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	04/16/2026

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 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, the FDA Food Code, the SOM, and staff interview, it was determined the facility failed to ensure ice machines were cleaned. This deficient practice had the potential to affect all facility residents who consumed ice prepared by the facility. This placed residents at risk for potential contamination of food and adverse health outcomes, including food-borne illnesses. Findings include:The FDA Food Code Section 4-602.11 Equipment Food-Contact Surfaces and Utensils documented surfaces of utensils and equipment contacting food that is not time/temperature control for food shall be cleaned in equipment such as ice bins and enclosed components of equipment such as ice makers, at a frequency specified by the manufacturer, or absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold.The SOM Appendix PP revised 7/23/25, documented equipment can become contaminated in various ways including improper sanitation.On 4/12/26 at 2:58 PM, the ice machine was observed to have a black residue along the interior metal plate of the ice machine.On 4/12/26 at 3:05 PM, the Dietary Manager confirmed there was a blackish brown residue along the interior metal plate of the ice machine. When asked how often the ice machine was cleaned, the Dietary Manager stated the ice machine was a rented unit and maintenance was responsible for cleaning the ice machine.On 4/12/26 at 3:50 PM, the Plant Operations Personnel confirmed a black substance in the ice machine and stated the rental company provides quarterly cleaning of the ice machines and monthly maintenance.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** Based on observation, resident interviews, and staff interviews, it was determined the facility failed to provide a homelike environment when a resident's closet doors and sink countertop were left unrepaired. This was true for 1 of 16 residents (Resident #9) whose rooms were observed. This created the potential for psychosocial harm and embarrassment if residents did not have a homelike environment. Findings include: Resident #9 was admitted to the facility on [DATE] and re-admitted to the facility on [DATE] with multiple diagnoses including cognitive communication deficit, muscle weakness, and hemiplegia and hemiparesis following a stroke (weakness and paralysis to one side of the body).On 4/13/26 at 2:50 PM, it was observed in Resident #9's room there were large, jagged round and oblong areas on Resident #9's closet doors with chipped, cracked, and missing paint exposing white and brown patches. Several long black scuff marks and scratches were observed along the mid to lower closet doors and to the bottom drawers of the closet. A large oblong and jagged area of the sink countertop was observed to be damaged and missing, exposing brown wood.On 4/13/26 at 2:59 PM, when asked if the room felt homelike, Resident #9 pointed to the closet doors and the sink countertop, huffed, and said, no. Resident #9 stated the room did not feel homelike due to the condition of the closet and the countertop and further stated she would like the closet doors painted and the counter fixed.On 4/16/26 at 1:57 PM, the Maintenance Director accompanied the surveyor to Resident #9's room and confirmed the closet doors, sink counter, and the lower corner wall near the sink needed to be repaired. He further stated the closet had been painted approximately 3 or more months ago. When asked for documentation for the repair, the Maintenance Director stated he did not keep documentation on painting repairs and that he only kept documentation on repairs to outlets, lights, wheelchairs, walkers, etc.

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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** Based on record review and staff interview, it was determined the facility failed to ensure a resident's comprehensive assessment was accurate. This was true for 1 of 2 residents (Resident #21) whose resident assessments were investigated for potential errors. This failure placed Resident #21 at risk for their needs to go unmet due to the inaccuracy. Findings include: Resident #21 was admitted to the facility on [DATE] for end of life care related to heart failure and chronic kidney disease. Resident #21's record documented a certification of terminal illness signed by a hospice physician on 2/2/26, prior to Resident #21's admission to the facility. Resident #21's Admissions MDS Assessment (Minimum Data Set- a standardized assessment tool that measures health status in nursing home residents) was completed 3/5/26. In the assessment, under section O, for special treatments, procedures, and programs, at item K1 for hospice services, K1 was marked no, indicating they were not receiving hospice services. On 4/15/26 at 4:27 PM, the Administrator stated Resident #21 admitted to the facility with hospice services and their admissions MDS assessment was not accurate.

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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. Based on observation, review of professional standards of practice, and staff interviews, it was determined the facility failed to ensure medications were prepared and administered safely and in accordance with nationally recognized standards. This failure was observed when licensed nurses pre-poured medications and left pre-poured medication cups including narcotics unsecured in medication carts. This deficient practice had the potential to affect all residents in the facility by increasing the risk of medication errors, contamination, diversion, and administration of medications to the wrong residents. Findings include:The Institute for Safe Medication Practices (ISMP) website, accessed 4/20/26, in the article titled, ISMP Guidelines for Safe Medication Practices in Long Term Care, documented medications should be prepared and administered immediately and should not be pre-poured for later administration. The ISMP further documented the following risks associated with pre-pouring medications:- Wrong resident errors- Wrong dose errors- Contamination- Loss of medication integrity- Inability to verify the five rights at the time of administrationa. On 4/12/26 at 9:50 AM, LPN #2 was observed in the 200 hall placing pre-poured medication cups into the top drawer of her medication cart.On 4/12/26 at 9:57 AM, LPN #2 stated a CNA had called out sick and LPN #2 had been assisting residents to get up all morning. She stated she was behind and pre-poured medications to pass them out faster. LPN #2 confirmed she should not pre-pour medications.b. On 4/12/26 at 10:39 AM, a medication cart was observed in the 100 hall. The cart was unlocked, and no staff were present in the area. Upon opening the top drawer of the cart, three medication cups were observed. Two cups were stacked together and labeled with one resident's name, and a third cup was labeled for a different resident's name.On 4/12/26 at 10:40 AM, LPN #1 stated the top stacked cup contained morphine and confirmed the narcotic had been signed out on the controlled substance log at 10:09 AM. She confirmed she should not pre-pour medications and disposed of the medications located in her top drawer.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of nationally recognized standard of practice, and staff interviews, it was determined the facility failed to prevent avoidable accidents by not ensuring residents received the level of supervision and assistance required by their care plans. This was true for 2 of 6 residents (#1 and #2) whose records were reviewed for accidents. This failure resulted in falls during care and created the potential for serious injury to all residents requiring assistance with transfers or repositioning. Findings include:The Agency for Healthcare Research and Quality (AHRQ) website, accessed 4/21/26, identifies preventable accidents as those resulting from failures in:- Supervision- Environmental safety- Communication- Adherence to care plans- Use of assistive devices- Staff traininga. Resident #1 was admitted to the facility 9/11/14 with multiple diagnoses including quadriplegia, anxiety disorder, and the need for assistance with personal care.An Annual MDS assessment dated [DATE], documented Resident #1 was cognitively intact and dependent on staff for rolling left and right in bed.Resident #1's care plan, revised 2/13/20, documented she was totally dependent and required assistance from two staff members for repositioning and turning in bed.The facility's I & A report dated 4/1/26, documented Resident #1 was being changed in bed by a CNA when she rolled off the bed. Resident #1 was observed yelling out in pain. When the nurse entered the room, she found Resident #1 lying on the floor slightly on her right side. The report documented that Resident #1 was transported by emergency medical services for further evaluation.An Interdisciplinary Team progress note dated 4/4/26 documented Resident #1 would be evaluated by therapy and occupational therapy to review environmental modifications, including assessing for appropriate bed size. The note also documented that Resident #1's activities of daily living needs would be evaluated for appropriate support staff.On 4/16/26 at 11:42 AM, the DON confirmed that two CNAs should have been in the room to assist with turning Resident #1 at the time of the fall on 4/1/26.b. Resident #2 was admitted to the facility on [DATE] with multiple diagnoses including difficulty in walking, muscle weakness, and the need for assistance with personal care.A Quarterly MDS assessment dated [DATE], documented Resident #2 required substantial/maximal assistance for chair, bed, and toilet transfers.Resident #2's care plan, revised 1/13/26, directed staff to use two staff members for stand and pivot transfers, both to and from her wheelchair.The facility's I & A report dated 4/8/26, documented a CNA was assisting Resident #2 with a stand-and-pivot transfer when the resident's legs buckled and she was assisted to the floor. The report documented Resident #2 was not wearing appropriate footwear for the transfer. When the nurse entered the room, she placed appropriate footwear on the resident and used two staff members to assist with transferring Resident #2 to her wheelchair after assessing her for injuries. The report documented that staff training was provided regarding safe transfers and proper footwear.A review of the facility's staff training dated 4/8/26, documented education was provided on safe transfers as well as reviewing and following the Kardex (a quick reference for the level of care to be provided by CNAs).On 4/16/26 at 9:26 AM, the DON confirmed Resident #2's fall could have been prevented if the care plan had been followed, as Resident #2 required the assistance of two staff members for transfers.

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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 record review and staff interview, it was determined the facility failed to ensure physician orders for oxygen therapy were followed for 1 of 1 residents (Resident #56) reviewed for oxygen therapy. This failure placed resident #56 at risk for adverse effects, including respiratory infections. Findings include: Resident #56 was admitted to the facility on [DATE] with multiple diagnoses including mild cognitive impairment, chronic obstructive pulmonary disease (COPD), and the need for assistance with personal care.Resident #56's medical record included the following physician orders:-Administer oxygen at 2 liters per minute via nasal cannula continuously, initiated 4/25/25.-Change tubing, clean filter, and change oxygen water every 7 days, initiated 12/1/25.A review of Resident #56's record documented the orders were followed as written.On 4/12/26 at 10:13 AM, Resident #56 was observed resting in bed with her nasal cannula in place connected to an oxygen concentrator. The attached humidifier bottle was dated 4/5/26, and the cannula storage bag was dated 3/29/26.On 4/12/26 at 10:38 AM, CNA #2 stated oxygen tubing is changed every 7 days and confirmed the date written on the bag reflects when the tubing was last replaced. CNA #2 confirmed Resident #56's oxygen tubing had not been changed in 14 days.

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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 record review and staff interview, it was determined the facility failed to ensure a medication was provided with adequate indications for its use. This was true for 1 of 6 residents (Resident #57) whose records were reviewed for unnecessary medications. This failure placed Resident #57 at risk for harm when they were taking a medication which they did not have a clinical diagnosis for. Findings include: The National Library of Medicine web page titled, Tamsulosin (generic for Flomax): Ureteral Stones, accessed 4/23/26, documented dosage and duration of Flomax use for kidney stones, Oral tamsulosin 0.4 mg daily, usually at bedtime, for 7 to 42 days or until expulsion of stones. Resident #57 admitted to the facility on [DATE] with multiple diagnoses including right sided hemiplegia and hemiparesis following a stroke, a seizure disorder, and dementia. Resident #57's record documented the following physicians order, dated 4/26/21:-Flomax 0.4 mg (a medication to relax urinary tract muscles, to make it easier to empty the bladder), give 1 capsule by mouth at bedtime [related to] stent removal and calculus of the kidney (kidney stones). On 4/16/26 at 1:46 PM, the DON stated, Resident #57 had not had treatment for kidney stones or a stent since his admission. She added, his records documented he had a ureteral stent and treatment for kidney stones in 2020, before his admission to this facility. The DON stated Resident #57 did not currently have any urological diagnoses to indicate the use of Flomax.

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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. Based on observation, facility policy review, and staff interview, it was determined the facility failed to ensure medications were stored in a safe and secure manner. This failure had the potential to affect all residents in the facility, as unsecured medications could be accessed by individuals for whom they were not prescribed, creating a risk for harm. Findings include:The facility's Medication Storage policy, revised April 2025, documented medications must be stored safely, securely, and properly in accordance with manufacturer or supplier recommendations and applicable federal and state regulations. The policy also stated that the medication supply would be accessible only to authorized personnel.On 4/12/26 at 10:39 AM, a medication cart was observed in the 100-hall. The medication cart was unlocked, and no staff were present in the area.On 4/12/26 at 10:41 AM, LPN #1 confirmed she had left the medication cart unlocked and stated it should have been locked.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review, and staff interviews, it was determined the facility failed to ensure residents' identifiable information was secured. This failure had the potential to affect all residents in the facility, as unsecured electronic records could allow unauthorized access to protected health information. It was also determined the facility failed to ensure resident records were accurately documented for 1 of 16 residents (Resident #8) reviewed for record accuracy. These failures created the potential for breaches of confidentiality and inaccurate medical documentation. Findings include:The facility's Resident/Patient Confidentiality policy, undated, documented that the HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule establishes national standards to protect individuals' medical records and other personal health information. The policy further documented that appropriate safeguards must be in place to protect the privacy of personal health information and that limits and conditions apply to the use and disclosure of such information without patient authorization.a. On 4/12/26 at 10:40 AM, a medication cart was observed in the 100-hall with a laptop attached. The laptop screen was on and displayed the facility's electronic medical record system with resident information visible. No staff were present at the cart.On 4/12/26 at 10:42 AM, LPN #1 stated she forgot to lock the screen and acknowledged she should have done so.b. Resident #8 was admitted to the facility on [DATE] with multiple diagnoses including generalized anxiety disorder, mild neurocognitive disorder, and schizoaffective disorder.Resident #8's care plan, revised 5/1/24, directed staff to monitor the resident every shift and notify the physician if the resident verbalized suicidal thoughts.A review of Resident #8's behavior monitoring records dated 1/1/26 through 4/15/26 documented that the resident had expressed suicidal thoughts on the following dates:- 3/6/26- 3/12/26- 3/19/26- 4/1/26- 4/2/26- 4/3/26- 4/10/26On 4/15/26 at 10:12 AM, a request was made for documentation of physician notification for Resident #8's reported suicidal statements.On 4/15/26 at 11:05 AM, the DON stated Resident #8 had not verbalized suicidal thoughts and reported the behavior monitoring records were inaccurately documented by the same nurse on each date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, 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 staff did not perform hand hygiene or use Personal Protective Equipment (PPE) for residents on Enhanced Barrier Precautions (EBP) during cares. This was true for 1 of 1 residents (Resident #1) observed for infection control during cares. This failed practice created the potential for adverse outcomes including infection due to cross contamination. Findings include: The facility's Hand Hygiene policy revised 12/2023 instructed staff to use an alcohol-based hand rub (ABHR) containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:-Before and after coming on duty;-Before and after direct contact with residents;-Before preparing or handling medications;-Before performing any non-surgical invasive procedures;-Before and after handling an invasive device (e.g., urinary catheters, IV access sites);-Before donning sterile gloves;-Before handling clean or soiled dressings, gauze pads, etc.;-Before moving from a contaminated body site to a clean body site during resident care;-After contact with a resident's intact skin;-After contact with blood or bodily fluids;-After handling used dressings, contaminated equipment, etc.;-After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident;-After removing gloves;-Before and after entering isolation precaution settings;-Before and after eating or handling food;-Before and after assisting a resident with meals; and-After personal use of the toilet or conducting your personal hygiene.-After removing and disposing of personal protective equipment.a. Resident #1 was admitted to the facility on [DATE] with multiple diagnoses including quadriplegia, Friedreich's ataxia (a disorder that affects some of the body's nerves and the heart), and neuromuscular dysfunction of the bladder (electrical signals are interrupted between your nervous system and bladder function). A review of Resident #1's physician orders dated 3/3/25 directed staff to maintain Enhanced Barrier Precautions: PPE required for high resident contact care activities for indwelling urinary catheter and percutaneous endoscopic gastrostomy tube (a PEG-tube is a feeding tube surgically placed directly into the stomach through the abdominal wall). An EBP sign was posted outside Resident #1's room directed all individuals to sanitize hands before entering and after leaving the room, and directed healthˆcare providers to wear gloves and gowns when performing highˆcontact residentˆcare activities, including: -Dressing/bathing -Transferring -Changing linens -Providing hygiene assistance -Changing briefs or assisting with toileting -Device care or use (central line, urinary catheter, feeding tube, tracheostomy) -Wound-care (any skin opening requiring a dressing) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/14/26 at 10:17 AM, CNA #1 was observed providing incontinence care and changing Resident #1's brief. CNA #1 removed PPE and exited Resident #1's room to obtain more supplies to provide care. No hand hygiene was performed after removing PPE or exiting Resident #1's room. On 4/14/26 at 10:21 AM, CNA #1 returned to Resident #1's room with supplies, performed hand hygiene, applied PPE, and resumed incontinence care for Resident #1. Upon completion of the task, CNA #1 disposed of PPE, gathered the trash, and performed hand hygiene at the sink. On 4/14/26 at 10:33 AM, CNA #1 obtained socks and clothing from Resident #1's closet. CNA #1 applied Resident #1's socks and then applied gloves to handle Resident #1's catheter for dressing tasks. CNA #1 was not observed to use hand hygiene before putting on gloves or donning a gown before handling Resident #1's catheter and dressing her. CNA #1 completed the dressing task, performed hand hygiene, and removed trash from Resident #1's room. On 4/14/26 at 10:48 AM, CNA #1 returned to Resident #1's room with CNA #3 and a hoyer lift. Neither CNA #1 nor CNA #3 were observed performing hand hygiene upon entering Resident #1's room. CNA #1 then donned a gown and CNA #3 donned a gown and gloves to transfer Resident #1 from her bed to her wheelchair. On 4/14/26 at 11:20 AM, when asked when hand hygiene is performed, CNA #1 confirmed hand hygiene is performed before and after cares, and upon entering and exiting resident's rooms. When asked when PPE is worn, CNA #1 stated it was their understanding PPE only needed to be worn when providing cares. When asked if PPE is needed when performing dressing tasks, CNA #1 stated they didn't think so. When asked to verify tasks on the EBP sign that require PPE, CNA #1 verified dressing as a task requiring PPE and stated they should have worn PPE to dress Resident #1. b. On 4/16/26 at 11:16 AM, LPN #3 was observed administering medications and nutrition to Resident #1 through her PEG-tube. LPN #3 was observed entering the residents room, introducing herself and explaining what she was going to do, and setting down the medications on Resident #1's over bed table. LPN #3 completed hand hygiene with ABHR, then donned PPE. LPN #3 picked up a graduated cylinder and a luer-lok piston syringe from beside Resident #1's sink, she turned on the water, and filled the graduated cylinder. LPN #3 then mixed water with the crushed medications appropriately and drew up the first medication in the piston syringe. LPN #3 accessed Resident #1's PEG-tube and administered the medications and nutrition as ordered. LPN #3 was not observed to change her gloves or perform hand hygiene between touching the sink and accessing Resident #1's PEG-tube. On 4/16/26 at 1:56 PM, the DON stated, LPN #3 should have changed gloves and completed hand hygiene after touching the sink and before accessing Resident #1's PEG-tube.