrator provided the requested information related to Resident #7 which was attached to a document titled, Investigation Process Checklist for an allegation which involved Resident #4. The document included emails and witness interviews, as follows: - A typed document had the Social Worker's name at the top and was dated 7/20/21. The document stated while working on an investigation of a complaint for a different resident, Resident #7 stated a while back a nurse had refused to give her medications. Resident #7 stated it was RN #4 when asked which nurse it was. Resident #7 also stated she had reported this to another social worker (who was no longer employed at the time of survey) and they had fixed things and there were no problems since them. The Social Worker documented he spoke with the social worker, who spoke with Resident #7, and she provided him information pertaining to Resident #7's grievance, including a resolution. The document stated the situation was non-reportable to the State Survey Agency. - A typed document had Interview with [Resident #7] at the top and was dated 7/21/21. The document did not include who conducted the interview. The document stated Met with [Resident # 7] for follow-up questions. Resident #7 stated she was speaking with a night shift nurse when she reported a past incident with RN #4 who told Resident #7 she needed to say please and thank you when receiving her medications. Resident #7 stated RN #4 walked out of her room and refused to give Resident #7 her medications. (continued on next page)

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	08/05/2021

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An email, dated 7/21/21 at 8:04 PM, from RN #5 to the Administrator, DNS, and the Social Worker, stated RN #5 was administering medication to Resident #7 that evening and she shared the Social Worker had come to see her yesterday about RN #4. RN #5 documented Resident #7 told her how RN #4 would come into her room with scheduled medications and said to Resident #7 you will get your medicine when you learn to say please and thank you and walked out of room with my medicine. RN #5 documented she called the Administrator that evening to report this incident and went back to Resident #7's room to write down exactly what was told to her by Resident #7. RN #5 stated Resident #7 was tearful when she went back in to write down what was said by RN #4 to Resident #7. - An email, dated 7/21/21 at 9:34 PM, from RN #1 to the Administrator, DNS, and Social Worker, stated Resident #7 told her yesterday the Social Worker had visited with her about incidents regarding a nurse. The email documented Resident #7 told her how the same nurse, RN #4, had held her medications until she said please and thank you. RN #1 documented after talking with another nurse that day the incident was not reported to the Social Worker like she had thought. The State Survey Agency's Long-Term Care Reporting Portal, from 4/26/21 to 8/2/21, included an investigation and documentation of an incident involving a different resident, Resident #4, which was submitted on 7/19/21 at 12:15 PM. The documentation from the facility included interviews conducted with staff and residents, including Resident #7, which stated she had filed a grievance about RN #4. There was also documentation from the staff interviews RN #5 had noted a grievance she reported for Resident #7. The State Agency's Long-Term Care Reporting Portal did not include a report for Resident #7 regarding her allegation of abuse by RN #4 b. Resident #4 was readmitted to the facility on [DATE], with diagnoses which included throat cancer, atrial fibrillation (an irregular and often fast heart rate), high blood pressure, and benign prostatic hyperplasia (an enlarged prostate gland, which can obstruct the outflow of urine). An admission MDS assessment, dated 6/29/21, documented Resident #4 had moderate cognitive impairment. The facility entered a report of an allegation of abuse on 7/19/21 at 12:15 PM, to the State Survey Agency's Long-Term Care Reporting Portal. The report documented the incident occurred on 7/18/21 at 2:00 PM, more than 24 hours after the incident occurred. The report stated Resident #4 reported RN #4 was belittling and short with him during cares. The report in the State Survey Agency Portal documented Staff was removed from the facility pending investigation. An investigation report, undated, documented Resident #4 made a report on 7/18/21 at 2:00 PM that He and his nurse [RN #4] had a disagreement with the way he takes his medications and felt the nurse to be rather short with him and made him feel stupid during cares. The report documented the investigation started on 7/19/21. The investigation report completed by the Social Worker was submitted to the State Survey Agency's Long-Term Care Reporting Portal on 7/26/21, 8 days after the alleged abuse occurred. (continued on next page)

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	08/05/2021

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator was conducted on 8/4/21 beginning at 4:40 PM, with the DNS present. The Administrator stated he became aware of the incident involving Resident #4 the morning of 7/19/21 when he opened his office door and saw the report which had been slipped underneath his door on the floor the night before. The Administrator stated he was not notified by staff immediately and policy was not followed. c. Resident #3 was readmitted to the facility on [DATE], with diagnoses which included heart failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), chronic obstructive pulmonary disease (progressive lung disease characterized by increasing breathlessness), high blood pressure, and depression. A quarterly MDS assessment, dated 7/20/21, documented Resident #3 had mild cognitive impairment and required extensive assistance from staff with toileting. An investigation report, undated, documented Resident #3 reported a nurse refused to provide a service for him and when he asked the nurse to get someone else who could the nurse left his room. The report documented Resident #3 then stated a different nurse came into his room and was verbally abusive. The report documented Resident #3 also stated the nurse had his face in his and was cursing at him about giving a hard time to his nursing staff and then left the room. The investigation report documented the alleged abuse occurred on 7/17/21 at 3:00 PM and was reported the State Survey Agency on 7/19/21, 2 days after the occurrence. The State Survey Agency's Long-Term Care Reporting Portal, from 4/26/21 to 8/2/21, included an investigation and documentation of an incident involving Resident #3, which was submitted on 7/20/21 at 3:15 PM. The documentation from the facility included the investigation report and interviews conducted with the nursing staff involved and Resident #3. The investigation report completed by the Social Worker was submitted to the State Survey Agency's Long-Term Care Reporting Portal on 7/27/21, 10 days after the alleged abuse occurred. During an interview on 8/4/21 beginning at 3:11 PM, the Social Worker was asked about the investigation report for Resident #3. The Social Worker confirmed the alleged abuse had taken place on 7/17/21 and he was not made aware of the incident until 7/19/21 when during a scheduled care conference Resident #3 told him what happened. The Social Worker confirmed the initial report of alleged abuse was 3 days after the occurrence and the investigation was completed and reported 10 days after the occurrence. During an interview on 8/4/21 beginning at 4:40 PM, the Administrator, with the DNS present stated facility policy was not followed and the allegations of abuse were not reported and investigated within the specified time frames. The facility failed to ensure allegations of resident abuse were reported within 2 hours to the State Survey Agency and the results of the investigations into allegations of abuse were reported within 5 days of the allegations.

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	135133	A. Building B. Wing	08/05/2021

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37963 Based on policy review, review of investigation reports, staff and resident interview, review of the State Survey Agency's Long-Term Care Reporting Portal, and review of staffing, it was determined the facility failed to ensure thorough investigations were completed for abuse. This was true for 2 of 15 residents (#4 and #7) who were reviewed for abuse allegations. This failure placed Resident #4 and Resident #7 at risk of further abuse and the other residents in the facility at risk for abuse. Findings include: The facility's abuse policy, dated June 2021, stated Each resident at Idaho Division of Veterans Services, Idaho State Veterans Home (ISVHs) has the right to be free from verbal, sexual, physical, and mental abuse; neglect; exploitation; mistreatment .and the responsibility of all employees, agents, students, and contractors of the facility (also referenced herein after as to 'covered individuals') to immediately protect the resident(s) and report any and all alleged violations related to abuse, (physical, mental, sexual and verbal) .against a resident .The ISVHs will take all allegations seriously by conducting proper, impartial, and thorough investigations into each alleged violation .Any covered individual who witnesses or suspects abuse (physical, mental, sexual and verbal), neglect, mistreatment .against a resident must ensure the resident(s) is safe and protected from harm . The policy's Investigation Process section stated the following: - Any employee under investigation for violation of this policy will be removed from the facility .until the investigation is completed. - Regardless of whether an allegation requires federal or state reporting .all allegation related to abuse (physical, mental, sexual and verbal), neglect, mistreatment .whether oral or in writing, must be thoroughly investigated by the facility . The policy stated The following steps will be utilized to assist in ensuring a proper, thorough, and impartial investigation . - The Principal Investigator must review statements and follow-up with interviews to clarify statements or conflicting information with other information obtained. - The investigation includes a conclusion and what preventative measure, or corrective action was taken. The policy was not followed. 1. The facility did not conduct a thorough investigation and protect residents from potential further abuse when RN #4 was alleged to have abused Resident #4 and Resident #7. Examples include: a. Resident #7 was admitted to the facility on [DATE], with diagnoses which included Parkinson's disease (a progressive disease of the nervous system that affects movement), Type 2 diabetes mellitus, and high blood pressure. (continued on next page)

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	135133	A. Building B. Wing	08/05/2021

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly MDS assessment, dated 5/19/21, documented Resident #7 was cognitively intact. During an interview on 8/3/21 beginning at 9:37 AM, Resident #7 stated RN #4 told her she had to say please and thank you before RN #4 would administer her medications. Resident #7 stated RN #4 then refused to give her medications and told her she would come back later and walked out of her room. Resident #7 stated RN #4 would not come back to her room and she had to ask another nurse for her medications. When asked what type of medications, Resident #7 stated her pain and anti-nausea medications. Resident #7 stated it happened a couple times and she reported it to a CNA. Resident #7 stated she had talked to the Social Worker about RN #4. Resident #7 stated she had not seen RN #4 for a while and she did not have an issue with the other nurses. The facility's grievances were reviewed from May 2021 to July 2021. Resident #7 had grievances in May 2021 and July 2021. There were no grievances about Resident #7's allegation for RN #4. On 8/4/21 at 10:20 AM, the Administrator provided information related to Resident #7 which was attached to a document titled, Investigation Process Checklist for an allegation which involved Resident #4. The document included emails and witness interviews, as follows: - A typed document had the Social Worker's name at the top and was dated 7/20/21. The document stated while working on an investigation of a complaint for a different resident, Resident #7 stated a while back a nurse had refused to give her medications. Resident #7 stated it was RN #4 when asked which nurse it was. Resident #7 also stated she had reported this to another social worker (who was no longer employed at the time of survey) and they had fixed things and there were no problems since them. The Social Worker documented he spoke with the social worker, who spoke with Resident #7, and she provided him information pertaining to Resident #7's grievance, including a resolution. The document stated the situation was non-reportable to the State Survey Agency. - A typed document had Interview with [Resident #7] at the top and was dated 7/21/21. The document did not include who conducted the interview. The document stated Met with [Resident # 7] for follow-up questions. Resident #7 stated she was speaking with a night shift nurse when she reported a past incident with RN #4 who told Resident #7 she needed to say please and thank you when receiving her medications. Resident #7 stated RN #4 walked out of her room and refused to give Resident #7 her medications. - An email, dated 7/21/21 at 8:04 PM, from RN #5 to the Administrator, DNS, and the Social Worker, stated RN #5 was administering medication to Resident #7 that evening and she shared the Social Worker had come to see her yesterday about RN #4. RN #5 documented Resident #7 told her how RN #4 would come into her room with scheduled medications and said to Resident #7 you will get your medicine when you learn to say please and thank you and walked out of room with my medicine. RN #5 documented she called the Administrator that evening to report this incident and went back to Resident #7's room to write down exactly what was told to her by Resident #7. RN #5 stated Resident #7 was tearful when she went back in to write down what was said by RN #4 to Resident #7. - An email, dated 7/21/21 at 9:34 PM, from RN #1 to the Administrator, DNS, and Social Worker, stated Resident #7 told her yesterday the Social Worker had visited with her about incidents regarding a nurse. The email documented Resident #7 told her how the same nurse, RN #4, had held her medications until she said please and thank you. RN #1 documented after talking with another nurse that day the incident was not reported to the Social Worker like she had thought. (continued on next page)

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	135133	A. Building B. Wing	08/05/2021

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Social Worker on 8/4/21 at 3:11 PM. The Social Worker stated he reviewed and investigated grievances and he was the abuse investigation coordinator. He stated while he had the title of coordinator allegations were discussed as a group with him, the Administrator, and the DNS. The Social Worker stated while investigating a different allegation of abuse for another resident he learned of the incident between Resident #7 and RN #4. The Social Worker stated after talking to Resident #7, he determined the incident was not reportable therefore, it was not reported (to the State Survey Agency), and no investigation was conducted. The facility failed to conduct an investigation for alleged abuse and failed to ensure Resident #7 and other residents were protected from abuse by RN #4. b. Resident #4 was readmitted to the facility on [DATE], with diagnoses which included throat cancer, atrial fibrillation (an irregular and often fast heart rate), high blood pressure, and benign prostatic hyperplasia (an enlarged prostate gland, which can obstruct the outflow of urine). An admission MDS assessment, dated 6/29/21, documented Resident #4 had moderate cognitive impairment. The facility entered a report of an allegation of abuse on 7/19/21 at 12:15 PM, to the State Survey Agency's Long-Term Care Reporting Portal. The report documented the incident occurred on 7/18/21 at 2:00 PM, and Resident #4 reported RN #4 was belittling and short with him during cares. The report in the portal documented the staff was removed from the facility pending an investigation. An investigation report completed by the Social Worker, undated, submitted to the State Survey Agency's Long-Term Care Reporting Portal documented Resident #4 made a report on 7/18/21 at 2:00 PM stating He and his nurse [RN #4] had a disagreement with the way he takes his medications and felt the nurse to be rather short with him and made him feel stupid during cares. The investigation documented in the conclusion section that Both residents were found to be alert and oriented and to have given a nearly identical account of the exchange during this med [medication] pass. Both have noted RN [RN #4] to be very nice the following day though her actions at the time were found to be sharp, belittling and inappropriate for her profession. There was no documentation in the investigation report Resident #4 and other residents were protected from further abuse by RN #4. During an interview on 8/4/21 at 4:40 PM, the Administrator, with the DNS present, stated the report did not include information whether the allegation was substantiated or unsubstantiated. Daily Staff Assignment sheets, dated 7/13/21 to 8/4/21, documented RN #4 worked 8 hours on 7/18/21 from 6:00 AM to 2:30 PM and worked 6 hours on 7/19/21. RN #4 completed a full shift on 7/18/21, the day Resident #4 alleged abuse and 6 hours the day following the allegation of abuse. When asked about the corrective action the facility took, during an interview on 8/4/21 beginning at 4:40 PM, the Administrator, with the DNS present, stated the report did not include that information, but RN #4 had been put on suspension while an investigation was conducted when he found out about the allegation of abuse by Resident #4. He stated she was normally off on Tuesdays and Wednesdays, which were the next subsequent days, and she returned to work on 7/29/21. (continued on next page)

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	135133	A. Building B. Wing	08/05/2021

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #3 was readmitted to the facility on [DATE], with diagnoses which included heart failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), chronic obstructive pulmonary disease (progressive lung disease characterized by increasing breathlessness), high blood pressure, and depression. A quarterly MDS assessment, dated 7/20/21, documented Resident #3 had mild cognitive impairment and required extensive assistance from staff with toileting. An investigation report, undated, documented Resident #3 reported a nurse refused to provide a service for him and when he asked the nurse to get someone else who could the nurse left his room. The report documented Resident #3 then stated a different nurse came into his room and was verbally abusive. The report documented Resident #3 also stated the nurse had his face in his and was cursing at him about giving a hard time to his nursing staff and then left the room. The investigation report documented the alleged abuse occurred on 7/17/21 at 3:00 PM and was reported the State Survey Agency on 7/19/21, 2 days after the occurrence. The investigation report included the following interviews: - An interview, dated 7/20/21, documented RN #3 stated around 3:00 PM on 7/17/21 she went to assist Resident #3 in his room. She stated he needed a urinal to urinate and she handed one to him and instructed him to push the call light when he was done. RN #3 stated later CNA #2 informed her Resident #3 had accused RN #3 of throwing the urinal at him. RN #3 stated she notified the other nurses on shift of the accusation, including LPN #1, and stated she told them it needed to be reported. RN #3 then stated LPN #1 went into Resident #3's room to talk to him and when he came back LPN #1 told RN #3 it sounded like Resident #3 was upset. - An interview, dated 7/21/21, documented LPN #1 stated he was told, by CNA #2, RN #3 was accused of throwing a urinal at Resident #3 and then leaving the room. LPN #1 then stated RN #3 told him she handed the urinal to Resident #3, assisted with his incontinence briefs, and told him to use the call light when he was done. LPN #1 stated he went to talk with Resident #3 and asked what happened. LPN #1 stated Resident #3 was still upset when he left the room and he did not report the incident because Resident #3 told him it didn't matter since nothing would happen anyway. - An interview, dated 7/21/21, documented CNA #2 was taking Resident #3 outside for a smoke break when he told her RN #3 had tossed his urinal at him. CNA #2 stated Resident #3 told her that a male nurse had come to his room and asked about the incident and got into his face. CNA #2 stated she was already aware of the incident and it was reported to several nurses. The investigation report documented in the conclusion section Resident #3 had provided multiple accounts regarding what happened on 7/17/21 and the staff involved, RN #3 and LPN #1, denied throwing the urinal at Resident #3 and shouting at him. The report document there did not appear to be any evidence of the alleged abuse. (continued on next page)

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	135133	A. Building B. Wing	08/05/2021

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Idaho State Veterans Home - Lewiston	821 21st Avenue Lewiston, ID 83501

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/4/21 beginning at 9:56 AM, RN #3 was asked about an incident with Resident #3 on 7/17/21. RN #3 stated Resident #3 had accused her of throwing a urinal at him and she found out when CNA #2 had told her. RN #3 stated she told the other nurses on shift about the allegation and LPN #1 went to Resident #3's room to investigate what happened. She stated when LPN #1 came back he stated Resident #3's story had changed and told RN #3 to work a different hall for the remainder of the shift. RN #3 stated the decision was made for her to stay because they were short staffed. She stated she was not scheduled to work the following day. RN #3 stated two days later during a care conference Resident #3 made the accusation and LPN #1 was placed on Administrative Leave. Daily Staff Assignment sheets, dated 7/13/21 to 8/4/21, documented LPN #1 worked 8 hours on 7/17/21, 7/18/21, and 7/19/21 from 2:00 PM to 10:30 PM. RN #3 worked 8 hours on 7/17/21 from 2:00 PM to 10:30 PM. There was no documentation in the investigation report Resident #3 and other residents were protected from further abuse by LPN #1 and RN #3. During an interview on 8/4/21 beginning at 3:11 PM, the Social Worker was asked about the investigation report for Resident #3. The Social Worker confirmed the alleged abuse had taken place on 7/17/21 and he was not made aware of the incident until 7/19/21 when during a scheduled care conference Resident #3 told him what happened. During an interview on 8/4/21 beginning at 4:40 PM, the Administrator, with the DNS present stated LPN #1 was placed on Administrative Leave beginning on 7/20/21 and returned on 7/23/21. The Administrator confirmed he was not placed on leave the day the allegation occurred because he was not aware of it at that time. The Administrator stated RN #3 was not placed on Administrative Leave. The facility failed to immediately protect residents from abuse and failed to conduct thorough investigations of allegations of abuse.