STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135010	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Weiser Care of Cascadia	331 East Park Street Weiser, ID 83672

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on observation and staff interviews, it was determined the facility failed to ensure residents were provided with a safe, clean, and homelike environment. This was true for 2 of 46 Residents (#28, #199) whose rooms were observed. This deficient practice created the potential for diminished quality of life and safety risk. Finding include: 1. Resident #28 was admitted to the facility on [DATE], with multiple diagnoses including dementia, diabetes, and osteoarthritis. On 9/23/24 at 11:15 AM, observed in Resident #28's room, the walls had scrapes, chipped paint , and holes. On 9/24/24 at 3:10 PM, the Administrator with the CNO present, stated the walls should have been repaired after last resident moved. 2. Resident #199 was admitted to the facility on [DATE], with multiple diagnoses including right shoulder infection and diabetes. On 9/22/24 at 2:26 PM, observed in Resident #199 room, the base board by the sink was missing and part of the base board was sticking out having the potential to cause a skin tear. On 9/25/24 at 1:02 PM, the Maintenance Manager stated the base board should have been fixed. 50983

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on record review and staff interview, it was determined the facility failed to complete a comprehensive MDS assessment when a resident experienced a significant change after developing a pressure ulcer to her right buttock. This was true for 1 of 5 residents (Resident #28) reviewed for pressure ulcers. This failure had the potential for harm if the facility staff did not recognize significant changes in the resident's health status and needs. Findings include: Resident #28 was admitted to the facility on [DATE], with multiple diagnoses including dementia, diabetes, and osteoarthritis. A review of Resident #28's record documented the following: On 7/25/24, a Skin Inspection Evaluation documented a silver dollar size-open wound on the right buttock/leg. On 7/26/24, a Skin & Wound Evaluation documented a new MASD (Moisture Associated Skin Damage) to the coccyx, measuring 2.8 cm x 1.8 cm. On 7/29/24, a Skin & Wound Evaluation documented the MASD to the coccyx had now progressed into a pressure injury (damage to the skin and underlying tissue caused by prolonged or intense pressure). On 8/12/24, a Wound Clinic Note documented Resident #28 had a stage 3 pressure injury to her right buttock, measuring 2 cm x 1.6 cm. Resident #28's quarterly MDS dated [DATE], documented she did not have pressure ulcer. On 8/15/24, Resident #28's Pressure Ulcer Investigation documented she should have had a significant change MDS completed. Resident #28's medical record did not document a significant change MDS was completed. On 9/25/24 at 10:25 AM, the Regional Clinical Nurse (RCN) confirmed Resident #28's quarterly MDS did not document Resident #28 had a stage 3 pressure ulcer and should have. The RCN stated there should have been a modification to correct the quarterly MDS and a significant change MDS should have been completed within 14 days of diagnosing the pressure ulcer.

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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** 51121 Based on observation, staff interview, policy and record review, the facility failed to follow comprehensive person-centered care plan for 1 of 4 residents (Resident #199) observed with wounds. This deficient practice created the potential for harm or adverse outcomes related to infection and skin breakdown. Findings include: Facility Prevention and Treatment of Pressure Ulcers and Other Skin Alterations policy revision date 7/13/18, documented With each dressing change or at least weekly (and more often when indicated by wound complications, or changes in wound characteristics), an evaluation of the PU/PI (pressure ulcer/pressure injury) or non-pressure skin alteration should be documented. At a minimum, documentation should include the date observed and : A. Location, staging if applicable; B. Size (perpendicular measurements of the greatest extent of length and width of the PU/PI), depth; and the presence, location and extent of any undermining or tunneling/sinus tract; C. Exudate, if present: type (such as purulent/serous), color, odor and approximate amount; D. Pain, if present: nature and frequency; E. Wound bed: Color and type of tissue/character including evident of healing or necrosis, and; F. Description of wound edges and surrounding tissue . as appropriate. Resident #199 was admitted to the facility on [DATE], with multiple diagnoses including right shoulder infection and diabetes. On 9/22/24 at 2:26 PM, observed bandages dated 9/11/24, on Resident #199's legs and on his left toe. On 9/22/24 at 2:30 PM, RN #2 stated skin tear bandaging should only stay on for three days and then be changed.

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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. 51121 Based on observation, review of policy, records review, and interviews, it was determined the facility failed to ensure Nursing Assistants (NAs) performed tasks which they had the knowledge, skills, and competences. This was true for 1 of 6 NAs observed in the facility. This had the potential for adverse effects and potential harm to residents medical and physical status. Findings include: Facility Indwelling Catheters policy Revision Date: 4/12/22, documented Infection control is followed in the care of indwelling catheters. Guidelines to prevent Catheter Associated Infections include but may not be limited to: Good hygiene is maintained at the catheter-urethral interface: cleaned daily with soap and water. Lippincott Nursing Procedures (9th edition) documented to avoid contaminating the urinary tract, always clean by wiping away from, never toward the urinary meatus. CDC Guidelines for Prevention of Catheter Associated Urinary Tract Infections 2009 documented, III. Proper Techniques for Urinary Catheter Maintenance, Do not clean the periurethral area with antiseptics to prevent CAUTI (Catheter Associated Urinary Tract Infection) while the catheter is in place. Routine hygiene (e.g., cleansing of the meatal surface during daily bathing or showering) is appropriate. The Agency for Healthcare Research and Quality (AHRQ) Safety Program for Long-Term Care: HAIs/CAUTI (Healthcare Acquired Infection) dated 3/2017, documented to only use soap and water when performing peri-care. Review of the facility Admission Packet, Residents Rights section, documented, The Resident has the right to be treated with respect and dignity. On 9/24/24 at 4:10 PM, observed CNA #1 and NA #2 use a Hoyer lift (a mobility tool that helps caregivers safely move patients from one surface to another) to transfer Resident #35 from her wheelchair to bed. During the process the window blinds were left open, exposing Resident #35's bottom and perineum area (the area of the body between the anus and the vulva in females) toward the open window. On 9/24/24 at 4:17 PM, observed CNA #1 and NA #2 prepare Resident #35 for catheter care with the window blinds left open, exposing the resident's urinary meatus area toward the open window. On 9/24/24 at 4:18 PM, observed NA #2 use peri-care wipes to wipe toward, not away from the meatus. On 9/24/24 at 4:28 PM, NA #2 stated she should have wiped away from, not toward the meatus. On 9/24/24 at 4:30 PM, CNA #1 and NA #2 stated they should have close the window blinds before transferring the resident to the bed and before performing catheter care.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 50983 Based on review of facility staffing records and staff interview, it was determined the facility failed to ensure an RN was on duty at least 8 hours a day, 7 days a week. This was true for 2 of 21 days reviewed. The failure created the potential for harm if routine and/or emergency nursing needs went unmet and had the potential to affect all residents living in the facility. Findings include: On 9/25/24 at 4:20 PM, review of the Licensed Nurse time punches for 9/1/24 to 9/21/24 documented the facility did not have an RN on duty for 8 consecutive hours on 9/7/24 and 9/8/24. On 9/26/24 at 9:05 AM, the Medical Records Manager, stated the CNO was scheduled to work on 9/7/24 for 6 hours and RN #2 was scheduled to work intermittently on 9/8/24. On 9/26/24 at 9:40 AM, the CNO stated she worked from home and did not work in the building on 9/7/24 or 9/8/24. She stated she knew the facility had to have 8 hours of RN coverage but did not know the hours needed to be consecutive.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 50983 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure nurse staffing information was accurate, posted daily for each shift, and kept for review for 18 months. This failed practice had the potential to affect the 46 residents residing in the facility and their representatives, visitors, and others who wanted to review the facility's staffing levels. Findings include: The facility's Posting of Licensed and Unlicensed Direct Care Staff policy, dated 11/28/17, documented, the facility posts daily, the total number and actual hours worked by RNs, LPNs, CNAs, and the resident census. The policy documented the daily posting were to be retained for a minimum of 18 months or as required by State law, whichever is greater. On 9/22/24 at 12:00 PM, the Daily Posted Staffing sheet was observed with the date 9/20/24, indicating the facility had failed to post the last two days of nursing hours. On 9/22/24 at 2:07 PM, the Administrator stated the medical records person should have posted the weekend nursing hours on Friday but must have missed it. On 9/25/24 at 3:10 PM, the Administrator stated the facility had not retained the Daily Posted Staffing Sheets for 18 months. 51121

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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. 49552 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure medications available for residents were dated and had not expired. This was true for 2 of 2 medication carts inspected. This failure created the potential for residents to receive expired medications with decreased efficacy. Findings include: The facility's Medication Management policy, revision date 10/15/22, documented medications are discarded by the expiration date unless indicated by the pharmacy and/or manufacturer's instructions to discard sooner. The facility's pharmacy Medication Storage and Administration Quick Reference Guide, revision date April 2024, documented injectable diabetes medications, pens, or vials, should have a label with resident identifiers, date opened, and expiration date. 1. On 9/23/24 at 10:29 AM, during the back hall medication cart audit, with RN #1 present, observed a box of Bisacodyl suppositories, with an expiration date of November 2023. On 9/23/24 at 10:31 AM, RN #1 stated the expired medication should have been taken off the medication cart. 2. On 9/23/24 at 10:33 AM, during the front hall medication cart audit, with RN #2 present, 2 insulin pens, not dated, were observed inside the top drawer of the medication cart. On 9/23/24 at 10:37 AM, RN #2 stated she was not sure if the insulin pens were used. She also stated the insulin pens should be dated when opened. On 9/25/24 at 9:09 AM, RN #2 stated the insulin pen was not dated and should have been.

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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. 51121 Based on observation, staff interview, policy review, and review of the Idaho Food Code, the facility failed to appropriately store and label food . This deficient practice had the potential to affect 25 of 26 residents who received meals in the facility and residents that eat snacks. This placed residents at risk for potential contamination and use of spoiled foods, and adverse health outcomes, including food-borne illnesses. Findings include: Review of the Idaho Food Code, revised February 2021, stated 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking . refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. The Facility's Food and Supply Storage policy dated 11/28/17, documented under Labeling and rotating food supply, For food products that are opened and not completely used or prepared at facility and stored, the product should be labeled as to its contents and use-by dates. On 9/22/24 at 12:08 PM, observed a non-dated open container of Soy sauce in the food storage area. On 9/22/24 at 12:09 PM, Lead [NAME] #1 stated it should have been dated. On 9/22/24 at 12:12 PM, observed in the walk in refrigerator, an opened Soy sauce container with no used by date. On 9/22/24 at 12:13 PM, Lead [NAME] #1 stated it should have been dated. On 9/24/24 at 9:55 AM, observed the back hall snack refrigerator, with the Culinary Manager present, the refrigerator temperatures had not been checked and documented for September 22, 23, and 24. On 9/24/24 at 10:00 AM, the Culinary Manager stated nursing staff should have checked the temperatures for the refrigerator and freezer on those dates but had failed to do so.

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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. 51121 Based on observation and staff interview, the facility failed to ensure adherence to infection control and prevention practices to provide a safe and sanitary environment. This failure had the potential to impact 25 of 26 residents that eat meals prepared in the kitchen, 2 of 2 residents (#35 and #200) for hand hygiene. Findings include: 1. On 9/22/24 at 1:01 PM, observed Activities Assistant #1 remove gloves but not wash hands, prior to pouring a resident a cup of lemonade. She did not sanitized her hands until after she delivered the lemonade to a resident in the dining room. On 9/22/24 at 1:04 PM, the Activities Assistant #1 stated she should have used hand sanitizer after removing gloves. 2. On 9/24/24 at 8:40 AM, observed Lead [NAME] #1 wipe down dirty counters in the kitchen and remove clean dishes from the washed area without changing gloves or washing her hands. On 9/24/24 at 9:01 AM, the Culinary Manager stated the lead cook should have removed her gloves, washed hands, and put on new gloves before handling the clean dishes. 3. On 9/23/24 at 8:10 AM, observed the Business Office Manager deliver a breakfast meal to Resident #35 in her room. Resident #35 was not offered hand hygiene before the meal. On 9/23/24 at 8:11 AM, observed the Business Office Manager deliver a breakfast meal to Resident #200 in his room. Resident #200 was not offered hand hygiene before the meal. On 9/25/24 at 1:18 PM, the CNO stated all staff should have been asking residents if they want to wash hands prior to eating their meal.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on observation and staff interview, the facility failed to provide a functional environment for residents to meet their physical needs. This was true for 1 of 46 residents (Resident #12). This deficient practice had the potential to cause harm and distress for residents with loss of independence. Findings include: Resident #12 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including, Myasthenia Gravis (a chronic autoimmune disease that causes muscle weakness by interfering with the communication between nerves and muscles) and left pelvis fracture. On 9/24/24 at 12:08 PM, observed Resident #12, who uses a wheelchair, could not reach the sink faucet and handles, soap, or paper towel dispenser in her room. On 9/24/24 at 1:50 PM, the Administrator stated he never knew the sink faucet and handles, soap, and paper towel dispensers could not be reached by residents sitting in a wheelchair and this should have been corrected.