STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River's Edge Rehabilitation & Living Center	714 North Butte Avenue Emmett, ID 83617

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 50603 Based on Resident Group interview, Resident Council Meeting minutes review, and staff interview, it was determined the facility failed to ensure resident concerns were addressed. These negative practices placed residents at risk of ongoing frustration and decreased sense of self-worth, as well as, unmet care needs, when issues of concern to them were not promptly addressed by the facility. Findings include: The Resident Council minutes from June 2024 through November 2024 documented residents' concerns. Examples include: a. Resident Council Minutes, dated 6/26/24, documented residents voiced issues related to dietary, housekeeping, and offsite activities. b. Resident Council Minutes, dated 7/25/24, documented residents' concerns including running out of milk, bread, and staples, not having fresh fruit, or menus being posted. Residents requested more outings to the movies and Baby Farms, concerns with Hand Hygiene in the kitchen, call light response time, staff behavior and responses to the residents. The Minutes did not document what actions were taken to address and resolve the concerns voiced during the 6/26/24 meeting. c. Resident Council Minutes, dated 8/29/24, documented residents' concerns with meals not matching personal preferences, wanting more outings, and staffing concerns related to too much staff in the morning and not enough in the evening, with limited help in the afternoon from 2:00 PM - 3:00 PM. They voiced concerns with missing laundry. The Minutes did not document what actions were taken to address and resolve the concerns voiced during the 7/25/24 meeting relating to outings, call light response time, staff behavior, and hand hygiene in the kitchen. d. Resident Council Minutes, dated 9/26/24, documented residents' request for more bingo and outings, housekeeping, and laundry concerns with stained clothes being returned to residents, meal temperatures, and call light response time. The Minutes did not document what actions were taken to address and resolve the concerns voiced during the 8/29/24 meeting relating to missing laundry, and staffing concerns. (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Resident Council Minutes, dated 10/24/24, documented residents' concerns with meal temperatures, requesting more bingo and outings, call light response time, delay in picking up meal trays, and housekeeping not cleaning or mopping their rooms well. The minutes did not document what actions were taken to address and resolve the concerns voiced during the 9/10/24 meeting outside of laundry concerns which had improved between 9/26/24 and 10/24/24. f. Resident Council Minutes, dated 11/21/24, documented residents' concerns with cold coffee being served, wanting more Bingo and outings, call light response time, meal trays not being picked up timely, missing laundry, dirty rooms, and stained clothes being returned. A Resident Group interview was attended by Resident #4, #12, #17, #18, #21, #47, and #49 on 12/3/24 at 3:00 PM. All the residents voiced concerns related to housekeeping, staffing, heating, and long call light response times. The residents stated these issues were an ongoing problem in the facility. On 12/4/24, a call light audit report was provided to surveyors, documented a completed call light audit from 10/28/24, which identified there was room for call light response time improvement. However, no additional follow-up was provided or documented the resident's had been informed of the call light audit results. The facility did not provide information regarding how the identified need for call light improvement would be addressed. On 12/4/24 at 4:52 PM, the Social Services Designee (SSD) stated concerns from Resident Council are taken to the staff stand up meetings and addressed there. The Administrator or DON will take the concerns and complete whatever follow-ups are needed. The residents' concerns about call lights, staff, and laundry have not been responded to on a separate form/report. These concerns continue to be brought up in the meetings. The SSD was not aware of any follow-up regarding the concerns. On 12/4/24 at 4:54 PM, a joint interview with the Administrator and Activities Director (AD), confirmed the AD was new to her position, and she ran the meetings with the SSD covering for her when she is not available. The AD and/or SSD take the resident's concerns to the Administrator, who will then do trainings with the staff or a complete a report to ensure the residents are being taken care of. The Admin and AD were unable to provide written responses provided to the Resident Council Meeting addressing their concerns. On 12/6/24 at 8:49 AM, during a follow-up interview with the Administrator, clarified concerns voiced at the Residents Council meeting are brought to the attention of staff during the following mornings IDT stand up meeting. The Administrator stated, he was not sure if the audit was taken back to the resident's, however, the residents are informed verbally of what is happening. We have not been writing everything down as it is discussed in the team meetings or when we inform the residents. He further stated the AD and SSD will keep the concerns on the resident council notes until the area of concern is fully resolved.

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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** 50983 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 1 of 8 residents (Resident #44) whose room was observed for cleanliness, safety, and homelike environment. This deficient practice created the potential for diminished quality of life and safety risk. Findings include: Resident #44 was admitted to the facility on [DATE], with multiple diagnoses including dementia, malnutrition, and hypertension. On 12/2/24 at 10:30 AM, observed Resident #44's room, to have: - A six inch section of baseboard near the bathroom not attached to the wall and a corner of the baseboard broken off. - A roll of toilet paper was hanging on the grab bar in Resident #44's bathroom and not on the toilet paper roll holder. - The grab bar in the bathroom, which had been painted, had large sections of chipped and peeling paint. - The hand washing sink was corroded with rust and chipped around the drain. On 12/4/24 at 10:21 AM, the Maintenance Director stated he was not notified there was a problem with the toilet paper roll or the sink and the Housekeeping Supervisor is usually responsible for putting in a work order. On 12/6/24 at 12:30 PM, the Housekeeping Supervisor, with the Administrator present, was shown photos of the baseboard, sink, and bathroom. The Housekeeping Supervisor stated the toilet paper should be attached to the toilet paper holder. The Housekeeping Supervisor and the Administrator stated there was no way to clean the sink and it would need replaced.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on review of the State Operations Manual, Apprendix PP, record review, and staff interview, it was determined the facility failed to ensure a notice of transfer was provided to the State Long Term Care Ombudsman when residents where transferred to the hospital. This was true for 4 of 5 residents (Resident #19, #30, #32, and #33) whose records were reviewed for hospital transfers. This deficient practice had the potential for harm if residents were discharged inappropriately without access to the Ombudsman who could inform them of their rights. Findings include: The State Operations Manual, Appendix PP, revised on 8/8/24 documented, Before transfers or discharges of 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. 1. Resident #19 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including spastic quadriplegic (paralysis of all four limbs) cerebral palsy and aphasia (a communication disorder that it makes it hard to use words). A Nursing Notes, dated 10/25/24 at 12:27 PM, documented Resident #19 vomited dark brown and black small to moderate amounts, and was transported to the emergency department for possible gastrointestinal bleeding. Resident #19's record did not include documentation the State Ombudsman was notified of his transfer to the hospital. On 12/5/24 at 11:22 AM, the Administrator stated he was not aware the State Ombudsman needed to be notified of facility-initiated discharges or hospital transfers. 2. Resident #30 was admitted to the facility on [DATE], with multiple diagnoses including TBI (Traumatic Brain Injury), anxiety, and diabetes. Resident #30's medical record documented he was transferred to the hospital on 11/7/24, and returned to the facility on [DATE]. Resident #30's medical record did not document the State Ombudsman was notified of the hospital transfer. 3. Resident #32 was admitted to the facility on [DATE], with multiple diagnoses including cancer, anemia, and heart failure. Resident #32's medical record documented he was transferred to the hospital on 12/18/23, and returned to the facility on [DATE]. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #32's medical record documented he was transferred to the hospital on 11/19/24, and returned to the facility on [DATE]. Resident #32's medical record did not document the State Ombudsman was notified of the hospital transfers on 12/18/23 or on 11/19/24. On 12/5/24 at 11:22 AM, The Administrator stated he was not aware the State Ombudsman needed to be notified of facility-initiated discharges or hospital transfers. 4. Resident #33 was admitted to the facility on [DATE], with multiple diagnoses including a fracture of the right leg, anemia, and congestive heart failure. A facility-initiated hospital stay from 11/21/24 through 11/26/24, did not include documentation the Ombudsman was notified of the hospital transfer. On 12/5/24 at 11:22 AM, the Administrator verified the Ombudsman is not being notified of resident's who are discharged from the facility or for hospitalization transfers. 36193 50603

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **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 ensure the MDS assessment accurately reflected a resident's status. This was true for 3 of 3 residents (#32, #48, and #52) whose MDS assessments were reviewed. This deficient practice had the potential for negative outcomes if the resident was not assessed and/or monitored due to inaccurate assessments. Findings include: 1. Resident #32 was admitted to the facility on [DATE], with multiple diagnoses including cancer, anemia, and heart failure. Resident #32's quarterly MDS assessment, dated 9/23/24, documented he had an active diagnosis of pneumonia. Resident #32's significant change MDS assessment, dated 11/25/24, documented he had an active diagnosis of pneumonia. On 12/05/24 at 3:57 PM, the DON stated Resident #32 had pneumonia on 6/27/24, which resolved. The DON confirmed the quarterly MDS assessment on 9/23/24 and the significant change MDS assessment, dated 11/25/24, was incorrect. 2. Resident #48 was admitted to the facility on [DATE], with multiple diagnoses including paraplegia (paralysis of the lower extremities), diabetes, and viral hepatitis. Resident #48's admission MDS assessment, dated 10/10/24, documented he was taking an anticoagulant (a medication that decreases blood clotting). Resident #48's physician orders did not document the use of an anticoagulant. On 12/5/24 at 4:03 PM, the DON stated she did not think Resident #48 was taking an anticoagulant, but she would verify with the MDS Coordinator. On 12/5/25 at 4:44 PM, the DON confirmed Resident #48 was not taking an anticoagulant and the MDS was coded incorrectly. 3. Resident #52 was admitted to the facility on [DATE], with multiple diagnoses including dementia, PTSD (Post Traumatic Stress Disorder), and anemia. Resident #52's medical record documented a PASARR level II (a comprehensive evaluation by the appropriate state-designated authority and determines whether the individual has a mental diagnosis, intellectual disability, or related condition, and recommends what, if any, specialized services and/or rehabilitative services the individual needs) was completed on 10/18/24. Resident #52's admission MDS assessment dated [DATE], documented Resident #52 did not have a PASARR level II evaluation. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/5/24 at 4:20PM, the DON stated resident #52's MDS should have documented a PASARR level II evaluation was completed.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on State Operation Manual Appendix PP, record review, and staff interview, it was determined the facility failed to refer residents for further evaluation when residents were diagnosed with a major mental illness. This was true for 1 of 3 residents (Resident #45) reviewed for Pre-Admission Screening and Resident Review (PASARR) level II evaluations. This deficient practice had the potential to cause harm if the residents' specialized services for mental health needs were not evaluated by an appropriate state-designated authority to provide coordinated care. Findings include: The State Operation Manual Appendix PP revised on 8/8/24, documented if a PASARR level I identified a major mental illness, an in-depth evaluation, known as a PASARR level II evaluation is completed by the state-designated authority, which must be completed prior to admission to a nursing facility. Resident #45 was admitted to the facility on [DATE], with multiple diagnoses including major depressive disorder (MDD), and dementia. Resident #45's care plan, created on 4/3/24, documented Resident #45 was prescribed antidepressant medication related to depression, and directed staff to monitor signs and symptoms of depression. On 6/5/24, the care plan was updated to include additional staff direction identifying Resident #45 as taking psychotropic medication related to MDD, dementia with behavioral disturbance, and Insomnia behavior management. Resident #45's pre-admission PASARR level I screening, dated 4/1/24, identified Resident #45's had MDD and she was taking paroxetine (antidepressant) 20 mg daily related to MDD. The preadmission PASARR level I was not forwarded to the appropriate state-designated authority. Resident #45's admission MDS, dated on 4/12/24, documented a PASARR level II was not completed. On 12/5/24 at 5:11 PM, the DON stated she was unaware the PASARR level I form was filled out incorrectly and a PASARR level II should have been completed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on observation, record review, policy review and staff interview, it was determined the facility failed to ensure medications were administered according to professional standards of practice. This was true for 2 of 2 residents (#18 and #25) whose records were reviewed and 1 of 6 residents (Resident #27) observed during medication administration. These failed practices created the potential for residents to experienced adverse effects when their medications were not administered according to the physician's order. Findings include: The facility's Care and Treatment policy and procedure, revised May 2020, documented in order to ensure the safety and accuracy of medication administration the following are the six rights of medication administration: 1. Right Resident - Resident is identified prior to medication administration. 2. Right Time - Medications are administered within the prescribed time frames. 3. Right Medication - Medications are checked against the order before they are given. 4. Right Dose - Medications are administered according to the dose prescribed 5. Right Route - Medications are administered according to the route prescribed. 6. Right Documentation - Document administration or refusal of the medication after the administration or attempt and note any concerns. 1. Resident #18 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including paraplegia (paralysis of the lower body), diabetes, and chronic pain. A physician's order, dated 8/7/23, documented Resident #18 was to receive Tramadol (opioid pain medication) 50 mg (milligrams) by mouth two times a day. A Medication Error Report, dated 10/9/24, documented Resident #18 was administered Norco (opioid pain medication) 5 mg instead of the scheduled Tramadol 50 mg. The report documented, This card was directly behind Tramadol card for different patient. On 12/4/24 at 4:02 PM, the DON stated Resident #18 was monitored and did not have adverse reactions after she received the wrong medication. The DON stated education was provided to the nurse who administered the wrong medication to Resident #18 regarding the six rights of medication administration. The DON also stated she did biweekly check-ins with the nurse and spoke to her regarding her time management. 2. Resident #25 was admitted to the facility on [DATE], with multiple diagnoses including esophagitis (inflammation of the esophagus) with unspecified bleeding. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Medication Error report, dated 10/30/24, documented Resident #25 was administered rivaroxaban (anticoagulant) 20 mg which was intended for another resident. On 12/4/24 at 4:02 PM, the DON stated LPN #1 was training RN #1 when the medication error occurred. LPN #1 handed Resident #36's rivaroxaban to RN #1 to administer it to the resident, but RN #1 administered the medication to Resident #25. The DON stated LPN #1 and RN #1 were educated regarding the six rights of medication administration. 3. Resident #27 was admitted to the facility on [DATE], with multiple diagnoses including chronic respiratory failure with hypoxia (low levels of oxygen in the body tissues). A physician' order, dated 4/18/24, documented Resident #27 was to receive ipratropium-Albuterol (a bronchodilator that relax the airway muscles) 0.5 - 2.5 mg/ml (milliliter) orally three times a day for shortness of breath. On 12/3/24 at 12:29 PM, the Medication Technician #1 administered Anoro Ellipta (a bronchodilator that relax airway muscles) to Resident #27. On 12/3/24 at 12:39, the Medication Technician #1, together with LPN #2, was asked what the physician's order for Resident #27 was. LPN #2, stated Resident #27, preferred to receive the Anoro Ellipta over ipratropium-Albuterol and they have an order to give Anoro Ellipta if Resident #27 refused the ipratropium-Albuterol. LPN #2, then reviewed the physician's order and stated she did not find the order for Anoro Ellipta. LPN #2, stated it was discontinued on 4/17/24. LPN #2, stated I don't know what happened. On 12/3/24 at 2:32 PM, the DON stated, Resident #27's Anoro Ellipta was discontinued on 4/17/24, and should not have received the medication.

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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** 50603 Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure resident-centered care was provided in accordance with professional standards of nursing practice and residents' comprehensive care plans. This was true for 2 of 17 residents (Resident #6, and Resident #19) reviewed for quality of care. This deficient practice had the potential to adversely affect or harm residents whose care and services were not delivered according to accepted standards of clinical practice. Findings include: 1. Resident #6 was admitted to the facility on [DATE], with multiple diagnoses, including metabolic encephalopathy (a brain dysfunction which impairs cerebral metabolism), diabetes, and hypoglycemia (low blood sugar). A physician's order, dated 9/12/24, directed staff to follow the Hypoglycemia protocol and to notify provider if blood glucose (BG) is less than 70 mg/dl, or if the levels were greater than 400 mg/dl. A review of Resident #6's medical record showed BG was over 400 mg/dl on the following days and times: - On 11/7/24 at 7:23 PM and 8:19 PM, the BG was 481 mg/dl. - On 11/8/24, the BG was 407 mg/dl. Resident #6's record did not include documentation the physician was notified when her blood glucose was greater than 400 mg/dl. On 12/5/24 at 4:41 PM, the DON stated the attending nurse notified the nurse practitioner of the high BG on both days, but she did not document the notification in Resident #6's chart. 36193 Resident #19 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including spastic quadriplegic (paralysis of all four limbs), cerebral palsy, and aphasia (a communication disorder that it makes it hard to use words). Resident #19's care plan, revised 8/20/19, documented he required two-person total assist to reposition and turn him in bed. On 12/4/24 at 11:26 AM, CNA #1 entered Resident #19's room and stated she would change his bed sheet. CNA #2 followed CNA #1 and told her she would help CNA #1 after answering the call light of another resident. CNA #1 was observed to reposition and turn Resident #19 to his left side, and then to his right side as she removed, and applied a new bed sheet. On 12/4/24 at 11:39 AM, when asked why she did not wait for CNA #2 before changing Resident #19's bed sheet, CNA #1 stated, I always do it by myself. Most of the time I can change him by myself. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 11:49 AM, the Unit Manager #1 reviewed Resident #19's care plan and stated Resident #19 should be assisted by two staff for bed mobility. CNA #1 should have waited for CNA #2 before changing his bed sheet.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 50983 Based on review of the State Operations Manual, Appendix PP, Nurse Aides (NA) job description, staffing schedules, personnel files, and staff interviews, it was determined the facility failed to ensure full-time employees working as a NA were either in a State approved training and competency evaluation program or had recently and successfully completed such a program. This was true for 4 of 11 NAs (NA #1, #2, #3, and #4) whose personnel files were reviewed. This failure had the potential to result in negative outcomes for the 54 residents living in the facility. Findings include: The State Operations Manual, Appendix PP, revised 8/8/24, documented, A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State. The facility's Nursing Assistant job description, dated 12/17/21, documented under section Qualifications: Education and/or Experience: - High School Diploma or equivalent - Graduate or student of an accredited CNA program The following employees had worked full-time as an NA beyond 4 months without obtaining their nurse aide certification: - NA #1 was hired 11/21/23. - NA #2 was hired 4/11/24 (completed the class but has not tested). - NA #3 was hired 6/5/24. - NA #4 was hired 6/13/24. On 12/6/24 at 11:45 AM, the HR Manager stated the facility was out of compliance with the NAs not being certified within 4 months of their hire date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River's Edge Rehabilitation & Living Center	714 North Butte Avenue Emmett, ID 83617

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on observation, record review and staff interview, it was determined the facility failed to ensure the medication error rate was less than 5%. This was true for 2 of 29 medications (6.9%) which affected 1 of 9 residents (Resident #41) whose medication administration was observed. This failure created the potential for Resident #41 to experience low or high blood sugars when she received an incorrect amount of insulin. Findings include: The insulin lispro website, accessed on 12/10/24, stated, Priming insulin pens is recommended to remove air from the needle to ensure full dose administration. Resident #41 was admitted to the facility on [DATE], with multiple diagnoses including diabetes. A physician's order, dated 11/21/24, documented Resident #41 was to receive the following medications: 1. Insulin Glargine 100 unit/ml, 15 units subcutaneously in the morning. 2. Insulin Lispro 100 unit/ml, inject per sliding scale before meals as follows when the blood glucose: - 0 - 100 = 0 unit - 101 mg/dl - 150 mg/dl = 5 units - 151 mg/dl - 200 mg/dl = 10 units - 201 mg/dl - 250 mg/dl = 12 units - 251 mg/dl - 350 mg/dl = 15 units - 351 mg/dl - 500 mg/dl = 18 units Notify provider if over 500 On 12/4/24 at 7:45 AM, RN #1 stated Resident #41 blood glucose was 256 ml/dl. RN #1 took the insulin lispro pen replaced the needle with a new one and dialed the pen to 15 units. RN #1 also took the insulin Glargine pen, replaced the needle with a new one and dialed the pen to 15 units. RN #1 then went to Resident #41's room and injected the insulin to Resident #41's lower abdomen. RN #1 was not observed to prime the insulin pens before dialing the prescribed dose of insulin for Resident #14. On 12/4/24 at 12:32 PM, when asked about the preparation of insulin pen injections, RN #1 stated she did not prime Resident #41's insulin pens. On 12/4/24 at 12:34 PM, the Unit Manager #1 stated insulin pens should be primed prior to administration to ensure resident receive the prescribed dose of insulin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River's Edge Rehabilitation & Living Center	714 North Butte Avenue Emmett, ID 83617

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 36193 Based on observation and staff interview, it was determined the facility failed to ensure infection control and prevention practices were maintained to provide a safe and sanitary environment when gown was not donned during sorting of dirty laundry. These failures had the potential for negative outcomes by exposing resident to the risk of infection and cross-contamination. Findings include: 1. The State Operation Manual Appendix PP, revised 8/8/24, documented, The facility staff should handle all used laundry as potentially contaminated and use standard precautions (gloves, gowns when sorting and rinsing). On 12/6/24 at 9:26 AM, the Laundry Personnel #1 was observed folding the clean laundry in the Laundry Room. When asked where the soiled linen was being sorted, the Laundry Personnel #1 stated it was being sorted in the Soiled Room, which was outside of the Laundry Room. The surveyor then asked the Laundry Personnel #1 to show the surveyor the Soiled Room. In the Soiled Room, the surveyor asked the Laundry Personnel #1 her process of sorting the dirty laundry. The Laundry Personnel #1 stated she would don gloves, open the plastic bags containing the dirty laundry, and place them inside the bin. When asked if she sorted the dirty laundry this morning prior to folding the clean laundry in the Laundry room, the Laundry Personnel #1 stated, Yes. When asked if she did wear a gown prior to sorting the dirty linen, the Laundry Personnel stated she did not wear a gown when she sorted the dirty laundry. On 12/6/24 at 9:41 AM, the DON stated gowns and gloves should be worn when sorting the dirty laundry.