STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135004	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boundary County Nursing Home	6640 Kaniksu Street Bonners Ferry, ID 83805

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents received restorative services as ordered. This was true for 2 of 3 residents (#17 and #18) reviewed for limited range of motion who did not receive restorative services as ordered. It was also determined the facility failed to assess the need for restorative services for 1 of 3 residents (Resident #19) whose records were reviewed for limited range of motion. These failures created the potential for decline in residents' range of motion. Findings include:The facility's Restorative Nursing Program policy, revised 10/19/25 documented, the purpose of the program is to maintain or improve the resident's optimal level of physical, mental, and psychological function.1.Resident #17 was admitted to the facility on [DATE] with diagnoses including ageˆrelated osteoporosis, chronic pain, and a fracture of the left hip joint. A review of the resident's restorative nursing program documented the following restorative interventions: -Range of motion in sitting position: marching in place with 2ˆlb ankle weights, 10 repetitions for 3 sets.-Long arc quad (LAQ) exercises with 2ˆlb weight, 10 repetitions for 3 sets.-Sitˆtoˆstand from chair, 10 repetitions. A review of Resident #17's care plan, initiated 5/22/25 documented, Resident #17 was to receive restorative nursing services 5 times per week. A review of Resident #17's restorative record dated 2/1/26 through 4/26/26, documented the following restorative sessions:-2/1/26 – 2/7/26 3 sessions-2/8/26 – 2/14/26 2 sessions -2/15/26 - 2/21/26 2 sessions-2/22/26 – 2/28/26 3 sessions -3/1/26 – 3/7/26 0 sessions-3/8/26 – 3/14/26 1 session-3/15/26 – 3/21/26 3 sessions-3/22/26 – 3/28/26 3 sessions-3/29/26 – 4/4/26 3 sessions-4/5/26 – 4/11/26 2 sessions-4/12/26 – 4/18/26 1 session-4/19/26 – 4/25/26 2 sessions The review of restorative services documented on several occasions Resident #17 was not offered services as per his plan of care 5 times per week. 2.Resident #18 was admitted to the facility on [DATE] with diagnoses including advanced physical debility, chronic pain, and chronic bilateral hand tremors. A review of Resident #18's restorative nursing program documented the following interventions:-Active range of motion to the left hand: open hand wide (highˆfive) for 5 repetitions.-Active range of motion to the left hand using a squeeze ball for 5 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	repetitions.-Fingerˆtoˆthumb pinches through all fingers for 5 repetitions. A review of Resident #18's care plan, initiated 6/25/25 documented, restorative services were to be provided 5 times weekly, and directed the restorative nurse to review the monthly program and as needed. A review of Resident #18's restorative record dated 2/1/26 through 4/26/26, documented the following restorative sessions:-2/1/26 – 2/7/26 1 session-2/8/26 – 2/14/26 0 sessions-2/15/26 – 2/21/26 0 sessions-2/22/26 – 2/28/26 5 sessions-3/1/26 – 3/7/26 3 sessions-3/8/26 – 3/14/26 2 sessions-3/15/26 – 3/21/26 2 sessions-3/22/26 – 3/28/26 0 sessions-3/29/26 – 4/4/26 4 sessions The review of restorative services documented Resident #18 was not offered services as per her plan of care 5 times weekly. On 4/30/26 at 4:22 PM, the Restorative Nurse stated residents receiving restorative services are scheduled for therapy on Tuesdays, Thursdays, and Saturdays. Upon review of the restorative therapy administration schedules for Residents #17 and #18, the Restorative Nurse confirmed the residents did not receive restorative services as indicated in their plans of care. 3. Resident #19 was admitted to the facility on [DATE] with multiple diagnoses including severe Alzheimer's dementia. On 4/28/26 at 9:57 AM, Resident #19 was observed lying in bed with the left hand closed in a fist. Resident #19's representatives were at the bedside. When asked about Resident #19's left fist, Resident #19's representatives stated the facility staff were notified, and the staff were going to look into occupational therapy for an evaluation of a hand splint. When asked if Resident #19 could open the left hand, Resident #19's representatives stated not really. Resident #19's representatives then opened Resident #19's left hand and placed the leg of a stuffed animal in Resident #19's hand. Resident #19's representatives stated they visited the facility often and would place the stuffed animal in Resident #19's hand to help keep the left hand open. A review of Resident #19's record documented the following Progress Notes: -On 4/13/26 at 1:03 PM, a Nursing Progress Note documented staff noted Resident #19 had been clenching her left hand. The note further documented an assessment was completed by the Restorative Nurse and both hands were noted to be clasped together but was able to open her hands upon request and touch. -On 4/20/26 at 1:03 PM, a Nursing Progress Note documented the Restorative Nurse assessed the left hand of Resident #19 and she was able to open the left hand after the inside of the hand was touched. The Nursing Progress note documented Resident #19 stated ow when opening the hand. Fingernails were noted to be making marks to the skin on the inside of the hand but was able to keep the hand open and was encouraged by the Restorative Nurse to keep the hand open. The Nursing Progress Note further documented the Restorative Nurse would consider a palm protector. On 4/30/26 at 6:21 PM, when asked about the palm protector, the DON confirmed there were no further notes entered regarding the palm protector by the Restorative Nurse. The DON further stated restorative services were discontinued on 4/26/26. A review of Resident #19's record did not show (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation Resident #19 was on restorative services. When asked why restorative services were discontinued, the DON stated she could not find any documentation from the Restorative Nurse. When asked if the physician had been notified of Resident #19's hand pain and clenching, the DON stated the provider was notified in February 2026 but did not see any further communication with the physician.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure residents were comprehensively assessed for a history of trauma, including identification of traumaˆrelated triggers. This was true for 3 of 3 residents (#7, 17, and 18) whose records were reviewed for traumaˆinformed care. This failure created the potential for psychosocial harm related to reˆtraumatization. Findings include:1.Resident #7 was admitted to the facility on [DATE] with multiple diagnoses including anemia, moderate dementia, and chronic pain.A review of Resident #7's care plan documented she had experienced sexual assault during her lifetime and expressed feeling safe in the facility.The care plan did not document the need for an annual trauma evaluation.A review of Resident #7's record identified an Annually/Quarterly Trauma Evaluation form, dated 4/24/26.The form included a section titled Staff Assessment asking whether the resident had exhibited any of the following since the last trauma evaluation:-Change in sleep patterns-Change in appetite/eating patterns-Patterns of behavioral change in response to specific situations-Change in caregiver preference with certain characteristics-New complaints of pain or health problemsThe form also included a section titled Licensed Nurse Determination with the following options:-Resident had changes that may be related to a postˆtraumatic event-Resident does not have changes related to a postˆtraumatic eventA review of Resident #7's evaluation showed the Staff Assessment section was blank, with no documentation completed by a licensed nurse. 2.Resident #17 was admitted to the facility on [DATE] with multiple diagnoses including ageˆrelated osteoporosis, chronic pain, and a fracture of the left hip joint.A review of the resident's care plan documented he reported traumatic events but stated he felt safe in his current environment. The care plan directed licensed nursing staff to complete a personˆcentered trauma evaluation annually, per resident preference.A review of Resident #17's record identified an Annually/Quarterly Trauma Evaluation form, dated 4/28/26.The form included a section titled Staff Assessment asking whether the resident had exhibited any of the following since the last trauma evaluation:-Change in sleep patterns-Change in appetite/eating patterns-Patterns of behavioral change in response to specific situations-Change in caregiver preference with certain characteristics-New complaints of pain or health problemsThe form also included a section titled Licensed Nurse Determination with the following options:-Resident had changes that may be related to a postˆtraumatic event-Resident does not have changes related to a postˆtraumatic eventA review of Resident #17's evaluation showed the Staff Assessment section was blank, with no documentation completed by a licensed nurse. 3. Resident #18 was admitted to the facility on [DATE] with multiple diagnoses including advanced physical debility, chronic pain, and chronic bilateral hand tremors.A review of the resident's care plan, initiated 3/21/23, directed the licensed nurse to complete a PersonˆCentered Trauma Evaluation annually, after a fall, or with a significant change. The care plan also documented that Resident #18 requested not to be evaluated quarterly.A review of Resident #18's record identified an Annually/Quarterly Trauma Evaluation form, dated 1/27/26.The form included a section titled Staff Assessment asking whether the resident had exhibited any of the following since the last trauma evaluation:-Change in sleep patterns-Change in appetite/eating patterns-Patterns of behavioral change in response to specific situations-Change in caregiver preference with certain characteristics-New complaints of pain or health problemsThe form also included a section titled Licensed Nurse Determination with the following options:-Resident had changes that may be related to a postˆtraumatic event-Resident does not have changes related to a postˆtraumatic eventA review of Resident #18's evaluation showed the Staff Assessment section was blank, with no documentation completed by a licensed nurse.On 4/30/26 at 3:55 PM, the ADON stated the trauma evaluations should be completed and confirmed the licensed nurse is responsible for documenting the assessment and determination.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on record review, observation, facility policy, and staff interview, it was determined the facility failed to ensure residents were free from medication error rates greater than 5%. This failure had the potential to affect all residents who receive medications in the facility by increasing the risk of adverse health outcomes. Findings include:The facility's Medication Administration Policy, revised 4/15/26, documented that the following rights of medication administration must be followed to ensure accurate identification of the medication and the resident prior to administration:-Right drug-Right dose-Right time (within one hour of the time ordered)-Right route of administration-Right patient/resident-Verification of accuracy if the resident questions a medicationOn 4/29/26 at 9:24 AM, LPN #1 was observed preparing and administering medications to Resident #3. During the medication preparation process, LPN #1 was asked to verify the following physician orders:-Metamucil capsule: give 1 capsule by mouth daily for constipation-Cranberry supplement: give 2 capsules for cystitis prevention (UTI prevention)On 4/29/26 at 9:29 AM, LPN #1 was unable to identify the correct dosage for the cranberry and Metamucil supplement and stated the order should have been clarified to include the specific dose to administer.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined the facility failed to ensure a food service employee wore a properly positioned hair restraint while preparing and handling resident food, as required by FDA Food Code SS2ˆ501.11 and 2ˆ402.11. This failure had the potential to result in hair contamination of residents' meals who consume food provided by the facility. Findings include:FDA Food Code S2ˆ501.11 requires that food employees 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 prevent hair from contacting exposed food.FDA Food Code S2ˆ402.11 states that consumers are particularly sensitive to food contaminated by hair. Hair can serve as both a direct and indirect vehicle of contamination. Food employees may contaminate their hands when touching their hair. Proper hair restraints prevent dislodged hair from falling into food and may deter employees from touching their hair.On 04/30/26 at 12:12 PM, during a trayˆline observation, Nutritional Aide #1 was observed in the kitchen preparing resident meal trays. Her hair guard was positioned only over the center of her head, leaving her bangs exposed and not fully contained within the hair restraint.During the same observation, Nutritional Aide #1 was asked to assist with preparing mashed potatoes for residents. She was observed leaving her trayˆline station and engaging in food preparation activities while continuing to wear the improperly positioned hair guard, with hair not fully restrained as required.On 04/30/26 at 12:27 PM, the Nutritional Services Director stated she had not noticed that Nutritional Aide #1's hair was not fully contained within the hair guard. She confirmed that the employee's hair should have been completely secured inside the hair restraint in accordance with facility policy and food safety standards.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record review, policy review, and staff interview, it was determined the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) Committee effectively identified, monitored, and corrected ongoing systemic issues related to the Restorative Nursing Program. This failure resulted in continued inability to meet the facility's established benchmark for restorative service (RA) completion and documentation across multiple consecutive quarters from 2024 through 2026. These findings demonstrate the QAPI Committee did not ensure the implementation of effective corrective actions or sustained performance improvement as required. Findings include:The facility's Quality Management Plan revised 1/29/26, documented the Interdisciplinary Quality Program's purpose is to develop and implement a systematic, coordinated, facility-wide approach to providing quality care and sustainability including efforts to pursue opportunities to continually improve patient care services, clinical performance, cost-effective care, and resolve identified areas of concern.The facility's Performance Improvement Plan (PIP), initiated January 2024, documented quarterly QAPI reports repeatedly identified failure to meet the benchmark that 75% of residents on a Restorative Program would have documentation completed per their individualized plan of care.A review of QAPI quarterly reports identified the following:2024: Third and fourth quarter reports documented: Benchmark not met. We will continue this project.2025: Fourth quarter report documented: Only 63% of residents had documentation of receiving RA.Benchmark was not met in the 1st, 2nd, 3rd, and 4th quarters.2026: Quarterly review documented: Completion only 67%, below the 75% benchmark.A review of the PIP from January 2024 through March 2026 documented that despite repeated failure to meet benchmarks, the QAPI Committee continued the same interventions quarter after quarter without implementing new or more effective corrective actions.A review of the PIP showed the same issues were identified in every quarterly report from January 2024 through March 2026, including:-Staff not always charting what they do in the new charting system.-CNAs not always checking the Restorative book for changes.-Charge nurses not proactive with ensuring RA completion daily.-Ongoing time constraints and staffing issues.A review of the PIP revealed no evidence that the QAPI Committee escalated the issue, revised the PIP, or implemented new strategies when benchmarks continued to be unmet.On 5/1/26 at 12:09 PM, the DON stated the plan had been in place for several years and confirmed they audit monthly and review findings with the committee. She also stated that education had recently been provided to all CNA's to assist with meeting resident needs for restorative services.Cross reference F688 and F726.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the State Operations Manual (SOM), record review, and staff interview, it was determined the facility failed to ensure a copy of a resident's advance directive was maintained in the medical record. This was true for 1 of 2 residents (Resident #12) whose records were reviewed for advance directives. This failure created the potential for an adverse outcome if Resident #12 became unable to communicate treatment preferences and those preferences were not available to guide care. Findings include:The State Operations Manual, Appendix PP, defines an Advance Directive as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.The Manual further explains that a Physician Orders for Lifeˆ Sustaining Treatment (POLST) form is a portable medical order designed to communicate a patient's treatment preferences during a medical emergency, based on the patient's current medical condition. The POLST form ensures emergency personnel and clinicians understand the patient's wishes regarding lifeˆ sustaining treatment. A POLST form is not an advance directive.Resident #12 was admitted to the facility on [DATE] with multiple diagnoses including coronary artery disease (CAD- a serious heart condition caused by plaque buildup that narrows arteries and restricts blood flow to the heart), major depressive disorder, and dementia.Resident #12's care plan revised 1/27/26 documented, Resident #12 had one page of a living will and Durable Power of Attorney for Health Care (DPOAHC) in their chart.On 4/29/26 at 2:29 PM, Resident #12's hard copy chart was reviewed for a living will and DPOAHC. One page of an untitled document dated 2/6/25 was located in Resident #12's hard copy chart which documented under Advanced Directive the following:Does the patient have a living will? The box titled yes was checked. If yes, where is the living will located? The line was left blank.Does the patient have a Durable Power of Attorney for Health care? The box titled yes was checked. Name of the person with the power of attorney: The line was left blank.On 4/29/26 at 2:32 PM, when asked about the complete living will and DPOAHC, the DON stated the documentation in Resident #12's chart was all the facility had. The ADON further stated Resident #12's POA refused to bring in a copy of the living will.On 4/29/26 at 2:34 PM, a request was made for documentation of refusals to provide a copy of the living will. No documentation was provided.On 4/29/26 at 2:51 PM, the DON confirmed the facility did not have a copy of Resident #12's advance directives.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to notify the Ombudsman of a resident's discharge. This was true for 1 of 1 residents (Resident # 23) whose record was reviewed for discharge documentation. This failure created the potential for adverse outcomes including the need for an advocate when the Ombudsman was not notified of Resident #23's discharge. Findings include:The State Operations Manual (SOM), Appendix PP, Notice before transfer, revised 7/23/25 documented:Before a facility transfers or discharges a resident, the facility must-Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.Resident #23 was admitted to the facility on [DATE] with multiple diagnoses including Alzheimer's dementia (memory loss and confusion) and epilepsy (seizure disorder).Resident #23's medical record documented Resident #23's spouse elected to take her home for care at home.A review of Resident #23's medical record did not include documentation the Ombudsman was notified of the discharge.On 4/30/26 at 11:11 AM, when asked for documentation of notification to the Ombudsman, the DON confirmed there was no documentation the Ombudsman had been notified of Resident #23's discharge.

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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** Based on record review and staff interview, it was determined the facility failed to ensure the comprehensive, personˆcentered care plan was revised to reflect accurate and current information for 1 of 8 residents (Resident #7) whose record was reviewed for care planning. This failure created the potential for inaccurate care planning and inconsistent implementation of care. Findings include:Resident #7 was admitted to the facility on [DATE] with multiple diagnoses including anemia (when blood doesn't have enough healthy blood cells), moderate dementia, and chronic pain.A review of Resident #7's physician orders documented:-An order dated 12/15/25 directing staff to administer aspirin 81 mg by mouth once daily for CAD.-An order dated 2/5/26 directing staff to administer sertraline (Zoloft-an antidepressant) 50 mg by mouth once daily for depression and chronic pain.A review of Resident #7's comprehensive care plan documented:-A problem statement indicating the resident had a history of anemia and required daily aspirin for antiplatelet therapy, with an initiation date of 5/5/20.-A directive for licensed nursing staff to administer antidepressants for chronic pain, with an initiation date of 7/17/24.On 4/30/26 at 11:45 AM, the MDS nurse stated the care plan should have been revised to reflect that sertraline (Zoloft) is administered for depression and chronic pain. She also stated Resident #7 no longer has an active diagnosis of anemia, and the care plan should have been updated to clarify the current clinical rationale for aspirin therapy.

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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** Based on Observation, record review, policy review, and staff interview, it was determined the facility failed to store the nebulizer mouthpiece appropriately and failed to change CPAP tubing. This was true for 1 of 1 residents (Resident #2) whose CPAP and nebulizer supplies were observed. This failure placed Resident #2 at risk of respiratory infection due to growth of pathogens (Organism that cause illnesses) in the respiratory equipment. Findings include:The Facility's nebulizer policy titled: Administering Medications through a small Volume (Handheld) Nebulizer documented the following:-Disassemble the nebulizer and wash with mild soap and water and rinse well. Place on paper towels or regular towel by the sink to air dry.-When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. a. Resident #2 was admitted to the facility on [DATE] with multiple diagnoses including Obstructive Sleep Apnea (OSA- a serious sleep disorder causing repeated airway collapse and breathing interruptions during sleep) and Chronic Obstructive Pulmonary Disease (COPD- a disease that causes airflow blockage and breathing related problems)A care plan initiated 12/16/25, directed staff to wash tubing and apparatus (mouthpiece) with soap and water after each use, and to let the pieces dry between uses.A physician's progress note dated 4/7/26 documented, Resident #2 was to continue formoterol fumarate (medication used to treat COPD) 20 mcg / 2 mL nebulizer twice daily.On 4/28/26 at 11:56 AM, Resident #2 was observed sleeping in a recliner in the den. Resident #2's nebulizer apparatus (mouthpiece) was observed resting on top of a book without a barrier on the bedside table next to the recliner. On 4/29/26 at 8:42 AM and 5:33 PM, Resident #2's nebulizer apparatus (mouthpiece) was observed in Resident #2's room in pieces on top of the bedside nightstand sitting on a white washcloth / towel.On 4/29/26 at 6:10 PM, RN #1 was asked to explain the facility's nebulizer process after administration of a breathing treatment. RN #1 explained the nebulizer apparatus (mouthpiece) gets washed out and laid out to dry on a towel. When asked how long it takes for the apparatus pieces to dry, RN #1 stated it took about an hour for the nebulizer pieces to dry. When asked where nebulizer pieces are stored, RN #1 stated the pieces are put back together and stored on a towel in the resident's nightstands.RN #1 then accompanied the surveyor to Resident #2's room where nebulizer pieces were observed on a white washcloth / towel on top of the bedside nightstand. RN #1 was observed putting the pieces of the apparatus back together and placed on a towel in Resident #2's bedside nightstand drawer. On 4/29/26 at 6:38 PM, when asked about nebulizer storage, the DON stated nebulizers should be stored in a bag. b. A care plan initiated 12/16/25 documented, Resident #2 used a Continuous Positive Airway Pressure (CPAP) machine related to obstructive sleep apnea. The care plan directed staff to obtain CPAP supplies per Lincare as recommended and to see the supply list in the hard copy chart. The care plan further directed the licensed nurses to check monthly and reorder / replace as needed.On 4/27/26 at 12:57 PM, Resident #2's CPAP machine was observed sitting on the bedside nightstand with the tubing dated in black ink 12/29.On 4/29/26 at 6:10 PM, RN #1 and the surveyor went to Resident #2's room. Resident #2's CPAP machine was observed on top of the bedside nightstand. RN #1 confirmed the CPAP tubing was dated 12/29. When asked how often CPAP tubing is changed, RN #1 stated she thought tubing was changed every 6 months.On 4/29/26 at 6:25 PM, the MDS nurse reviewed Resident #2's care plan and stated CPAP supplies are changed/replaced per Lincare recommendations and recommendations were listed in Resident #2's hard copy chart. The MDS nurse, and RN #1, with the surveyor reviewed Resident #2's hard copy chart which documented CPAP tubing was to be changed/replaced every 3 months. When asked when Resident #2's CPAP tubing should have been changed, RN #1 and the MDS nurse confirmed Resident #2's CPAP tubing should have been changed in March 2026.

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	135004	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boundary County Nursing Home	6640 Kaniksu Street Bonners Ferry, ID 83805

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, it was determined the facility failed to ensure staff with the appropriate competencies directed the care and oversight of the Restorative Nursing Program. This was true for 1 of 1 Restorative Nurse whose personnel record was reviewed for required competencies. This failure placed residents at risk for unmet or undetected restorative needs due to the absence of qualified assessments and oversight. Findings include:The facility's Restorative Nursing Program Policy, revised 10/29/25, documented the Restorative Nurse, Restorative Aide, physical therapist, occupational therapist, speech therapist, and the Director of Nursing are responsible for overseeing the program.The policy further documented that an assessment and evaluation is to be initiated for all residents when a functional decline is noted, and that a nurse or appropriate therapist is responsible for reˆevaluating and initiating or updating the restorative plan of care.1. Resident #19 was admitted to the facility on [DATE] with multiple diagnoses including severe Alzheimer's dementia. On 4/28/26 at 9:57 AM, Resident #19 was observed lying in bed with the left hand closed in a fist. Resident #19's representatives were at the bedside. When asked about Resident #19's left fist, Resident #19's representatives stated the facility staff were notified, and the staff were going to look into occupational therapy for an evaluation of a hand splint. When asked if Resident #19 could open the left hand, Resident #19's representatives stated not really. Resident #19's representatives then opened Resident #19's left hand and placed the leg of a stuffed animal in Resident #19's hand. Resident #19's representatives stated they visited the facility often and would place the stuffed animal in Resident #19's hand to help keep the left hand open. A review of Resident #19's record documented the following: -On 4/13/26 at 1:03 PM, a Nursing Progress Note documented staff noted Resident #19 had been clenching her left hand. The note further documented an assessment was completed by the Restorative Nurse and both hands noted to be clasped together but able to open hands upon request and touch. -On 4/20/26 at 1:03 PM, a Nursing Progress Note documented the Restorative Nurse assessed the left hand of Resident #19 and she was able to open the left hand after the inside of the hand was touched. The Nursing Progress note documented Resident #19 stated ow when opening the hand. Fingernails were noted to be making marks to the skin on the inside of the hand but was able to keep the hand open and was encouraged by the Restorative Nurse to keep the hand open. The Nursing Progress Note further documented the Restorative Nurse would consider a palm protector. On 4/30/26 at 6:21 PM, when asked about the palm protector, the DON confirmed there were no further notes entered regarding the palm protector by the Restorative Nurse. The DON further stated restorative services were discontinued on 4/26/26. A review of Resident #19's record did not show documentation Resident #19 was on restorative services. When asked why restorative services were discontinued, the DON stated she could not find any documentation from the Restorative Nurse. When asked if the physician had been notified of Resident #19's hand pain and clenching, the DON stated the provider was notified in February 2026 but did not see any further communication with the physician. (continued on next page)

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	135004	A. Building B. Wing	05/01/2026

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.Resident #18 was admitted to the facility on [DATE] with multiple diagnoses including advanced physical debility, chronic pain, and chronic bilateral hand tremors. A review of Resident #18's care plan, initiated 6/25/25 documented, restorative services were to be provided 5 times weekly, and directed the restorative nurse to review the program monthly and as needed. A review of the Resident #18's restorative program documented the following interventions: -Active range of motion to the left hand: open hand wide (highˆfive) for 5 repetitions-Active range of motion to the left hand using a squeeze ball for 5 repetitions-Fingerˆtoˆthumb pinches through all fingers for 5 repetitions A review of restorative documentation from 2/1/26 through 4/26/26 documented, Resident #18 frequently refused restorative services due to pain. A review of the Nursing Progress Notes documented the following: -On 2/25/26 at 11:01 AM: Resident #18 frequently refused restorative services; the restorative nurse documented she would evaluate the need for increased pain medication. -On 3/31/26 at 9:33 AM: Resident #18 refused her leftˆhand palm protector on 3/30/26 due to painful manipulation of the hand. -On 4/30/26 at 12:53 PM: the Restorative Nurse documented, Resident #18 did not tolerate passive range of motion to the left hand and staff could barely place the palm protector. On 4/28/26 at 4:39 PM, Resident #18 was heard yelling from her room in a high pitch tone. A licensed nurse was observed applying a palm protector to her left hand while the resident vocalized pain. On 4/30/26 at 8:30 AM, RN #2 stated Resident #18 is always in pain during palm protector application and sometimes refuses restorative services due to pain. He stated Resident #18 did not have a set painˆmanagement plan prior to restorative interventions and that he sometimes administered PRN pain medication beforehand but not all the time. On 4/30/26 at 4:29 PM, the Restorative Nurse stated she had notified the provider of Resident #18's pain and completed an evaluation that resulted in discontinuation of the restorative program. A request for documentation of provider notification was made, and no documentation was provided. On 4/30/26 at 4:32 PM, when asked who oversees the restorative program and determines initiation or discontinuation of services, the Restorative Nurse stated she completes the assessment and sends a notification to the provider to inform him whether the resident is appropriate for restorative services. On 5/1/26 at 8:57 AM, a request was made for the Restorative Nurses' job description and competency records. No documentation was provided. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/26 at 9:54 AM, the Director of Nursing stated the facility did not have a Restorative Nurse job description, and the Restorative Nurse did not have qualifications, training, or education documentation in her personnel file related to restorative services.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, SOM, and staff interview, it was determined the facility failed to ensure the required daily staffing information was posted in a manner that informed residents, visitors, and resident representatives of the staff available to meet resident needs. This failure had the potential to affect all residents who receive services in the facility by limiting access to accurate staffing information. Findings include:The SOM, Appendix PP requires facilities to post the following information daily in a location readily accessible to residents and the public:-Facility name-Current date-Total number of hours worked by each staff category per shift (Registered Nurse, Licensed Practical Nurse, Certified Nursing Assistant)-Resident censusDuring observations the posted staffing information on these dates did not include all required elements, including the facility name, current date, census, and the breakdown of licensed and unlicensed staff by category (Registered Nurse, Licensed Practical Nurse, Certified Nursing Assistant).- 4/27/26 at 1:38 PM- 4/28/26 at 10:30 AM-4/26/26 at 5:30 PMOn 4/29/26 at 5:33 PM, the DON confirmed the posting is required to include the facility name, the current date, census, and the number of licensed and unlicensed staff by category (Registered Nurse, Licensed Practical Nurse, Certified Nursing Assistant) and she confirmed the posting did not include all required elements.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the SOM, record review, and staff interview, it was determined the facility failed to ensure residents were free from duplicate medication orders. This was true for 2 of 5 residents (#10 and #12) whose records were reviewed for unnecessary medications. This failure placed Resident #10 and Resident #12 at risk for psychosocial harm if they did not receive the least invasive treatment first. Findings include:The SOM, Appendix PP, revised 7/23/25 documented: Duplicate therapy refers to two or more medications of the same pharmacological class/category without a clear distinction of when one medication should be administered over another.1. Resident #10 was admitted to the facility on [DATE] with multiple diagnoses including severe dementia and constipation.Resident #10's care plan dated 6/25/25 directed licensed staff to monitor for constipation, if no bowel movement on 2nd, 3rd, or 4th day, the licensed nurse was to administer medications and treat as ordered. The care plan further directed staff to offer prune juice and if no bowel movement on day 3 to consider PRN Dulcolax tab.Resident #10's Medication Administration Record (MAR) documented the following medication orders:-Bisacodyl (Dulcolax) suppository 10mg: 1 rectally as needed (PRN) for constipation, dated 3/11/24-Bisacodyl (Dulcolax) 5mg tab: 1 by mouth at 8:00 AM and 5:00 PM for constipation, dated 10/23/24-Bisacodyl (Dulcolax) 5mg tab: 1 by mouth daily as needed (PRN) for constipation, dated 7/3/25There was no indication documented in Resident #10's MAR on which medication to give first.On 4/30/26 at 3:33 PM, when asked which medication should be administered first, the DON stated the least invasive medication was always administered first. When asked when Resident #10 last received the oral and rectal PRN bisacodyl, the DON stated Resident #10 last received the oral PRN bisacodyl on 1/31/26 and received the rectal PRN bisacodyl on 2/18/26. When asked if Resident #10 received the oral PRN bisacodyl on 2/18/26, the DON stated there was a progress note documenting Resident #10 received prune juice on 2/16/26, milk of magnesia (over-the-counter laxative) on 2/17/26, and then was administered the rectal PRN bisacodyl on 2/18/26. The DON further stated she believed the suppository was administered because Resident #10 already had scheduled oral bisacodyl tablets. 2. Resident #12 was admitted to facility on 2/6/25 with multiple diagnoses including dementia, right sacral fracture (a break in the tailbone), and chronic pain.A review of Resident #12's care plan dated 2/19/25 directed licensed nurses to assess Resident #12's pain three times per day, as needed, and to monitor for non-verbal signs and symptoms of pain.Resident #12's MAR documented the following medication orders:-Acetaminophen (Tylenol) 650mg suppository: 1 rectally every 6 hours as needed for pain, dated 12/29/25-Acetaminophen (Tylenol) 325mg tab: 2 tablets (650mg) by mouth over 4 hours for chronic pain, dated 2/25/25There was no indication documented in Resident #12's MAR on which medication to give first.On 4/30/26 at 3:38 PM, when asked which medication should be administered first, the DON stated the oral tablet should be administered first. The DON further stated Resident #12 probably had never used the suppository. The DON did a 90 day look back and stated Resident #12 had not used the suppository. The DON further stated that Resident #12 had used the oral PRN acetaminophen medication on 4/16/26. When asked if the oral PRN acetaminophen was effective, the DON stated an assessment had been conducted after Resident #12 was administered the medication and stated the assessment documented zero pain, indicating the medication was effective. When asked if the rectal PRN acetaminophen was necessary, the DON stated, probably not.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of McGeer's Criteria Surveillance for Infection, record review, and staff interviews, it was determined the facility failed to ensure antibiotic stewardship was implemented and residents had appropriate clinical indications for the use of antibiotics. This was true for 1 of 1 resident (Resident #10) whose record was reviewed for antibiotic use. This deficient practice created the potential for Resident #10 to receive unnecessary treatment for a suspected urinary tract infection and/or develop multi-drug-resistant organism. Findings include:The Revised McGeer's Criteria for urinary tract infection (UTI) without an indwelling catheter documented both 1 and 2 must be fulfilled:1. At least one of the following signs or symptoms:-Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate-Fever or leukocytosis (extremely high white blood cell count), and 1 or more of the followingAcute costovertebral angle pain or tenderness (pain elicited at the angle formed by the 12th rib and spine)Suprapubic painGross hematuria (the presence of visible blood in the urine)New or marked increase in incontinenceNew or marked increase in urgencyNew or marked increase in frequency- If no fever or leukocytosis, then 2 or more of the following:Suprapubic painGross hematuriaNew or marked increase in incontinenceNew or marked increase in urgencyNew or marked increase in frequency2. At least one of the following microbiologic criteria:ˆ 10ˆ cfu/mL of no more than two organisms in a voided urine sampleˆ 10^2 cfu/mL of any organism in a catheterized specimenResident #10 was admitted to the facility on [DATE] with multiple diagnoses including severe dementia, recurrent UTIs, and insomnia (a common sleep disorder characterized by difficulty falling asleep, staying asleep, or waking too early).Resident #10's care plan dated 12/9/19, documented Resident #10 was incontinent of bowel and bladder related to impaired cognition with the inability to recognize the need to toilet. Resident #10's care plan directed staff to monitor for signs and symptoms of UTI.A nursing progress note dated 3/16/26 at 6:14 PM, documented Resident #10 was exhibiting manic behavior, was loud, hallucinating, and had decreased oral intake. The note documented urinary incontinence, a urine dip was performed, the provider was notified, and an order was obtained for a urine culture and Keflex (antibiotic) was started.A review of Resident #10's record did not include documentation of worsening urinary symptoms meeting McGreer's Criteria.On 4/30/26 at 3:48PM, the IP confirmed the facility followed McGreer's Criteria for antibiotic stewardship. The IP showed the surveyor a quarterly tracking report for antibiotics which documented Resident #10 did not meet McGreer's Criteria. When asked if the nursing staff should have done a urinalysis on Resident #10, the IP stated no. When asked if the nurses followed McGreer's Criteria, the IP stated no.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and staff interview, it was determined the facility failed to ensure Certified Nursing Assistants (CNAs) received a minimum of twelve (12) hours of annual inˆservice training as required. This was true for 1 of 3 CNAs (CNA #1) reviewed for annual competency requirements. This deficient practice had the potential to affect all residents receiving care from CNAs, as inadequate training places residents at risk for harm due to staff not being fully prepared to safely provide required services. Findings include:On 04/29/26 at 11:57 AM, a request was made for the annual education records of three CNAs.A review of CNA #1's education documentation showed 10.47 hours of completed training for the current annual period, which did not meet the required 12ˆhour minimum.On 04/29/26 at 2:39 PM, the DON confirmed CNA #1 did not have the required 12 hours of annual CNA training. The DON stated CNA #1 had been skipping the course and taking the test, resulting in incomplete training hours. The DON further stated the facility was implementing a new program that would require staff to complete the full course content before being permitted to take the test.