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	04/26/2019

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on staff interview, record review, policy review, grievance log review, and review of Incident and Accident reports, it was determined the facility failed to ensure its policies were implemented to protect residents from potential physical abuse. This was true for 1 of 15 residents (Resident #3) reviewed for abuse. This deficient practice placed Resident #3, and the other 56 residents residing in the facility, at risk for physical and/or psychosocial harm. Findings include: The facility's Abuse Prevention Program Policy, revised 10/2016, documented the facility was committed to protecting their residents from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion by anyone. The facility had a zero tolerance policy for resident mistreatment, neglect, abuse, or misappropriation of resident property. The policy documented physical abuse included hitting, slapping, pinching, kicking etc. The facility's Abuse Prevention Program Policy documented the individual conducting the investigation should at a minimum: *Interview the person(s) reporting the incident. *Interview any witnesses to the incident. *Interview the resident (as medically appropriate). *Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. *Interview the resident's roommate, family members, and visitors. *Interview other residents to whom the accused employee provides care or services. *Review all events leading up to the alleged incident. *Employee(s) accused of resident abuse were to be removed from the facility and could not work until the investigation was completed. This policy was not followed. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including dementia with behavioral disturbance, depression, and obstructive uropathy (difficulty urinating). A quarterly MDS assessment, dated 4/16/19, documented Resident #3 had severe cognitive impairment, required the assistance of one or two staff members for his ADLs, and he had an indwelling catheter. An Incident and Accident (I&A) report, dated 9/18/18 at 1:30 AM, documented Resident #3 had an unwitnessed fall with no injury. The I&A report documented Resident #3 was found kneeling on the floor with both hands resting on his bed. Resident #3 was not wearing his non-skid socks and said Help, help, help me up. On 4/25/19 at 4:21 PM, the DON said CNA #3 told her RN #1 slapped Resident #3's ears and CNA #3 was concerned about Resident #3's safety in the facility. The DON said she clarified to CNA #3 the difference between the words slapping the ears and cupping the ears. The DON said she explained and demonstrated to CNA #3 the difference between cupping the ears and slapping the ears. The DON said Resident #3 was hard of hearing and it could be RN #1 was trying to get his attention because he was not wearing his hearing aid the night he fell . The DON said she interviewed RN #1, and RN #1 told her she put her hands on Resident #3's ears to get his attention. The DON said she was not sure if she kept the written report from CNA #3. On 4/25/19 at 4:46 PM, LSW #2 who was the Abuse Coordinator, said there was no investigation done into the alleged abuse because the DON clarified to CNA #3 the difference between the words slapping and cupping. LSW #2 said RN #1 did not slap Resident #3's ears, instead RN #1 cupped her hands against Resident #3' ears to get his attention. LSW #2 said there was no abuse to Resident #3, it was instead a misuse of words. On 4/25/19 at 5:28 PM, during a telephone interview, RN #1 said during her shift on 9/18/18, she heard Resident #3 calling for help and saying, help me, help me. RN #1 said she found Resident #3 kneeling on the floor with his hands resting on his bed. RN #1 said she asked CNA #3 to get the Hoyer lift (a mechanical lift) while she assessed Resident #3 for injury. RN #1 said Resident #3 was still yelling for help even though she was already in his room, and it became louder and louder. RN #1 said she tapped Resident #3's ears to let him know she was already there and trying to help him but Resident #3 kept yelling. RN #1 said she then used her foot to tickle Resident #3's feet to get his attention, but Resident #3 kept yelling for help. On 4/25/19 at 6:00 PM, CNA #3 said on 9/18/18, she heard Resident #3 yell for help and found Resident #3 kneeling on the floor next to his bed. CNA #3 said she called RN #1 for help. CNA #3 said Resident #3 kept on yelling for help even though they were already in his room trying to assist him. CNA #3 said RN #1 stood behind Resident #3 to support him and every time Resident #3 yelled for help RN #1 kicked his feet. CNA #3 said Resident #3's catheter tubing was caught between one of his legs and the floor and when RN #1 pulled him back to a sitting position Resident #3 yelled stop you are hurting me. CNA #3 said she then saw RN #1's hands about 12 inches away from Resident #3's ears and she then slapped his ears. CNA #3 said her command of the English language was not good, so she described it in her report as a clapping sound. CNA #3 said it was really loud and it mimicked the sound of clapping your hands. CNA #3 said she reported the incident to the Unit Manager the following morning and she was asked to provide a written report of the incident. CNA #3 said the DON talked with her and explained to her the difference between cupping of the ears and slapping of the ears. CNA #3 said she described what she saw and heard that night in her written report. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CNA #3 then provided a copy of her written report to the surveyor. CNA #3's unedited written report documented the following: *RN #1 kicked Resident #3 in the feet each time he screamed help me. *RN #1 told Resident #3 to stop screaming as they were there to help him and that he made her headache more and she did not feel well. *When Resident #3 screamed again RN #1 kicked him on his left side between the lower back. *RN #1 pulled back on Resident #3 to get him from a kneeling to a sitting position and Resident #3 said stop it you are hurting me. *Resident #3 screamed for help again and RN #1 slapped both of his ears. Resident #3 told RN #1 to stop because it was hurting him. On 4/26/19 at 9:44 AM, the Administrator, with the DON present, said when the words cupping the ears and slapping the ears were clarified with CNA #3 it should have been documented and included in the incident report. The Administrator said it was unfortunate they could not provide that document. The Administrator said he was not notified of CNA #3's report. The DON said she did not notify the Administrator of the incident because it was concluded there was no abuse to Resident #3. The DON said there was a language barrier between CNA #3 and RN #1. On 4/26/19 at 11:02 AM, during the follow-up interview with the Administrator, DON, RCM, and LSW #2, the surveyor provided a copy of CNA #3's report for review. The DON and the RCM both said this was the first time they had seen the report. LSW #2 said CNA #3's report was not in his Grievance log. LSW #2 said if CNA #3's report was submitted to him it would be in his Grievance log. The DON said when CNA #3 came to her she had a written report on a piece of paper taken from a notebook and she was unable to find it. The Administrator then read CNA #3's report and after reading the report, the surveyor asked the Administrator what he would have done if he had the report earlier. The Administrator said, without a doubt it will be reported to the State portal and an investigation initiated. The facility failed to follow its policies and procedures when it did not retain the written allegation of abuse, conduct a thorough investigation, and protect Resident #3 and the other 56 residents residing in the facility by removing the accused staff member from the facility until the investigation was completed. * Refer to F609 as it relates to the failure of the facility to report allegations of abuse to the administrator and State Survey Agency within 2 hours, as specified in its policy. * Refer to F610 for futher details related to the failure of the facility to thoroughly investigate allegations of abuse, as specified in its policy.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on staff interview, record review, facility policy review, Incident and Accident Report review, Grievance Log review, and State Survey Agency Reportable Incidents Database review, it was determined the facility failed to ensure allegations of abuse were investigated and written allegations of abuse were not altered to minimize the severity of the allegations. This was true for 1 of 15 residents (Resident #3) reviewed for abuse. The health and safety of all residents residing in the facility were placed in immediate jeopardy when a) Resident #3 was at risk of ongoing abuse by facility staff and b) the other 56 residents residing in the facility were at risk of being subjected to abuse without detection and intervention. Findings include: The facility's Abuse Prevention Program Policy, revised 10/2016, documented all reports of resident abuse, neglect, and injuries of unknown origin, were to be investigated. All employees, facility consultants, attending physicians, family members, and visitors were to promptly report any incident or suspected incident of neglect or abuse, including injuries of unknown source, to facility management. The policy documented physical abuse included hitting, slapping, pinching, kicking, etc. The facility's Abuse Prevention Program Policy documented the individual conducting the investigation should at a minimum: *Interview the person(s) reporting the incident. *Interview any witnesses to the incident. *Interview the resident (as medically appropriate). *Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. *Interview the resident's roommate, family members, and visitors. *Interview other residents to whom the accused employee provides care or services. *Review all events leading up to the alleged incident. *Employee(s) accused of resident abuse were to be removed from the facility and could not work until the investigation was completed. This policy was not followed. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including dementia with behavioral disturbance, depression and obstructive uropathy (difficulty urinating). A quarterly MDS assessment, dated 4/16/19, documented Resident #3 had severe cognitive impairment and he required the assistance of one to two staff members for his ADLs, and he had an indwelling catheter. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A care plan, revised 3/25/19, documented Resident #3 was at risk for falls related to impaired balance, confusion, and impulsive behaviors. The care plan interventions included encouraging Resident #3 to wear non-skid socks, keep his pathways clear and free from clutter, keep his room well lit, keep his call light within reach, and to provide him with supportive care. An Incident and Accident (I&A) report, dated 9/18/18 at 1:30 AM, documented Resident #3 had an unwitnessed fall with no injury. The I&A report documented Resident #3 was found kneeling on the floor with both hands resting on his bed. Resident #3 was not wearing his non-skid socks and said Help, help, help me up. On 4/25/19 at 4:05 PM, the Resident Care Manager (RCM) said she remembered a conversation with CNA #3 where she reported RN #1 yelled at Resident #3. The RCM said she did not remember exactly what CNA #3 told her, but she remembered talking to the DON about her conversation with CNA #3. The RCM said she and the DON spoke to Resident #3 and asked him if he felt safe in the facility. RCM said Resident #3 said yes. On 4/25/19 at 4:21 PM, the DON said CNA #3 told her RN #1 slapped Resident #3's ears and CNA #3 was concerned about Resident #3's safety in the facility. The DON said she clarified to CNA #3 the difference between the words slapping the ears and cupping the ears. The DON said she explained and demonstrated to CNA #3 the difference between cupping the ears and slapping the ears. The DON said Resident #3 was hard of hearing and it could be RN #1 was trying to get his attention because he was not wearing his hearing aid the night he fell . The DON said she interviewed RN #1, and RN #1 told her she put her hands on Resident #3's ears to get his attention. The DON said she was not sure if she kept the written report from CNA #3. On 4/25/19 at 4:46 PM, LSW #2 who was the Abuse Coordinator, said there was no investigation done into the alleged abuse because the DON clarified to CNA #3 the difference between the words slapping and cupping. LSW #2 said RN #1 did not slap Resident #3's ears, instead RN #1 cupped her hands against Resident #3' ears to get his attention. LSW #2 said there was no abuse to Resident #3, it was instead a misuse of words. On 4/25/19 at 5:28 PM, during a telephone interview, RN #1 said during her shift on 9/18/18, she heard Resident #3 calling for help and saying, help me, help me. RN #1 said she found Resident #3 kneeling on the floor with his hands resting on his bed. RN #1 said she asked CNA #3 to get the Hoyer lift (a mechanical lift) while she assessed Resident #3 for injury. RN #1 said Resident #3 was still yelling for help even though she was already in his room, and it became louder and louder. RN #1 said she tapped Resident #3's ears to let him know she was already there and trying to help him but Resident #3 kept yelling. RN #1 said she then used her feet to tickle Resident #3's feet to get his attention, but Resident #3 kept yelling for help. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 4/25/19 at 6:00 PM, CNA #3 said on 9/18/18 she heard Resident #3 yell for help and found Resident #3 kneeling on the floor next to his bed. CNA #3 said she called RN #1 for help. CNA #3 said Resident #3 kept on yelling for help even though they were already in his room trying to assist him. CNA #3 said RN #1 stood behind Resident #3 to support him and every time Resident #3 yelled for help RN #1 kicked his feet. CNA #3 said Resident #3's catheter tubing was caught between one of his legs and the floor and when RN #1 pulled him back to a sitting position Resident #3 yelled stop you are hurting me. CNA #3 said she then saw RN #1's hands about 12 inches away from Resident #3's ears and she then slapped his ears. CNA #3 said her command of the English language was not good, so she described it in her report as a clapping sound. CNA #3 said it was really loud and it mimicked the sound of clapping your hands. CNA #3 said she reported the incident to the Unit Manager the following morning and she was asked to provide a written report of the incident. CNA #3 said the DON talked with her and explained to her the difference between cupping of the ears and slapping of the ears. CNA #3 said she described what she saw and heard that night in her written report. CNA #3 then provided a copy of her written report to the surveyor. The words in the report were changed as follows: * kick was changed to tap * hit him was changed to tap his * lower back was changed to l[ower] flank * slap was changed to [NAME] The changes were not initialed or dated. Unedited, CNA #3's written report documented the following: * RN #1 kicked Resident #3 in the feet each time he screamed help me. * RN #1 told Resident #3 to stop screaming as they were there to help him and that he made her headache more and she did not feel well. * When Resident #3 screamed again RN #1 kicked him on his left side between the lower back. * RN #1 pulled back on Resident #3 to get him from a kneeling to a sitting position and Resident #3 said stop it you are hurting me. * Resident #3 screamed for help again and RN #1 slapped both of his ears. Resident #3 told RN #1 to stop because it was hurting him. On 4/26/19 at 9:44 AM, the Administrator, with the DON present, said when the words cupping the ears and slapping the ears were clarified with CNA #3 it should have been documented and included in the incident report. The Administrator said it was unfortunate they could not provide that document. The Administrator said he was not notified of CNA #3's report. The DON said she did not notify the Administrator of the incident because it was concluded there was no abuse to Resident #3. The DON said there was a language barrier between CNA #3 and RN #1. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 4/26/19 at 11:02 AM, during the follow-up interview with the Administrator, DON, RCM, and LSW #2, the surveyor provided a copy of CNA #3's report for review. The DON and the RCM both said this was the first time they had seen the report. LSW #2 said CNA #3's report was not in his Grievance log. LSW #2 said if CNA #3's report was submitted to him it would be in his Grievance log. The DON said when CNA #3 came to her she had a written report on a piece of paper taken from a notebook and she was unable to find it. The Administrator then read CNA #3's report and after reading the report, the surveyor asked the Administrator what he would have done if he had the report earlier. The Administrator said, without a doubt it will be reported to the State portal and an investigation initiated. The facility failed to investigate the allegation of abuse to Resident #3 and protect him further abuse, as documented in its Abuse Prevention Program Policy. Additionally, the original written allegation of abuse was altered and neither the original or altered written allegation was retained by the facility. On 4/26/19 at 1:10 PM, the Administrator was notified verbally and in writing of the Immediate Jeopardy to residents' health and safety. 37888

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31923 Based on record review, staff interview, and policy review, it was determined the facility failed to ensure residents' care plans were revised as care needs changed. This was true for 1 of 2 residents (#108) reviewed for care plan revision and had the potential for harm if cares and/or services were not provided due to inaccurate information. Findings include: The facility's comfort care policy, dated ,d+[DATE], documented: * Terminal comfort care provides supportive care for residents and their families during the end stage of life by enabling them to participate in interactions of their choice, in a supportive environment, with assistance of compassionate caregivers. * Nursing will coordinate the plan of care and will collaborate closely with other disciplines as necessary including hospice care if ordered by the physician. * The resident care plan will be initiated/updated to define appropriate goals and interventions. Resident #108 was admitted to the facility on [DATE] with multiple diagnoses including Alzheimer's Dementia. A significant change in condition MDS assessment, dated [DATE], documented Resident #108 declined in cognition, ADLs, continence of bowel, and had weight loss. Resident #108's medical record documented the election of comfort care on [DATE]. Resident #108's care plan was last reviewed and updated on [DATE]. The care plan did not reflect the election of comfort care or interventions to meet the needs of Resident #108's end of life care. On [DATE], at 5:30 PM, the MDS Coordinator said it had been her responsibility to update the care plan. She said she had not updated the care plan prior to [DATE], when Resident #108 expired.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37888 Based on observation, resident and staff interview, record review, and policy review, it was determined the facility failed to ensure residents were provided with bathing consistent with their needs. This was true for 1 of 15 (#7) residents reviewed for bathing. This failure created the potential for residents to experience embarrassment, a decreased sense of self-worth, skin impairment and compromised physical and psychosocial well-being. Findings include: The facility's policy for bathing, dated 1/2015, documented the facility will provide quality resident grooming and hygiene to include bathing/showering of residents at a minimum of once weekly and/or resident preference. If a resident is unable or unwilling to shower as scheduled, the shower will be referred to the next shift until the shower is completed. Resident #7 was admitted to the facility on [DATE], with multiple diagnoses which included a stroke, impaired balance, and weakness. A quarterly MDS assessment, dated 4/16/19, documented Resident #7 was cognitively intact, did not reject care, and bathing activity did not occur. A quarterly MDS assessment, dated 1/22/19, documented Resident #7 was cognitively intact, did not reject care, and required the physical assistance of one person for bathing. A care plan, dated 5/12/18, documented Resident #7 required extensive assistance with bathing and liked her hair shampooed with showers twice weekly. If Resident #7 refused her shower, the care plan directed staff to reapproach her at a later time. If she refused the second offer, staff were to notify the licensed nurse. On 3/12/19 at 6:29 PM, a nursing note documented Resident #7's HAIR VERY OILY, NEEDS BETTER HYGIENE. Resident #7's January 2019 ADL record documented she received a shower or bath on 1/1/19, 1/8/19, and 1/22/19. The record documented she refused bathing on 1/10/19 and 1/15/19. Resident #7's February 2019 ADL record documented she received a bath on 2/11/19. There were no documented refusals. Resident #7 did not receive a bath or shower for 19 days (1/23/19 through 2/10/19). Resident #7's March 2019 ADL record documented she received a shower or bath on 3/2/19, 3/14/19, and 3/26/19. There were no documented refusals. Resident #7 did not receive a bath or shower for 11 days (3/3/19 through 3/13/19) and another 11 days (3/15/19 through 3/25/19). Resident #7's April 2019 ADL record documented she received a shower or bath on 4/2/19. There were no documented refusals. Resident #7 received 8 out of 32 scheduled showers over 4 months. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/19 at 9:39 AM, Resident #7 was observed in her room, her hair appeared oily and uncombed. She took her hair in her hand and said, I would like to have more showers. Look at how dirty my hair is. Resident #7 stated the last shower she received was 3 weeks ago, on 4/2/19. Resident #7 stated the CNAs offer her showers at 10:00 AM and 3:00 PM but those are not the best times for her. She stated she had refused showers a few times when she did not feel good, but the CNAs did not offer the shower a second time. On 4/24/19 at 10:00 AM, Resident #7 was in her room, sitting on her bed. Her hair was oily. She stated she had not received a shower. On 4/24/19 at 1:49 PM, the DON stated Resident # 7 often refused her showers and the ADL record should have reflected those refusals. The DON was unable to provide documentation Resident #7 was offered a shower on the shift following her refusals. The DON agreed Resident #7 should have had more than 8 showers in 4 months. When the DON was informed Resident #7 said her showers were only offered to her at 10:00 AM or 3:00 PM, the DON stated that maybe she did not like those times. The DON said perhaps Resident #7 should be asked about when she would like to receive showers. On 4/25/19 at 1:05 PM, Resident #7's ADL record documented a shower was provided with staff assistance. Resident #7 did not receive a bath or shower for 22 days (4/2/19 through 4/24/19).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31923 Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure professional standards of care were followed for 2 of 2 residents (#38 and #57) reviewed for transfers and respiratory care. These failed practices placed residents at risk of falls and adverse effects from inhaled medications. Findings include: 1. Resident #38 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including congestive heart failure (progressive lung diseases characterized by increasing breathlessness) and diabetes. An admission MDS assessment, dated 3/16/19, documented Resident #38 required extensive assistance from 2 staff for transfers. On 4/24/19, at 2:05 PM, the facility's beautician was observed as she assisted Resident #38 from the stylist chair in the beauty shop to her wheelchair. The beautician pulled a wheelchair in front of Resident #38, leaving very little room between the front of the wheelchair and the resident's knees as she sat in the stylist chair. The beautician placed her right forearm under Resident 38's left armpit and her left hand on Resident #38's left forearm. The beautician began to lift and pull on Resident 38's arm to encourage her to a standing position. Resident #38 stood and grabbed onto the arm of the wheelchair and was able to pivot and sit in the wheelchair. She did not stand erect and required multiple attempts to reach a standing position. The beautician did not use a gait belt and did not use proper and safe transfer techniques while moving Resident #38's into her wheelchair. Resident #38's plan of care documented she required the assistance of 2 people for all transfers. On 4/24/19 at 2:10 PM, the beautician said she was balancing Resident #39 while she transferred to the wheelchair. She said she did not know how to determine if residents were to receive staff assistance for transfers while in the beauty shop. She then asked if she had done something wrong. The beautician said she had assisted other residents into and out of the stylist chair. The beautician stated she had not received training on the transfer of residents. CNA #1 entered the salon to assist with another resident and confirmed Resident #38 required staff assistance with transfers. On 4/24/19, at 2:40 PM, the DON said the facility did not have a method of training people like the beautician regarding transfers of residents, and the facility did not have a policy to address this. 36193 2. The facility's undated policy for Medication Administration and Medication Orders, directed staff to instruct the resident to gargle or rinse their mouth with water and spit after using a steroid metered dose inhaler and to caution the resident not to swallow the water. This policy was not followed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #57 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (progressive lung diseases characterized by increasing breathlessness). On 4/24/19 at 4:15 PM, RN #3 was observed as she gave Symbicort inhaler (combination of steroid and a bronchodilator) to Resident #57. Resident #57 took two puffs of Symbicort and gave it back to RN #3. Resident #57 was not observed rinsing his mouth after taking the puff of Symbicort. On 4/24/19 at 4:54 PM, RN #3 said she should have asked Resident #57 to rinse his mouth with water and spit it out after taking two puffs of Symbicort.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37888 Based on record review, observation, and staff interview, it was determined the facility failed to ensure bed rail consents were in place prior to the use of bed rails. This was true for 3 of 3 residents (#3, #36, and #55) reviewed for bed rail use. This failure created the potential for harm as it prevented the resident and/or resident representative's ability to make informed decisions related to the risk and benefits for bed rails. Findings include: 1. Resident #55 was admitted to the facility on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (a progressive lung disease that restricts breathing) and vascular dementia. An Admission MDS assessment, dated 4/4/19, documented Resident #55 had moderately impaired cognition and required extensive assistance from 2 people for bed mobility and transfers. A bed rail assessment, dated 3/28/19, documented bilateral 1/2 bed rails were utilized to aid Resident #55 with bed mobility. Resident #55's medical record did not include a consent that informed him or his representative of the risks or benefits of bed rail use. On 4/22/19 at 2:00 PM and 4/23/19 at 11:53 AM, a 1/2 bed rail was observed in the up position on the upper right and left side of Resident #55's bed. On 4/25/19 at 3:20 PM, the DON stated the facility did not obtain a consent for the use of bed rails and the risks and benefits were not reviewed with Resident #55 or his representative prior to the use of the bed rails. 36193 2. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including dementia with behavioral disturbance, depression and obstructive uropathy (difficulty urinating). Resident #3's care plan documented he had a transfer bar (a form of bed rail attached to the bed to assist people with bed positioning and transfers) on the left side of his bed to aid him with bed mobility. Resident #3's bed rail assessment, dated 1/17/19, documented bed rails were indicated and served as an enabler to promote independence. Resident #3's medical record did not include a consent that informed him or his representative of the risks and benefits of bed rail use. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/19 at 9:26 AM and on 4/25/19 at 10:30 AM, Resident #3 was in bed and transfer bar was present on the left side of his bed. On 4/25/19 at 2:10 PM, RN #4 said she explained to the residents and their families the risk and benefits of using bed rails. RN #4 said she told the residents and their families bed rails could cause bruising, skin tears, and possible death due to entrapment. RN #4 said she asked for the residents' and their families for verbal consent, but it was not documented. 3. Resident #36 was admitted to the facility on [DATE], with multiple diagnoses including anxiety disorder, altered mental status, and paraplegia (paralysis of the lower half of the body with involvement of both legs). Resident #36's care plan documented he had bilateral 1/4 bed rails to aid him with bed mobility. Resident #36's bed rail, dated 3/12/19, documented bed rails were indicated and served as an enabler to promote independence. Resident #36's medical record did not include a consent that informed him or his representative of the risks and benefits of bed rail use. On 4/23/19 at 11:16 AM, 4/24/19 at 1:44 PM, and 4/25/19 at 9:58 AM, Resident #36 was observed in bed and bed rails were present to both sides of his bed. On 4/25/19 at 2:10 PM, RN #4 said she told the residents and their families bed rails could cause bruising, skin tears, and possible death due to entrapment. RN #4 said she asked for the residents' and their families for verbal consent, but it was not documented.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37888 Based on record review, observation, staff interview, and policy review, it was determined the facility failed to ensure specific target behaviors were identified and monitored for residents receiving psychotropic medications. This was true for 4 of 4 residents (#10, #36, #37, and #53) reviewed for psychotropic medications. This failed practice created the potential for harm should residents receive psychotropic medications that were unnecessary or ineffective. Findings include: The facility's policy for the use of psychotropic medications, dated 1/2015, did not address the monitoring of specific target behaviors. The facility's policy for the mood/behavior review, dated 11/2017, did not address the monitoring of specific target behaviors. The facility's Behavior Monitoring flowsheet provided CNAs with 13 standardized choices to select exhibited behaviors from, which included pushing, biting, and abusive language. Resident behaviors were monitored each shift and if a behavior listed on the monitor was exhibited, the CNA checked that box. The flowsheet did not provide resident-specific behaviors related to depression or anxiety. The Behavior Monitoring flowsheet also offered CNAs the option to select from the following choices: * None of the above observed * Resident not available * Resident refused * Not applicable a. Resident #36 was admitted to the facility on [DATE], with multiple diagnoses including anxiety and depression. A quarterly MDS assessment, dated 3/5/19, documented Resident #36 was cognitively intact and he received anti-anxiety and anti-depressant medication daily. Resident #36's April 2019 physician's orders included the following: *Buspirone HCL (anti-anxiety medication) 10 mg twice a day for anxiety disorder. *Buspirone HCl 5 mg once a day in the morning for anxiety disorder. *Paroxetine HCl (anti-depressant medication) 20 mg once a day in the morning for other recurrent depressive disorders. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #36's care plan documented he had ineffective coping related to depressive disorder and anxiety, and he received anti-depressant and anti-anxiety medications. The care plan directed staff to monitor/record per facility protocol the occurrence of target behaviors including violence/aggression towards staff/others, continual/repetitive yelling/calling out, repetitive voiced anxiety, and worries/fears. Resident #36's Behavior Monitoring flowsheet, dated 3/27/19 to 4/24/19, documented repeats movement one time, yelling and screaming 2 times, none of the above 65 times, and not applicable 21 times out of 89 opportunities. Resident #36's progress notes did not correlate with his Behavior Monitoring flowsheet dated 3/27/19 to 4/24/19. Examples include: - A Nurse's Progress Note, dated 4/3/19 at 9:57 AM, documented Resident #36 had yelled for help and when staff asked him what he needed, Resident #36 said he did not need help. Resident #36 continued to yell for help and said he did not need help whenever the staff approached him. This was not documented in the Behavior Monitoring flowsheet. - A Recreation Assistant Progress Note, dated 4/11/19 at 3:59 PM, documented Resident #36 started calling for help when he arrived in the Activity room. Resident #36 left the Activity room, came back later and called for help again and left the Activity room. Resident #36 went back to the Activity room for the third time and stated, I want to lie down, Help me. Nursing was notified, but Resident #36 went back again into the Activity room and was given ice-cream. Resident #36 said he did not know what he needed and he was escorted out of the Activity room. This was not documented in the Behavior Monitoring flowsheet. On 4/22/19 at 4:15 PM, Resident #36 was heard yelling Help me, help me, help me. When the surveyor entered Resident #36's room and asked what he needed, Resident #36 said he was afraid something might happen to him and he did not know what it was. Resident #36's yelling for help was not documented in the Behavior Monitoring flowsheet or in the Nurse's Progress Notes. b. Resident #10 was admitted to the facility on [DATE], with multiple diagnoses including anxiety disorder. A quarterly MDS assessment, dated 1/29/19, documented Resident #10 was cognitively intact, had no behaviors, and received antidepressant medication daily. A physician's order, dated 10/31/18, directed staff to provide sertraline (anti-depressant medication) 150 mg daily related to anxiety disorder. A care plan, dated 1/10/18, documented Resident #10 had depression and an anxiety disorder. The care plan interventions directed staff to monitor Resident #10 for and record feelings of sadness, loss of pleasure and interest in activities, feelings of worthlessness or guilt, change in appetite/eating habits, change in sleep patterns, diminished ability to concentrate, and change in psychomotor skills. Resident #10's Behavior Monitoring flowsheet, dated 3/27/19 through 4/24/19, documented choices of none of the above observed 73 times and not applicable 15 times out of 88 opportunities. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Resident #37 was admitted to the facility on [DATE], with multiple diagnoses including depression and anxiety. A quarterly MDS assessment, dated 3/5/19, documented Resident #37 had severe cognitive impairment and exhibited wandering behavior 1-3 days out of the last 7 days. A physician's order, dated 2/27/19, directed staff to provide Resident #37 with divalproex (anti-seizure/mood stabilizer) 500 mg 3 times daily for dementia with Lewy Bodies (dementia accompanied by changes in behavior, cognition, and movement). A care plan, dated 1/9/19, documented Resident #37 had dementia with Lewy Bodies and interventions directed staff to monitor and record target behaviors of verbal/physical aggression, threats, and refusing cares and medications. Resident #37's Behavior Monitoring flowsheet, dated 3/27/19 through 4/25/19, documented wandering 1 time, none of the above observed 81 times and not applicable 5 times out of 87 opportunities. d. Resident #53 was admitted to the facility on [DATE], with multiple diagnoses including anxiety disorder, depression, and Post-Traumatic Stress Disorder (PTSD) (a mental disorder that can develop after a person is exposed to a traumatic event). A quarterly MDS assessment, dated 3/26/19, documented Resident #53 was cognitively intact, had verbal behavioral symptoms (threatening, screaming at, cursing at others) directed at others 1-3 days out of the last 7 days, and received an antidepressant daily. A physician's order, dated 3/15/19, directed staff to provide Resident #53 with mirtazapine (anti-depressant medication) 7.5 mg at bedtime daily related to depression. A care plan, dated 3/6/19, documented Resident #53 had depression, anxiety, and PTSD. The care plan interventions did not include specific behaviors for staff to monitor. A quarterly Mood/Behavior Medication Review, dated 3/13/19, documented Resident #53 was monitored for hopelessness, insomnia, verbalizing negative statements, tearfulness, and flashbacks. Resident #53's Behavior Monitoring flowsheet, dated 3/27/19 through 4/24/19, documented none of the above observed 69 times and not applicable 19 times out of 87 opportunities. On 4/24/19 at 10:46 AM, LPN #1 stated he monitored residents' behaviors daily, however, he did not chart them every day. LPN #1 stated residents who started a new psychotropic medication were placed on alert charting for 30 days and those residents were monitored and documented on daily. LPN #1 said after the 30-day alert charting was completed, residents were monitored daily but only documented on if they exhibited a behavior. On 4/24/19 at 2:48 PM, LSW #1 stated CNAs documented resident behaviors on the Behavior Monitoring flowsheet and nurses documented resident behaviors in their nursing notes. LSW #1 stated the Behavior Monitoring flowsheet was not specific for each resident and there were no specific target behaviors monitored for individual residents. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/25/19 at 9:52 AM, LPN #2 stated if a resident exhibited a behavior, she documented it in the resident's progress notes and informed the Social Worker and the physician. She stated she did not chart if there were no behaviors exhibited. On 4/25/19 at 1:59 PM, CNA #2 stated she documented a resident's behavior in their medical record. CNA #2 said if the exhibited behavior was not an offered choice, she wrote a note about the behavior. The facility failed to ensure resident specific behaviors were identified, documented, and monitored. 36193

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 36193 Based on observation and staff interview, it was determined the facility failed to ensure expired medications were removed from the medication cart and not available for administration to residents. This was true for 1 of 2 medication carts. This failed practice created the potential for adverse effects if residents received expired medications with decreased efficacy. Findings include: On 4/25/19 at 11:05 AM, during the inspection of the [NAME] Medication Cart with LPN #2, a medication card containing 14 tablets of Oxycodone 5 mg had two stickers, one on the front and one on the back with different expiration dates. The sticker on the front of the medication card read use by 8/7/18 and the sticker on the back of the medication card read 2/19. LPN #2 said 8/7/18, the date on the front, was the date the medication order was placed. LPN #2 then called the RCM and the RCM said she was told by the pharmacist the date on the back, 2/19, was the expiration date. On 4/25/19 at 11:27 AM, the pharmacist said the 14 tablets of Oxycodone 5 mg were expired and were going to be destroyed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure infection control measures were consistently implemented and followed. This was true for 2 of 15 residents (#34 and #36) observed for infection prevention practices. This failure created the potential for harm by potentially exposing residents to the risk of infection and cross contamination. Findings include: 1. The facility's policy for Handwashing, revised 1/2015, directed staff to wash their hands before and after resident contact, before and after performing any procedure, after sneezing or blowing their nose, after using the toilet, before handling food, and when hands become obviously soiled. The facility's policy for Using Gloves, dated 1/2015, directed staff to wash their hands after removing gloves. These policies were not followed. Resident #36 was admitted to the facility on [DATE], with multiple diagnoses including peripheral vascular disease. On 4/24/19 at 1:47 PM, LPN #1 was observed while performing wound care to wounds on Resident #36's feet. LPN #1 performed hand hygiene, applied clean gloves, and then used scissors to cut the old dressing from Resident #36's right foot. LPN #1 unwrapped the dressing from Resident #36's right foot and then cut the old dressing on Resident #36's left foot and unwrapped the dressing from his left foot. LPN #1 washed Resident #36's right foot with normal saline and applied Silvasorb gel (a medication used to aid wound healing) wearing the same gloves he used to remove Resident #36's old dressings. LPN #1 then removed his gloves and applied new gloves without performing hand hygiene. LPN #2 next applied Aquacel AG (a type of wound dressing) and wrapped Resident #36's right foot with Kerlix (a bandage roll). LPN #1 then washed Resident #36's left foot with normal saline and wrapped it with Kerlix wearing the same gloves. LPN #1 placed the scissors he used to cut the old wound dressings back into a pouch and put the pouch in his pocket without cleaning the dirty scissors. LPN #1 then put away the wound dressing material and placed them back inside a zip lock plastic wearing the same gloves. On 4/24/19 at 2:07 PM, LPN #1 said hand hygiene should be performed in between residents' care and before entering and leaving a resident's room. LPN #1 said he did not perform hand hygiene after removing his gloves when he performed wound care to Resident #36. LPN #1 said he did not clean the scissors before or after using them. On 4/24/19 at 2:17 PM, RCM said hand hygiene should be performed before and after each resident contact and anytime gloves were removed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The facility's policy for Equipment/Supplies Cleaning/Disposal Schedule, revised 1/2015, directed staff to soak and rinse nebulizer tubing and the attachment with water, then set on a paper towel to air dry after each use. This policy was not followed. Resident #34 was admitted to the facility on [DATE], with multiple diagnoses including COPD. A physician's order, dated 9/26/18, included Duoneb (a medication used to treat airway narrowing), inhale orally 4 times a day related to chronic obstructive pulmonary disease (progressive lung diseases characterized by increasing breathlessness). On 4/24/19 at 4:08 PM, RN #3 entered Resident #34's room with a Duoneb vial in her hand. Resident #34's nebulizer cup was connected to the nebulizer mouthpiece and was on top of his bed. RN #3 took the nebulizer cup and poured the Duoneb into it and connected the cup to the nebulizer mouthpiece and gave it to Resident #34. RN #3 then turned on the nebulizer machine and left Resident #34's room. On 4/24/19 at 5:02 PM, RN #3 said Resident #34 preferred to turn off his machine once he was done with his nebulization treatment and leave the nebulizer cup and the nebulizer mouthpiece on top of his bed. RN #3 said Resident #34 had one more nebulization treatment before he went to sleep. RN #3 said the nebulizer cup and nebulizer mouthpiece were cleaned once a day by the night shift staff. On 4/25/19 at 5:00 PM, the RCM said the nebulizer cup and the nebulizer mouthpiece should be washed after each use and placed on top of a paper towel to air dry.