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	01/26/2018

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39184 Based on record review and interview, it was determined the facility failed to complete a comprehensive assessment when a resident experienced a significant change in their health and functional status. This was true for 1 of 14 sample residents (#26) and had the potential for harm if facility staff did not recognize changes in the resident's health status and needs. Findings include: Resident #26 was admitted on [DATE] with multiple diagnoses including malignant neoplasm (cancer) of the pancreas, prostate, and colon. Resident #26's 11/22/17 Admission MDS Assessment documented the following: * Cognitively intact. * No behaviors indicating an acute change in mental status. * There were no verbal behavioral symptoms towards others. * Did not reject care. * Did not exhibit wandering. * The resident required supervision-oversight, encouragement or cueing when walking in his room, extensive assistance with bed mobility, one person physical assistance with transfers, supervision when walking in his room, and one person physical assistance with locomotion. * Always continent of bowel. * There were no falls in the last 1-6 months prior to admission or since admission. Resident #26's Nursing Note, dated 11/16/17 at 1:52 PM, documented he appeared alert and oriented times 4. A Physician Note, dated 11/22/17, documented no anxiety, no depression, no memory loss. Resident #26's Nursing Notes documented the following: (continued on next page)

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* On 12/6/17 at 3:21 PM, Resident #26 fell in his room and sustained two skin tears on his left arm. * On 12/27/17 at 10:50 AM, new orders were received to increase the Fentanyl patch to 25 mcg and morphine sulfate 5 mg every 4 hours as needed for breakthrough pain. * On 1/6/18 at 1:57 PM, Resident #26 was in a very grumpy mood and refused to let me help him at all . refused to let me change his dressing on his forehead too. *On 1/8/18 at 3:16 AM, Resident #26's day and night seems up side down. The resident used his call light to ask for the time and where his medications were, then came out of his room to ask for the time. Resident #26's Incident Note, dated 1/9/18 at 9:39 PM, documented he was found on the floor in his room. A Restorative Progress Note, dated 1/10/18 at 12:17 PM, documented a transfer bar was placed on the right side of his bed to assist with turning, repositioning, and safe transfer. A Behavior Progress Note, dated 1/15/18 at 5:38 AM, documented Resident #26 seemed restless for the past three nights, coming to the nurse's station to ask the time then traveling back and forth between the nurse's station and his room. Once [in] a while he would talked to staffs [sic] in a[n] angry tone and loud voice. A Nursing Note, dated 1/22/18 at 5:48 PM, documented a Wanderguard (alarm) was placed due to the Resident #26 propelling himself outside the building. Resident #26's clinical record documented he had additional falls on 1/23 and 1/25/18. *Nursing Note, dated 1/24/18 at 10:58 PM, documented Lorazepam (an anti-anxiety medication) 0.5 mg one-half tablet every 4 hours as needed for anxiety related to end of life, anxiety, air hunger, or restlessness. On 1/25/18 at 10:08 AM, the DON said it was noticed the resident exhibited changes starting on 1/5/18, such as his behavior and wandering, anxiety and restlessness. The DON said they had been looking at doing a change in condition assessment all week and discussed doing the assessment on that day. On 1/25/18 at 12:59 PM, the MDS nurse said the care plan was updated on that day due to the resident's fall earlier in the day. The MDS nurse said the change in condition assessment was mentioned in the morning on that day, they were going to do the assessment the next day anyway, and the resident had a few changes but not as extensive as I would expect. Resident #26's admission MDS documented he did not have cognitive deficits, did not have behaviors or wandering, did not have bowel incontinence, and had no falls in the previous 1-6 months prior to admission. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Beginning on 12/27/17, Resident #26 began to demonstrate significant changes in mood, sleep patterns, behavioral symptoms, bowel continence and experiencing falls. The facility failed to recognize a major decline in Resident #26's physical and mental condition.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37888 Based on record review and staff interview, it was determined the facility failed to develop and implement a baseline care plan within 48 hours of admission for 1 of 3 residents (#43) sampled for accurate and person-centered care plans. This created the potential for harm when the care plan failed to provide direction for care. Findings include: Resident #43 was admitted to the facility on [DATE] with diagnoses that included Adult Failure to thrive, Diabetes Mellitus Type 2, and dementia. A hospital Patient Discharge Report, dated 12/13/17, documented open skin measuring 1.0 cm by 1.0 cm to the left posterior hip with Mepilex placed and red/excoriated skin to the buttocks and scattered bruising and abrasions on the arms, legs, hands, and feet. The Admission Nursing Assessment, dated 12/13/17, documented a scar to the right lower leg and to the side of right foot as the only skin impairments. A Progress note, dated 12/13/17, documented Resident #43's feet were very dry with layers of skin present between toes and very long, thick toe nails. The baseline care plan, dated 12/13/17. documented preventative care for skin integrity. The assessment area for staff to document pressure ulcer, stages, and locations was blank. On 1/25/18 at 9:00 AM, the Director of Nursing stated she saw the skin impairment was not documented on the nursing assessment the day after admission.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39184 Based on observation, record review, and staff interviews, the facility failed to ensure: * Neurological assessments were completed appropriately after resident falls. * Narcotic Card Count sheets were consistently signed by both the offgoing and oncoming nurse. * The quantity of remaining narcotic medication cards was consistently documented. This was true for 3 of 3 sampled residents (#26, #50, and #205) reviewed for accidents and 2 of 2 medication carts reviewed for narcotic count sheets. This failure had the potential for harm should residents have undetected changes in neurological status after a fall and had the potential for undetected misuse and/or diversion of controlled medications, and had the potential for harm if a controlled medication was not available when needed. Findings include: The facility's Policy and Procedure for Neurological Assessments, dated 1/2015, documented the following: Residents that have a fall with a suspected head injury such as: bruise, scrap[e], lying in suspected position suggestive of hitting head, or any other condition which warrants neurological checks will have a Neurological Assessment completed. The procedure for neurological assessment was documented as follows: * every 15 minutes times 4 * every 30 minutes times 4 * every 1 hour times 4 * every 4 hours times 4 * every 24 hours times 2 The facility's Policy and Procedure for Controlled Substances, dated 1/2015, documented the following: * Licensed nursing staff were directed to account for all controlled substance inventory. * The oncoming nurse and outgoing nurse were directed to physically count each controlled substance and verify the count with the inventory sheet. 1. Resident #50 was admitted on [DATE] with multiple diagnoses including COPD, chronic atrial fibrillation (irregular heart rhythm), and abdominal aortic aneurysm. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #50's quarterly MDS Assessment, dated 12/26/17, documented moderate cognitive impairment, one person physical assist with transfers, and supervision-oversight when walking in his room or corridor. Resident #50's care plan documented he was at risk for falls and directed staff to provide interventions including the following: a rolling walker, wheelchair, gait belt, non-skid socks, auto-locking wheelchair brakes, extensive assist times 1 with bed mobility, and follow facility fall protocol if a fall should occur. The interventions were initiated on 10/5/17. Resident #50's Incident Report, dated 12/30/17 at 6:30 PM, documented an un-witnessed fall in his room. The CNA reported to [the] LN that [the] resident told her he had a fall in his room and had got himself up [sic]. Resident #50's Incident Note, dated 12/30/17 at 10:03 PM, documented he reported to a CNA that he fell in his room when he got weak and fell to the floor on his left side. The resident was able to get up by himself and denied hitting his head. Resident #50's Secure Conversation Note, dated 12/31/17 at 8:57 PM, documented he fell in his room right after dinner and did not tell a staff member until 8:30 PM. The resident got himself up and no injuries were found. The resident denied hitting his head, and neurological checks were initiated. Resident #50's Neurological Assessment Flowsheet documented sleeping on 12/31/17 at 12:15 AM, 1:15 AM, and 2:15 AM. On 1/25/18 at 4:51 PM, the DON said neuro checks probably should have been done in the areas indicated on the Neurological Assessment Flowsheet. 2. Resident #26 was admitted on [DATE] with multiple diagnoses including malignant neoplasm (cancer) of the pancreas, prostate, and colon. Resident #26's 11/22/17 Admission MDS Assessment documented he was cognitively intact, required extensive assistance with bed mobility, one person physical assistance with transfers, supervision when walking in his room, and one person physical assistance with locomotion. Resident #26's care plan directed staff to follow the facility fall protocol when a fall occurs. The intervention was initiated on 11/17/17. Resident #26's Incident Report, dated 1/5/18 at 6:15 AM, documented he was found on the floor in his room lying on his right side. There was blood on his fingers and the floor and a 3 X 2 (3 by 2) wound on his forehead. The Resident Description documented I was trying to get up. The Incident Report documented the Resident self transfers without regard to safety. He transferred from bed and slipped, hitting his forehead on the bed frame. Resident #26's Incident Note, dated 1/5/18 at 10:11 AM, documented the unwitnessed fall as documented in the Incident Report. Resident #26's Neurological Assessment Flowsheet documented BREAKFAST on 1/5 at 7:00 and 7:15 AM and Sleeping on 1/5 at 9:15 PM and 1/6 at 1:15 AM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #26's Incident Note, dated 1/23/18 at 10:08 PM, documented he was found on the floor next to his bed, sitting on buttocks, and the resident claims he just slid out of bed. The incident note documented a pile of blankets was intertwined with his legs. On 1/23/18 at 10:35 AM, LPN #1 said Resident #26 was found on the floor this morning at 3:30 AM. A bruise was noted on the resident's right knee. On 1/25/18 at 9:46 AM, Resident #26's legs were on the floor and he was on his right side, hanging onto the side rail with his upper body partially on the bed. The resident's right knee was on the floor with the lateral (side) aspect of the knee and lower leg in full contact with the floor. Several staff members assisted the resident back into bed by lifting him off the floor and onto the bed. Resident #26's Nursing Note, dated 1/25/18 at 10:39 AM, documented he was sliding out of bed and was hanging onto the transfer rail . The nursing note documented This LN blocked [the] resident's feet so they would not continue sliding, a gait belt was placed on [the]resident .Staff assist of 4 bucket lifted resident back to a sitting position on the bed .neuro checks will continue from previous fall, 15 minute checks were implemented and staff in serviced. Will continue to monitor [the] resident. Resident #26's Incident Note, dated 1/25/18 at 10:00 AM, documented the fall as in the Nursing Note. A small abrasion was noted to the sacrum (tailbone area). Resident #26's Incident Report, dated 1/25/18 at 10:00 am, documented the un-witnessed fall as in the Nursing Note and Incident Note. The resident recently started Ativan (an anti-anxiety medication) as needed, was trying to get out of bed without assistance, agitated and anxious. Resident #26's Neurological Assessment Flowsheets documented the facility failed to document neuro checks 4 times out of 38 opportunities from 1/5-1/12/18 and 25 out of 57 opportunities from 1/23-1/27/18, as directed by the facility's policy and procedure and the resident's care plan. On 1/25/18 at 4:51 PM, the DON said neuro checks probably should have been done in the areas indicated on the Neurological Assessment Flowsheet. 3. Resident #205 was admitted on [DATE] with multiple diagnoses including cerebrovascular disease (disease of the vessels of the brain), low back pain, generalized osteoarthritis, and lack of coordination. Resident #205's Fall Risk Assessment, dated 1/18/18 at 4:13 PM, documented he had 1-2 falls in the past 3 months and was at moderate risk for falls. Resident #205's care plan, dated 1/19/18, documented he was at risk for falls and directed staff to provide cueing/limited assistance with ambulation, a walker, gait belt, shoes, non-skid socks, wheelchair with auto-locking brakes, and limited assist of 1 with bed mobility. The resident experienced a fall on 1/19/18 at 2:40 PM and fell again on 1/20/18 at 4:55 PM. Staff were directed to check on Resident #205 frequently and complete neurological checks according to facility policy, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #205's Incident Report, dated 1/19/18 at 2:40 PM, documented an un-witnessed fall in his room. The resident's roommate saw him slide to the floor when he attempted to get up and he landed on his bottom. Resident #205 was unable to provide a description of what happened. Resident #205's Medicare A: Skilled Note, dated 1/19/18 at 4:10 PM, documented he required extensive assist of 2 for transfers and he Will try to get up without help. Had a fall on day shift. Pleasantly confused. Resident #205's Incident Report, dated 1/20/18 at 4:20 AM, and Incident Note, dated 1/20/18 at 4:20 AM, documented an un-witnessed fall in the dining room. Resident #205 was found by a CNA sitting on the floor and his left hand was holding onto the rail next to the dining room. The resident said he was trying to go over there as he pointed toward the medication cart. Resident #205's Neurological Assessment Flowsheet documented the following: * in therapy on 1/19 at 2:45 PM and 3:15 PM * Refused on 1/19 at 3:45 PM and 4:15 PM * Dinner on 1/19 at 5:15 PM * Refused on 1/19 at 6:15 PM, 7:15 PM, and 8:15 PM * Breakfast on 1/20 at 7:15 AM, 8:15 AM, and 9:15 AM On 1/25/18 at 4:51 PM, the DON said we know he could move and there was no change because he was eating breakfast. The DON said neuro checks probably should have been done in the areas indicated on the Neurological Assessment Flowsheet. 4. On 1/26/18 at 8:41 AM, the Narcotic Card Count sheet was reviewed for the [NAME] Hall medication cart. The # column (area where the quantity of remaining medication cards should be entered) was blank in 6 out of 76 opportunities. RN #1 said there was no reason why the numbers were not entered. RN #1 said the numbers should be entered in each indicated area and should match the actual count. On 1/26/18 at 9:01 AM, the Narcotic Card Count sheet was reviewed for the East Hall medication cart. The Narcotic Card Count sheet did not document the signatures of both the offgoing and oncoming nurses in 4 of 76 opportunities. The # column was blank in 19 out of 76 opportunities. LPN #2 said there should be two signatures each time and the quantity should be entered in each of the indicated areas. LPN #2 said she was not sure why the information was not entered.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37888 Based on observation, staff interview, resident interview, and record review, it was determined the facility failed to prevent the development and worsening of pressure ulcers, and failed to provide services to promote healing, prevent infection, and prevent new ulcers from developing for 2 of 7 residents (#43 and #107) reviewed for pressure ulcers. This failure resulted in harm to Resident #107 when he developed multiple pressure ulcers which became infected. Resident #43 was also harmed when he developed multiple pressure ulcers. Findings include: 1. Resident #107 was admitted to the facility on [DATE] with multiple diagnoses which included diabetes mellitus, type 2, stroke, chronic kidney disease, and vascular dementia. The medical record indicated he was discharged on [DATE] to the hospital and readmitted to the facility on [DATE]. The Admission Nursing Assessment, dated 10/3/16, documented a stage 1 pressure sore on the coccyx. The pressure ulcer was described as non-blanchable skin with redness, measuring 0.03 cm L(length) x (by) 0.03 cm W(width) x 0.00 cm D (depth). Resident #107's Admission MDS assessment, dated 10/10/16, documented significant cognitive impairment, a stage 1 pressure ulcer (intact skin with non-blanchable redness of a localized area usually over a bony prominence), pressure reducing devices were in place for bed and chair, required extensive assist of two or more staff for bed mobility, transfers, and toileting and did not reject care. The Braden Scale assessment, completed on 10/3/16 placed Resident #107 at risk for pressure ulcers. A Care Plan for wound to right heel, dated 10/4/16, documented the wound would resolve without complication. Interventions directed staff to inform MD of worsening and signs and symptoms of infection. A care plan, dated 10/18/16, documented the Resident was not consistently able to manage pressure relief. The care plan goal, dated 10/18/16 and revised on 1/19/17, and 4/7/17, documented measures will be in place to ensure his skin remains intact and free of breakdown through the review period. Interventions included an air mattress to bed, and directed staff to check inflation every shift and as needed, observe heels daily for redness, purple discoloration, blistering, and bogginess when providing cares, changing clothes, and assisting to bed for naps or the night, complete skin assessments weekly and notify MD of any new areas of concern, observe skin for signs of infection and breakdown, report any areas of open skin, document location, size, treatment of skin injury, and report failure to heal, signs or symptoms of infection to MD, float heels while in bed wheelchair cushion to assist off-loading. An unscheduled MDS assessment, dated 11/21/16, documented Resident #107 had an unstageable wound with slough and/or eschar, no measurements were documented. The location was not documented. Nurse progress notes, dated 1/3/17, documented Resident #107 was seen at the wound clinic that day. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A hospital History and Physical, dated 1/3/17, documented Resident #107 was transferred from the wound clinic to the emergency room for significantly worsening bilateral heel pressure ulcers, in the setting of uncontrolled diabetes. The assessment documented the right foot had a very large right heel blister which appeared ruptured. The left foot also had a very large blister which appeared intact. The redness extended across the top of the foot and up onto the middle aspect of the shin. X-ray of the right foot showed diffuse forefoot and midfoot soft swelling suggestive of edema or cellulitis. An X-ray of the left foot showed similar findings. A hospital Discharge Summary, dated 1/6/17, documented a debridement of the heel ulcers in the operating room was completed on 1/4/17. Resident #107 received antibiotic therapy for cellulitis. The facility's Admission Nursing Assessment, dated 1/6/17, documented the wound to the right heel measured 4.0 cm length x 6.2 cm width x 0.01 cm depth and the wound to the left heel measured 5.2 cm length x 3.0 cm width x 0.1 cm depth. The assessment documented the wounds as other-debridement. The note documented bilateral heels with superficial debridement, skin surrounding macerated soft edges, no drainage noted, applied new dressings per orders. A Care Plan, dated 1/9/17, documented Resident #107 had pressure ulcers to bilateral heels and shearing, pressure to coccyx, gluteal folds r/t decreased sensation, fragile skin, immobility, poor circulation, and incontinence. The goal, dated 1/9/17 and revised on 4/7/17, was for the wounds to show signs of healing over next review. Interventions included staff to assess and document location, size, depth, undermining, color, odor, and presence of necrotic tissue, assess treatment plans for further decline, describe exudate or wound drainage, alert MD for signs of infection: redness, swelling, drainage, warmth at site, or elevated temperature, culture drainage as MD orders, notify of results, float heels while in bed wheelchair cushion to assist off-loading. Each intervention was dated 1/9/17. The care plan did not direct staff to use off-loading heel sage boots for the resident. The quarterly MDS assessment, dated 1/10/17, documented 2 unstageable pressure ulcers not present on prior assessment. The MDS provided measurement of the largest ulcer, which measured 7.0 cm in length, 5. 0 cm wide, and 0.5 cm deep. Physician's order, dated 1/12/17, documented for Resident #107 to wear sage boots at all times for off-loading due to bilateral heel wounds. Resident #107's Weekly Skin/Wound Progress Note (WS,) Wound Care Note (WCN,) and Wound Assessment (WA,) documented pressure ulcers to the right heel, gluteal fold and left heel as follows: -Wound #1-Right Heel: *1/12/17-WS-not documented, *1/19/17-WS-pink with no eschar, no measurements, *1/19/17- WCN-4.0 cm x 5.9 cm x 0.05, wound bed was 76-100% eschar, unstageable, resident is inactive at the skilled nursing facility and was in a wheelchair most of the time and noticed that both of the heels were resting on foot pedals with sage boots on, *1/26/17-WS-pink, very dry and flaky, no measurements, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*2/2/17-WS-yellow drainage with scant amount of bleeding, heel black with macerated edges, spongy, no measurements, *2/9/17-WS-draining a small amount of yellow discharge, resident complained of pain to the right heel during dressing change, no measurements, *2/10/17-WCN-3.6 cm x 5.3 x 0.4 cm, wound bed 76-100% eschar, unstageable, macerated callous and increased light green drainage, culture completed, resident's wife said the resident is not compliant with off-loading the right heel and makes successful attempts to remove the sage boots, physical therapy to evaluate wheelchair for positioning to maximize off-loading of heels. A wheelchair evaluation was completed on 3/28/17, *2/17/17-WCN-3.6 cm x 5.9 cm x 0.3 cm, culture results showed multiple bacteria, dry, black adherent eschar over the calcaneal tuberosity (bone near the heel.) *2/21/17-WS-slightly larger than a silver dollar, gray in center, pink around the center with yellow/white along the edges, a small amount of drainage noted, no odor or bleeding, *2/28/17-WS-slightly larger than a silver dollar with yellow and spongy pink tissue surrounding, old dressing shows small amount of yellow discharge, no measurements, *3/3/17-WCN-3.0 cm x 3.0 cm x 0.1 cm, a large amount of serosanguineous, (yellowish fluid with small amounts of blood,) strong odor, removed devitalized tissue, biofilm, and slough, *3/7/17-WS-wound bed yellow and spongy with pink skin surrounding, no eschar, *3/7/17-WA-3.0 cm x 2.0 cm x 0.01 cm, wound bed pink with yellow, spongy tissue, small amount of drainage, no odor, no tunneling or undermining, surrounding skin normal color for resident, wound edges irregular and smooth, improved since last dressing change, *3/14/17-WS-wound bed yellow/pink, firm, *3/14/17-WA-3.0 cm x 2.5 cm x 0.0cm, wound bed yellow and firm with smooth pink tissue surrounding, no odor, no tunneling or undermining, small amount of yellow drainage, *3/17/17-WCN-2.7 cm x 2.2 cm x 0.1 cm, debrided devitalized tissue, biofilm, and slough, *3/21/17-WS-slightly yellow with pink, granulated wound bed, *3/28/17-WS-dressing clean, dry and intact, no measurements, *3/30/17-WCN-resident was in a new wheelchair with right padding along pressure points, 2.3 cm x 1.4 cm x 0.1 cm, removed devitalized tissue, biofilm, and slough, unstageable, *4/2/17-WA-2.0 cm x 1.5 cm x 0.1 cm, minimal yellow drainage with a foul smell, resident complained of some pain, surrounding skin is pink and improving, *4/4/17-WS-dressing changed and dry and intact, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*4/9/17-WA-stage 2 pressure ulcer, 2.0 cm x 1.5 cm x 0.1 cm, wound appears to be healing, some yellow drainage with a foul smell, resident complained of some pain, surrounding skin is pink. *4/11/17-WS- dressing changed and dry and intact, *4/11/17-WCN-2.0 cm x 0.9 x cm x 0.1 cm, stage 3 pressure injury, *4/17/17-WA-stage 2 pressure ulcer, 4.0 cm x 1.5 cm x 0.2 cm, purulent scant drainage with moderate odor, pink/beefy surroundings, *4/18/17-WS- dressing changed and dry and intact, *4/20/17-vascular stage 2 wound, 4.0 cm x 1.4 cm x 0.2 cm, small amount of yellow drainage, pink/beefy surroundings with scant bleeding. -Wound #2, #4, & #5-Gluteal Fold: *1/12/17-WS-reddish/purple to bilateral buttocks, the skin to coccyx was blanchable, raw/pink skin, *1/19/17-WS-blanchable to the coccyx, *1/26/17-WS-blanchable to the coccyx, *2/9/17-WS-blanchable to the coccyx, excoriation to bilateral buttocks, *2/21/17-WS-blanchable to the coccyx, excoriation to bilateral buttocks improving, *2/28/17-WS-blanchable to the coccyx, *3/7/17-WS-blanchable to the coccyx, *3/14/17-WS-blanchable to the coccyx, excoriation to bilateral buttocks continued, no open areas, *3/21/17-WS-blanchable to the coccyx, excoriation to buttocks almost resolved, open area to right gluteal fold, bleeding a small amount, no measurements, *3/27/17-WA-shearing impairment to the right gluteal fold, 3.8 cm x 4.0 cm x 0.1 cm, superficial shearing with rough edges with greenish, yellow, color, pink wound bed with surrounding wound red, very tender to the touch. *4/2/17-WA-right gluteal fold shearing wound, 4.0 cm x 3.8 cm x 0.1 cm, pink with yellow drainage, thin line of black skin. *4/4/17-WS-blanchable to the coccyx, excoriation to the buttocks improving, gluteal fold showed no drainage or bleeding, *4/9/17-WA- shearing wound stage 2, 4.0 cm x 6.0 cm x 0.1 cm. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*4/11/17-WS-excoriation continues to buttocks, blanchable to the coccyx, gluteal fold grayish color, no bleeding or drainage, *4/11/17-WCN-wound #4-a new unstageable wound to the left ischial, 7.0 cm x 4.8 cm x 0.05 cm, obscured full-thickness, wound #5-a new stage 2 pressure sacral ulcer, 2.3 cm x 0.4 cm x 0.05 cm, with eschar, a new patch of dull gray skin (pressure necrosis) under left buttock skin fold, *4/17/17-WA-right gluteal fold shearing wound, 5.5 cm x 5.0 cm x 0.2 cm, unstageable, *4/18/17-WS-excoriate site to coccyx with no open area, brownish/black spongy sore to left gluteal fold with yellow/pink surrounding skin, scant amount of bleeding with a foul odor, *4/20/17-WA-left gluteal fold vascular unstageable wound, 6.0 cm x 5.2 cm x 0.7 cm, thick gray eschar, very foul odor, moderate yellow drainage with scant bleeding, wound bed tunneling 2 cm toward 1 o'clock position, surrounding skin reddened, wound condition deteriorating since last treatment. -Wound #3-Left Heel: *1/12/17-WS-heel raw/pink, *1/19/17-WS-pink, no eschar, *1/19/17-WCN-unstageable pressure injury with obscured full-thickness skin and tissue loss, 1 cm x 0.9 cm x 0.05 cm, wound bed is 76-100% epithelialization, *1/26/17-WS-pink, no measurements, *2/2/17-WS-pink and intact, no measurements, *2/9/17-WS-pink and intact, no measurements, *2/10/17-WCN-resolved. -Wound #6-Left Lateral Abdomen: *3/14/17-WS-not documented, *3/17/17-WCN-stage 2 pressure ulcer to the left lateral abdomen, 2.1 cm x 2.0 cm x 0.05 cm, small amount of sero-sanguineous drainage, Resident #107 was in a new larger wheelchair, order to place a pillow under arm to alleviate pressure and for physical therapy to evaluate, *3/21/17-WS-shearing site to left abdomen is improving, the wound bed is pink/yellow, *3/28/17-WS-shearing to left side continues to improve with treatment, *3/30/17-WCN-1 cm x 0.9 cm x 0.05 cm, small amount of sanguineous drainage, no odor, wound bed 76-100% slough, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*4/4/17-WS-scabbed site to left side abdomen improving, *4/11/17-WS-scabbed site to left side abdomen improving, *4/18/17-WS- scabbed site to left side abdomen. A progress note dated 4/22/17, documented Resident #107 was transferred to the hospital via ambulance and admitted to the hospital with a diagnosis of sepsis. On 1/26/18 at 7:45 AM, RN #2 (Senior RN) stated she would expect family and MD to be notified immediately when changes in wounds were observed and for notification be documented in the progress notes under nursing. RN #2 said that with any change of condition, the MD would be notified and staff would follow direction from the MD. On 1/26/18 at 8:15 and 10:40 AM, the DON stated she or RN #2 were to be notified regarding wounds. The wounds should show up on weekly skin checks and hopefully would show up in the clinical notes, or they would call you or show the DON. The DON stated the MD rounded every 60 days on the residents in the facility and said the MD seldom looked at the wounds. The DON stated the MD was responsible for the management of all care and the wound clinic MD would make recommendations. The DON stated the interventions were put in place, but could not force the resident to keep the sage boots on. The DON stated the resident was repositioned and turned, if we could, even on an air bed. She said there were only a few notes which documented the resident refused or resisted cares. The DON said there was inconsistent monitoring of the wounds and there was inconsistency regarding staging, sizing and characterizing the wounds. She said she was not sure why there was a delay regarding the wheelchair evaluation. The DON said she was not aware Resident #107 had a pressure to the left heel. The DON stated Resident #107 did not come back to the facility. I think he passed away. He was a very sick man. 2. Resident # 43 was admitted to the facility on [DATE] with diagnoses that included adult failure to thrive and type 2 diabetes mellitus, HTN, COPD, Dementia, and depression. The Admission Nursing Assessment, dated 12/13/17, documented Resident #43 had scars to the right leg and foot, and extremely dry skin to feet and toes. The hospital Discharge Report, dated 12/13/17, documented Resident #43 had excoriation to the buttocks and an open area to the left posterior hip. The baseline care plan, dated 12/13/17, documented preventative care under the skin integrity. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Care Plan, dated 12/14/17 and revised on 1/11/18, documented the Resident was not consistently able to manage pressure relief. The care plan goal, dated 12/14/17 and revised 12/27/17, documented measures will be in place to ensure his skin remains intact and free of breakdown through the review period. Interventions included sage boots to bilateral feet as resident will allow, if Resident #43 refuses, encourage resident feet on heel lift, initiated on 12/22/17 and revised on 12/27/17 and an air mattress initiated on 12/14/17 and revised on 12/22/17. A Care Plan, dated 12/22/17 and revised on 1/11/17, documented shearing to coccyx and vascular wounds to right and left heel. The care plan goal was for Resident #43 to remain comfortable during anticipated declines. Interventions directed staff to turn and reposition every 2 hours and as needed as he will allow. Physician Orders, dated 12/13/17, did not include direction to staff for wound care. The Admission MDS, dated [DATE], Resident #43 had minimal impairment, required extensive assist for bedmobility, dressing, and personal hygiene. The MDS documented Resident #43 had one stage 2 pressure ulcer. A Treatment Administration Record, dated 1/12/18 directed staff to check proper inflation of air mattress every shift. The task was signed each shift from 12/30/17 to 1/12/18. The facility's Weekly Skin and Wound Assessments documented Resident #43 developed 3 wounds. Wound #1 Coccyx: 12/20/17 Pressure/SDTI -a deep purple/red area to the entire coccyx area measured and measured 6.0 x 6.0 cm 1/11/18 Shearing/Stage two- 1.3 x 0.1 x 0.1 cm slight purulent slough. 1/14/18 Vascular- 2.2 x 1.0 x 0.0 cm wound bed yellow/white slough 1/16/18 Vascular- 2.0 x 1.1 x 0.01 cm white center 1/23/18 Vascular-2.0 x 1.1 x 0.01 cm Wound #2 Right heel 1/11/18 Vascular/unstageable 3.0 x 2.0 x .00 cm eschar area black in color. 1/14/18 Vascular/unstageable 3.5 x 2.0 x 0.0 cm Wound black 1/16/18 Vascular/unstageable 3.8 x 3.8 x 0.0 cm dark area with soft black tissue 1/23/18 Vascular/unstageable 2.8 x 2.8 x 0.0 cm dark area surrounding heel with thick hard center Wound #3 Left heel (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	1/11/18 Vascular/unstageable 3.0 x 3.0 x 0.0 cm eschar area black in color. 1/14/18 Vascular/unstageable 4.0 x 3.0 x 0.0 cm wound black 1/16/18 Vascular/unstageable 1.8 x 1.8 x 0.0 cm dark area with hard black tissue 1/23/18 Vascular/unstageable 3.8 x 3.8 x 0.0 cm dark area surrounding heel with thick hard center. A nursing note, dated 1/11/18, documented attempt to contact family regarding Resident #43's declining health. On 1/25/18 at 9:00 AM, the DON stated, it is hard to meet the care plan goal when the resident came in with a wound. When asked about the changes in the types of wounds, i.e. vascular, pressure, SDTI, shearing, etc. , the DON stated the wrong terminology was used. The DON stated the nurses do assessments, treatment, and documentation of the wounds but they do not have certification or training in wound care. When asked where the direction to nursing the airbed settings are checked was, the DON stated, We push down on it, if you feel the frame, or if they are on it, if it is too tight, they are going to roll out. LPN #3 stated to determine the proper airbed setting she put her hand between the bedframe and mattress to see if you feel the resident. The manufacturer's directions for use guided user: to check to see if suitable pressure is selected by sliding one hand between the air mattress and the air/foam base under the resident's buttock. User should be able to feel the space between their hand and the resident's buttocks with the acceptable range being 1-1.5 inches. On 1/26/18 at 8:05 AM, LN #3 stated Resident #43 had pedal pulses and his feet were warm to the touch. No documentation was found in the medical record to indicate Resident #43 had vascular impairment. On 1/26/18 at 10:40AM, RN #2 stated she completed wound rounds and compared weekly wound measurements provided by the nurses. RN #2 stated she did not assess the wounds, complete dressing changes or measurements. The medical record did not reflect referal to the wound clinic. The DON stated Resident #43 had bad skin, we tried turning him, he just wanted to be left alone.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39184 Based on observation, staff interview and record review, the facility failed to ensure adequate supervision of residents to prevent falls. This was true for 2 of 3 sample residents (#26 and #205) reviewed for accidents and who experienced multiple falls after admission to the facility. This failure placed the residents at risk for harm and injury from falling. Findings include: The facility's undated policy and procedure for Falls and Fall Risk Managing documented the following: * Staff were directed to identify appropriate fall risk interventions with input from the attending physician. * The attending physician, in corroboration with the consultant pharmacist and nursing staff, would identify and adjust medications that may be associated with an increased risk of falling, or indicate why those medications could not be tapered or stopped . * If the underlying cause of falling could not be readily identified or corrected, staff were directed to try a variety of interventions until falling decreased or stopped or until the falls were identified as unavoidable. * Staff were directed to monitor and document the resident's response to fall risk interventions. * In the case where the resident continued falling, staff were directed to re-evaluate whether the interventions were appropriate. The attending physician would assist staff as needed in identifying causes of the resident's falls. 1. Resident #26 was admitted on [DATE] with multiple diagnoses including malignant neoplasm (cancer) of the pancreas, prostate, and colon. Resident #26's Fall Risk Assessment, dated 11/16/17 at 2:02 PM, documented he had 1-2 falls in the past 3 months and was at moderate risk for falls. Resident #26's 11/22/17 Admission MDS assessment documented he was cognitively intact , required extensive assistance with bed mobility, one person physical assistance with transfers, supervision when walking in his room, one person physical assistance with locomotion, extensive assistance with dressing, and extensive assistance with toileting and personal hygiene. The MDS assessment documented Resident #26 used a cane or crutch and walker, was occasionally incontinent of urine, and had no falls in the two months prior to admission. Resident #26's care plan documented he had impaired mobility and was at risk for falls. The following interventions were documented on Resident #26's care plan: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Staff were directed to provide extensive assistance with ambulation, bed mobility, and transfers, and offer greater assistance as needed. The interventions were initiated on 11/17/17 and updated on 1/25/18. * Resident #26 used a walker, gait belt, shoes, non-skid socks, and wheelchair. The interventions were initiated on 11/17/17. * Staff were directed to follow the facility fall protocol when a fall occurs. The intervention was initiated on 11/17/17. * Staff were directed to encourage Resident #26 to use the call light to ask for assistance. * Staff were directed to observe and report to the charge nurse any signs or symptoms such as unsteady gait, disorientation, confusion, somnolence (appearing sleepy or lethargic), dehydration, or unstable blood pressure. The intervention was initiated on 11/17/17. * Resident #26's care plan documented he used a transfer bar on the right side of his bed to increase independence with bed mobility. The intervention was initiated on 1/10/18 and updated on 1/11/18. Resident #26's Order Summary Report, active as of 12/1/17, documented a Fentanyl Patch (a narcotic pain medication) 12 mcg to be applied every 3 days. The Fentanyl patch was ordered on 11/17/17. Resident #26's Order Summary Report, active as of 1/1/18, documented Fentanyl Patch 25 mcg to be applied every 3 days. The increased dosage of Fentanyl patch was ordered on 12/27/17. Resident #26's January MAR documented lorazepam (an anti-anxiety medication) 0.5 mg, one-half tablet was administered on 1/24/18 at 7:47 PM. Resident #26's Incident Report, dated 12/6/17 at 2:10 PM and Incident Note, dated 12/6/17 at 3:12 PM, documented a staff member witnessed the resident fall in his room as he walked to the restroom. Resident #26 was using a cane and was wearing non-skid socks as he walked in the room. He reached for the toilet handle and his right leg wasn't working right. When the nurse arrived, the resident was sitting on his bed and two skin tears were discovered on his left arm. Resident #26 said he was trying to reach the handle so he could use the bathroom, he missed the handle and fell . The Incident Note documented current care plan interventions as Ambulate independent or standby assist. New care plan interventions were documented as Ambulate independent or standby, which was identical to the current care plan intervention. Resident #26's Nursing note, dated 12/6/17 at 3:21 PM, documented he fell and sustained two skin tears on his left arm. The skin tears were cleansed with normal saline, steri-stips (adhesive skin closure strips) and a dressing were applied. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #26's Incident Report, dated 1/5/18 at 6:15 AM, and Incident Note, dated 1/5/18 at 10:11 AM, documented he was found on the floor in his room lying on his right side. There was blood on his fingers and the floor and a 3 X 2 (3 by 2) wound on his forehead. The Resident Description documented, I was trying to get up. Range of motion was normal, the resident was transferred to a wheelchair, vital signs were taken and the wound was cleaned and dressed. The Incident Report documented the Resident self transfers without regard to safety. He transferred from bed and slipped, hitting his forehead on the bed frame. The Incident Note documented current care plan interventions as he is able to transfer without without assistance, wear non skid socks. New care plan interventions were documented as to continue with care plan. Resident #26's Incident Report, dated 1/9/18 at 9:00 PM, and Incident Note, dated 1/9/18 at 9:39 PM documented he was found on the floor between the bed and caught under the bedside table. A small skin tear was noted on his left hand and redness was noted on the left side of his head. The Resident Description documented the resident was attempting to transfer from his wheelchair to the couch (known as the bed) and he fell . Resident #26 did not cooperate well with questions or commands and was assisted off the floor into bed. the Incident Report documented a transfer bar would be added to Resident #26's bed, he would be encouraged to use the call light more often, and staff would be educated to assist him to bed before 9:00 PM. The Incident Note documented current care plan interventions included non-skid socks, use wheelchair to transfer, and encourage the resident to call for assistance with transfers. New care plan interventions were to encourage the resident to use his call light. The intervention that directed staff to encourage the resident to use the call light was initiated on 11/17/17, which was prior to the fall. Resident #26's Incident Note, dated 1/23/18 at 10:08 PM documented he was found on the floor next to his bed, sitting on buttocks, and the resident claims he just slid out of bed. The incident note documented a pile of blankets was intertwined with his legs. Current care plan interventions were frequent checks, encouraging use of the call light, offer toileting, and reposition every 2-4 hours. New care plan interventions included continuing the care plan, attempting to toilet the resident more, offering soft music, and having personnel sit with the resident as advised. On 1/23/18 at 10:35 AM, LPN #1 said Resident #26 was found on the floor that morning at 3:30 AM. A bruise was noted on the resident's right knee. On 1/23/18 at 12:15 PM, Resident #26's family member said the resident refused to go to the hospital after a fall earlier this month when he got out of bed without asking for help. On 1/25/18 at 9:46 AM, Resident #26 was partially on the floor in his room, lying on his right side with his legs on the floor and his upper body partially on the bed. Resident #26 was hanging onto the side rail, his right knee was on the floor with the lateral (side) aspect of the knee and lower leg in full contact with the floor. Several staff members assisted the resident back into bed by lifting him off the floor and onto the bed. Resident #26 smelled of fecal material and was found to be incontinent of stool as staff checked and changed his incontinence brief. On 1/25/18 at 9:46 AM, CNA #1 said she walked by and saw Resident #26 sliding out of bed, he smelled of fecal material and was probably trying to get to the bathroom. Per CNA #1, Resident #26 was last taken to toilet at 6:00 AM and toileting was offered every 2 hours. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #26's Nursing Note, dated 1/25/18 at 10:39 AM, documented he was sliding out of bed and was hanging onto the transfer rail . The nursing note documented the LN blocked the resident's feet so they would not continue sliding, a gait belt was placed on the resident, and Staff assist of 4 bucket lifted resident back to a sitting position on the bed .neuro checks will continue from [the] previous fall, 15 minute checks were implemented and staff in serviced. Will continue to monitor [the] resident. Resident #26's Incident Note, dated 1/25/18 at 10:00 AM, documented the fall as in the Nursing Note. A small abrasion was noted to the sacrum (tailbone area). New care plan interventions documented every 15 minute checks. Resident #26's Incident Report, dated 1/25/18 at 10:00 AM, documented the un-witnessed fall as in the Nursing Note and Incident Note. The resident recently started taking Ativan (an anti-anxiety medication) as needed, he was trying to get out of bed without assistance, agitated and anxious. Noted to be incontinent of bowel at [the] time of [the] fall. On 1/25/18 at 10:08 AM, the DON said Resident #26 exhibited changes in status on 1/5/18, such as his anxious/restless behavior and wandering. A Wanderguard was initiated, (a device attached to the resident's wheelchair that triggers an audible alarm if the resident passes a certain point when traveling throughout the building) and the frequency of checking on the resident was increased to every hour. The frequency of checking on the resident was increased to every 15 minutes. The physician was notified of Resident #26's restlessness and an order for Ativan (an anti-anxiety medication) was obtained. The DON said she would expect staff to toilet Resident #26 before meals and at bedtime and offer when he is restless. The DON said that an increase in dosage of Fentanyl patch (a narcotic pain medication) and adding Ativan might make Resident #26 more confused, but maybe he would rest better. The DON said she did not think the increased dose of Fentanyl patch was related to Resident #26 having more falls. Resident #26's Resident Safety Checks documented every 15 minute safety checks were initiated on 1/25/18 at 10:15 AM. Resident #26 was assessed to be at moderate risk for falls on admission and subsequently experienced 5 falls while in the facility. The facility failed to implement changes to the resident's care in a timely manner to prevent additional falls. 2. Resident #205 was admitted on [DATE] with multiple diagnoses including cerebrovascular disease (disease of the vessels of the brain), low back pain, generalized osteoarthritis, and lack of coordination. Resident #205's Fall Risk Assessment, dated 1/18/18 at 4:13 PM, documented he had 1-2 falls in the past 3 months and was at moderate risk for falls. (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	01/26/2018

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #205's care plan, dated 1/19/18, documented he was at risk for falls and directed staff to provide cueing/limited assistance with ambulation, a walker, gait belt, shoes, non-skid socks, wheelchair with auto-locking brakes, and limited assist of 1 with bed mobility. The care plan documented Resident #205 fell on [DATE] at 2:40 PM and fell again on 1/20/18 at 4:55 PM. Staff were directed to check on Resident #205 frequently, complete neurological checks according to facility policy, ensure the resident was wearing proper fitting footwear, ensure that his environment was free from clutter and obstacles, increase the level of supervision when in his room and/or in common areas, and observe for signs and symptoms of acute illness. Resident #205's Incident Report, dated 1/19/18 at 2:40 PM, documented an un-witnessed fall in his room. The resident's roommate saw him slide to the floor when he attempted to get up and he landed on his bottom. Resident #205 was unable to provide a description of what happened. After the fall, Resident #205 was taken to the lobby and was sitting in a recliner. Resident #205's Medicare A: Skilled Note, dated 1/19/18 at 4:10 PM, documented he required extensive assist of 2 for transfers, and he Will try to get up without help. Had a fall on day shift. Pleasantly confused. Resident #205's Nursing Note, dated 1/19/18 at 9:21 PM, documented he was very antsy on evening shift. The resident was trying to get up and walk without assistance, and a few minutes after he took his pills they were found on the floor half dissolved. Resident #205's Incident Report, dated 1/20/18 at 4:20 AM, and Incident Note, dated 1/20/18 at 4:20 AM, documented an un-witnessed fall in the dining room. Resident #205 was found by a CNA sitting on the floor, and his left hand was holding onto the rail next to the dining room. The resident said he was trying to go over there as he pointed toward the medication cart. Resident #205 denied hitting his head. He was assisted from the floor with a Hoyer (mechanical) lift. Other information in the Incident Report documented the resident did not sleep all night. He was moving back and forth in the north dining room .He did rest in the recliner with the CNA next to him for about less than 10 min[utes]. He was incontinent of bowel when found him sitting on the floor. The Incident Note documented Current Care Plan Interventions included stand by assist with transfer. Closer observations. New Care Plan Interventions included continue to do closer observations. On 1/25/18 at 4:51 PM, the DON said Resident #205 was recently moved to the East hall and that he was not the same as when he came in for the initial tour of the facility prior to admission. The DON said the resident fell on the first night in the facility and was moved to this hall closer to the nurse's station. The DON said she did not see from the documentation what was done to prevent the falls. The facility did not provide documentation of increased supervision or other interventions aimed at preventing additional falls.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39184 Based on observation, record review, and resident and staff interviews, it was determined the facility failed to ensure staff changed residents' oxygen humidifiers and cannulas (tubing that delivers oxygen) per physician orders. This was true for 1 of 2 sample residents (#50) reviewed for respiratory care. This failure created the potential for harm from respiratory infections due to the growth of pathogens (organisms that cause illness) in oxygen humidifiers and cannulas. Findings include: The facility's Policy and Procedure for Oxygen Therapy-Respiratory Care, reviewed 1/15, documented Change masks and cannula as needed and in accordance with the facility's equipment changeover schedule. Resident #50 was admitted on [DATE] with multiple diagnoses, including COPD and chronic atrial fibrillation (irregular heart rhythm). Resident #50's quarterly MDS assessment, dated 12/26/17, documented he received oxygen therapy while a resident. Resident #50's Order Summary Report, Active Orders As Of 1/1/18, documented the following: * Oxygen at 2 liters to keep oxygen saturation levels above 90% every evening and night. * Change oxygen tubing on the first and third Tuesday and as needed each month. Resident #50's MAR, dated 1/1-1/31/18, documented oxygen was administered every evening and night shift 1/1/8-1/23/18 and evening shift on 1/24/18. On 1/22/18 at 2:11 PM, Resident #50's oxygen humidifier and cannula were labeled 1/3. The resident said he wore it at night and he did not know when they last changed it. On 1/24/18 at 2:50 PM, the DON said oxygen tubing and water should be changed 2 times per month, every other Tuesday. The DON said Resident #50's oxygen humidifier and cannula was last changed on 1/3/18 and should have been changed on 1/16 by night shift.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39184 Based on observation, record review, and staff interview, the facility failed to remove expired medications from the medication cart and Pyxis (a medication dispensing system). This was true for one of two medication carts reviewed and one random resident (#105), and had the potential to affect any resident who received medication from the Pyxis. This failure created the potential for harm should the residents receive expired medication with decreased efficacy. Findings include: Resident #105 was admitted on [DATE] with multiple diagnoses including malignant neoplasm (cancer) of the liver, lung, and larynx (throat), and COPD. Resident #105's MAR, dated 1/1-1/31/18, documented MOUTHWASH SOLUTION: MIX 10 MLS (milliliters) of each in a cup: viscous lidocaine (a topical anesthetic), Benadryl elixir, Mylanta-Swish and swallow 30 minutes before meals and at HS (bedtime) . The mouthwash solution was documented as given each day on 1/3-1/9/18. On 1/26/18 at 8:30 AM, the [NAME] Hall medication cart contained a bottle of diphenhist (Benadryl elixir). The medication bottle was labeled for Resident #105 with directions consistent on the MAR. The label on the diphenhist bottle documented an expiration date of 12/17 and the bottle was opened on 1/3/18. RN #1 said she would not use that medication bottle and she did not think Resident #105 was getting that medication. RN #1 said the pharmacy checks for expired medications monthly and we check all the time. On 1/26/18 at 9:31 AM, the Pyxis contained a bottle of Polyethylene Glycol (a laxative) that was labeled with an expiration date of 4/16, and a tube of Nystatin cream (a topical anti-fungal) with an expiration date of 2/17. Pharmacy staff said the expired medications should not be used, and they monitor for expired medications randomly and print a report once a week to check expiration dates. Resident #105 received multiple doses of a medication that expired the previous month, and the Pyxis contained two medications that were expired and available to be dispensed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31867 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure food was prepared and served under sanitary conditions when a staff member was observed in the kitchen without facial hair restraints. This affected 14 of 14 sampled residents (#s 3, 8, 9, 14, 16, 26, 28, 32, 38, 43, 50, 53, 155, and 205) and had the potential to affect all residents who dined in the facility. This failure created the potential for contamination of food and exposed residents to potential disease-causing pathogens. Findings include: The 2013 FDA Food Code, Chapter 2, Part 2-4, Hygiene Practices, Hair Restraints, subpart 402.11, Effectiveness, documented, (A) Except as provided in (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food . The facility's Personnel Policy, dated 2015, documented food service personnel were required to wear hairnets. On 1/22/18 at 1:38 PM, the CDM (Certified Dietary Manager) was observed throughout the kitchen, without a facial hair restraint to cover his goatee beard and mustache. On 1/24/18 at 11:45 AM, the CDM was observed throughout the kitchen, without a facial hair restraint to cover his goatee beard and mustache. On 1/24/18 at 12:11 PM, the CDM delivered a covered container of soup to the steam table in the main dining room. The steam table had uncovered food ready to be served, as the CDM reached over the uncovered food and placed the container in the steam table. His facial hair was unrestrained and was directly over the uncovered food. On 1/24/18 at 1:45 PM, the CDM was in the kitchen without a facial hair restraint to cover his goatee beard and mustache. The CDM said anyone coming into the kitchen should wear a hair restraint and said his beard and mustache were fine, because he kept the facial hair short. He said he required those with a longer beard or mustache to either wear a facial restraint or to shave. He said he leaned over the steam table to deliver the hot soup and did not deliver the soup on the side with the sneeze guard, because he did not want to potentially burn staff who were standing near that side of the steam table. On 1/24/18 at 2:10 PM, the CDM said he had reviewed the regulations and said he should have been covering his facial hair while in the kitchen.