STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135042	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Ridge Care	210 West Lacrosse Avenue Coeur D'Alene, ID 83814

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 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on observation, record review, policy review, review of the State Survey Long-Term Care Reporting Portal and interviews, it was determined the facility failed to ensure residents were free from abuse and neglect. This was true for 6 of 8 residents (#4, #18, #20, 26, 46 and #56) reviewed for abuse and neglect. These deficient practices resulted in residents being subjected to neglect, abuse, and ongoing verbal abuse with the potential for physical and/or psychosocial harm. Findings include: -Residents #4, #20, #26, and #46 experienced mental and psychosocial harm when they were verbally abused by Resident #61. - Resident #56 experienced neglect when she did not receive wound care for a pressure ulcer. - Resident #18 experience physical harm from the facility staff during cares. The facility's Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property Policy, dated 8/22, stated a resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The policy defined verbal and mental abuse as oral, written, or gestured language that includes disparaging and derogatory terms to the resident or their families or within their hearing distance regardless of their age, ability to comprehend or disability, that would demean or humiliate, resulting in pain or mental anguish. Mental abuse can be verbal or non-verbal. It includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation. 1. Facility and resident records documented multiple incidents of Resident #61's verbal abuse of Residents #4, #20, #26, and #46, and incidents of verbal and physical aggression which residents witnessed resulting in mental and psychosocial harm, as follows: - Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and chronic hypertensive kidney disease. A quarterly MDS assessment dated [DATE] documented Resident #4 was cognitively intact. - Resident #20 was admitted to the facility on [DATE] with multiple diagnoses including multiple sclerosis, Todd's paralysis, aphasia, and mixed receptive-expressive language disorder. A quarterly MDS assessment dated [DATE], documented Resident #20 was severely cognitively impaired. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Some	- Resident #26 was admitted to the facility on [DATE] with multiple diagnoses including anemia, fracture of the femur, osteoporosis, and unspecified dementia. An Annual MDS assessment, updated 8/14/24, documented Resident #26 was severely cognitively impaired. - Resident #46 was admitted to the facility on [DATE] with multiple diagnoses including acute and chronic respiratory failure with hypoxia, pulmonary embolism, diabetes, and congestive heart failure. A Quarterly MDS assessment, dated 7/9/24, documented Resident #46 was cognitively intact. a. An I&A report dated 8/12/24, documented Resident #61 became agitated, he yelled and cursed at Resident #20. Resident #26 witnessed this and told Resident #61 he needed to stop yelling and cursing at Resident #20. Resident #61 then began yelling at Resident #26. A physician's assessment, dated 8/14/24, recommended that referrals be made for Resident #61 to an autism specialist for evaluation and to a neurologist or geriatric specialist for further evaluation for management of Resident #61's dementia. No documentation was found in Resident #61's records that he was referred to an autism specialist, a neurologist or geriatric specialist. A nursing progress note for Resident #61, dated 8/17/24, documented Resident #61 was yelling outside of Resident #4's room and was verbally aggressive towards Resident #26, cussing and yelling at her. Resident #34 walked by and told Resident #61 to stop talking to her like that. Resident #61 and Resident #34 began yelling and cussing at each other before being separated by staff. An I&A report, dated 8/17/24, documented Resident #34 left the nurses office because Resident #61 was yelling indiscriminately [at Resident #26] and was speaking aggressively, so Resident #34 told Resident #61 to stop speaking to people that way. Resident #34 stated, Resident #61 then became aggressive towards him, spitting in his face, saying the F-word and F-your family repeatedly using the F-word and putting his middle finger in Resident #34's face. Resident #34 returned to his room, called the police, and made a report. The report documented the facility could not identify why Resident #61 was verbally aggressive towards Resident #26. Resident #61 was moved to a different hall with police assistance. Seventeen residents were assessed if they felt safe in the facility and if they were fearful of any residents. Resident #3, #20, #26, and #30 stated they were fearful of Resident #61. The report further documented Resident #61 was moved to another room. The report concluded Resident #61 has many triggers which influence his aggression and behaviors, directly related to his Autism and OCD diagnoses. The facility is working to place Resident #61 in a different environment as he would benefit from placement in a smaller setting that manages behaviors. The facility did educate staff on Resident #61's triggers, and indicated they would update his care plan as new triggers were identified. A Social Services progress note, dated 8/23/24 at 5:36 PM, documented a new unidentified resident in the facility (stated she was fearful of Resident #61 because he kept coming into her room and he had threatened her. The resident reported Resident #61 yelled and cursed at her several times, and that Resident #61 was angry at her because she was staying in his previous room. The resident told the SSD that if she was not able to move to a different area of the building, she would have her daughter take her home. The resident reported she has called her daughter several times and told her daughter she did not feel safe in the facility. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Grievances reviewed for August 2024 did not show documentation of this interview. No I&A report was found regarding this incident. A nursing progress note for Resident #61, dated 9/7/24 at 3:19 PM, documented Resident #61 was standing over Resident #26 who was sitting in her wheelchair in the entrance of her room. Resident #61 screamed and yelled profanity to Resident #26. When asked, Resident #61 stated Resident #26 told him to stop entering her room. An I&A report dated 9/7/24, documented Resident #26 stopped Resident #61 from entering her room, stating, Why are you entering my room, do not come into my room. Resident #61 then yelled and screamed at Resident # 26, Fuck you lady, go fuck yourself, who the fuck to you think you are? It stated Resident #26 has poor short-term memory and does not remember the previous incidents with Resident #61. The report concluded Resident #26 will redirect or scold Resident #61 when he raises his voice, triggering Resident #61's negative responses to her. As Resident #26 does not remember the interaction, she did not show signs or symptoms of psychosocial harm. A SBAR note, dated 9/13/24 at 4:20 PM, documented a nurse reported Resident #61 had frequent outburst of cursing and yelling at residents and staff. The note documented, Today Resident #61 stated I am going to slit all of your cock sucking mother fucking throat, I am going to take a knife and slit all your throats. I am going to just shoot this mother fucking place up and kill y all. The SBAR documented Resident #61's primary provider recommended Resident #61 be sent to the ER for psych evaluation and should not return to the facility at this time. A hospital progress note for Resident #61, dated 9/13/24, documented, The staff at the facility where [Resident #61] resides has said [Resident #61's] behavior has been escalating and he becomes loud and makes threats and frightens the other residents. [Resident #61] has not been physically aggressive. However, due to the nature of his [Resident #61's] statements that he was going to kill kitchen staff [Resident #61] will not be accepted back to the facility at this point. Resident #61 was diagnosed to have aggressive behavior due to dementia. b. Facility residents were interviewed about abuse and neglect, as follows: During an interview on 10/08/24 at 11:39 AM, Resident #4 was asked if she felt safe in the facility, and if the staff and residents were treating her well. She stated, I don't feel safe with [Resident #61]. He came into my room, yelling at me, and I spoke back to him. He left. I see him around the facility, and I don't make eye contact. I look down or towards the wall. During an interview on 10/08/24 at 10:23 AM, Resident #46 was asked about if she felt safe in the facility, and if the staff and residents were treating her well. She stated, Resident #61 used to live across the hall from me and would wander into my room. I didn't feel safe. I know he doesn't like women. They moved him, and it's been better, but I still don't know if I should fear him as I can't move, and [staff] don't come very quickly when I press the call light. I also think about what I have nearby to pick up and defend myself if he does come back. c. A Resident Council Meeting was conducted on 10/8/24 at 2:30 PM. During the Resident Council meeting Resident's #4, #17, #18, #25, #30, #34, #36, and #49 voiced concerns regarding Resident #61, as follows: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	All eight residents in attendance stated Resident #61 makes their life in the facility uncomfortable and were fearful of him. When asked if they felt safe in the facility, all residents at the Resident Council Meeting listed above, turned their head to the surveyor, with large eyes and expressions of fear shaking their head and stating out loud, NO! The residents in attendance stated Resident #61 made them feel as they needed to adjust their behavior to include looking down and away if they were passing him in the hallway. Resident #17 and #34 stated they felt the need to step in between female staff or residents to keep everyone safe. Resident #34 stated he was unhappy calling the police didn't get a respectful response as the facility is labeled the [name of the facility] loonies. During an interview on 10/11/24 at 1:31 PM, with the Administrator, he was asked what the facility was doing regarding the behavior of Resident #61 and ensuring the safety of the facility residents. The Administrator stated, We have had to send Resident #61 to the hospital to get psych evaluations. No one was available to see him here as our facility is not set up for these types of evaluations. The Administrator stated the facility had been working to get Resident #61 placed into an appropriate facility to care for his specific diagnoses. Staff have been educated on Resident #61's specific triggers, and how to redirect him. 2. Physical abuse by CNA #2 directed at Resident #20: An I&A report dated 3/17/24, documented CNA #2 swatted Resident #20's bottom. CNA #2 was terminated. The I&A documented CNA #2's background check was not completed prior to her working in the facility. On 10/10/24 at 10:04 AM, the Administrator stated background checks are received prior to placing employees on the floor with the residents. On 10/11/24 at 2:30 PM, the Administrator clarified the facility uses a service which provide preliminary approval based on background check that does not include fingerprinting. Finger printing must be completed within the first month. CNA #2 had not been working at the facility long enough to get her fingerprints taken or assessed before she was terminated. On 10/11/24 at 11:54 AM, the DON stated she has been employed for two weeks and she was not familiar with this complaint. She will be looking into the case to see what happened. The DON stated, in her experience, nursing staff are not allowed to work with residents without having a clear background check prior to employment. 43353 3. Resident #56 did not receive wound treatment for her pressure ulcer. Resident #56 was admitted to the facility on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease. The resident was on Hospice care upon admission and discharged to a Hospice Facility on 09/17/24. Review of Resident #56's admission MDS dated [DATE], documented Resident #56 was cognitively intact. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #56's Health Status Note dated 08/25/24 documented Resident had approximately a five-centimeter (cm) diameter, non-blanchable pressure ulcer with multiple two-millimeter openings on her coccyx area. A staff member from the Hospice agency stated that she was sending a nurse to assess the resident's coccyx area for an air mattress. Review of Resident #56's record did not include an order for treatment of her wound. Also Resident also did not include a care plan for her wound. During an interview on 10/10/24 at 2:52 PM, the ADON stated, Resident #56's did have a wound and [the facility's] our wound care physician was not following her care. She said the resident was a hospice patient, and they were responsible for providing wound care orders and treatments. She confirmed there were no orders, skin assessments, or a care plan for Resident #56, or one from the Hospice Agency. During an interview on 10/10/24 at 2:53 PM, the Administrator stated, I didn't know what occurred regarding this resident until last week, when the daughter came in to pick up her belongings after she passed away at the hospice house. Yes, we are still the primary caregivers, but they took care of the wound. Ultimately her daily care is our responsibility. Their hospice doctor writes their orders for their patients. The service agreement we have with Hospice of North Idaho transferred over with the sale of the building. I have reached out to them for an /updated agreement. During an interview on 10/11/24 at 1:30 PM, the DON stated, If the resident is admitted to this facility, then we are the primary caregivers and responsible for them. I don't know why or how this occurred since I only arrived last week. However, since learning about this resident, I met with the RN of our current hospice resident, and we have come to an agreement that she must see myself or the unit manager prior to leaving so that we can coordinate care and we're always on the same page. The DON confirmed there was no collaboration with the Hospice Agency that was providing care to Resident #56 while she was a resident at the facility. She said she only knew the Hospice nurse came weekly to see the resident. She further said, this shouldn't have happened and won't happen again. Review of Service Agreement between Hospice of [name of hospice agency] and [name of facility] signed 06/10/19 revealed: 4.2 Facility Services: a) The Facility will comply with all applicable state and/or federal regulations when providing care to residents who have elected Hospice. Basic services will include the following . iii) Nursing services as required by Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities . vi) Supervision of Facility staff providing services under the Hospice Plan of Care established by the Hospice team . vii) Services provided will be consistent with the services provided to the resident before hospice care . b) Ensure that each Hospice resident receives treatments, medications and diet as prescribed, and is kept clean, comfortable and well groomed . e) Allow, members of the IDT, as identified in the Plan of Care to attend, counsel, treat and serve Hospice residents . k) Except as otherwise provided herein, the services of the facility provided pursuant to the terms of this Agreement shall be made available to hospice residents 24 hours a day, 7 days a week. During this term or any succeeding terms of this Agreement, the Facility will hold itself (including a sufficient number of its personnel, as determined by the Facility and the Hospice as having the requisite skills) available to finish, and shall furnish the services and facilities contracted for herein. 36193 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	4. Physical abuse directed by Resident #130 to Resident #18. Resident #18 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including left hemiplegia and hemiparesis (paralysis and weakness on one side of the body) following stroke and diabetes. a. A review of an investigative summary report uploaded to the State's Long-Term Care Reporting Portal, dated 5/28/24, documented [Resident #18] reported to a staff that [Resident #130] tried to block her from going out to the smoking area. She stated [Resident #130]would not move, and they had an argument. [Resident #18] stated [Resident #130] reached over and slaped her to each side of her face. The investigation report documented [Resident #18] was noted to have a scratch, approximately 6.2 x 0.4 on the left side of her face. There was also one small superficial open area at the top of the scratch closer to her ear. [Resident #130 was interviewed and stated [Resident #18] was blocking the exit to the smoking area and had an argument. [Resident #130] stated she pushed [Resident #18's] wheelchair out of the way but did not touch any part of [Resident #18]. The investigation report documented [Resident #130] had a large brace on her hand and wrist that could have easily caused a scratch if there was contact made with [Resident #18's] face. Activities and nursing staff were interviewed and all report stated that prior to the incident [Resident #18] did not have a scratch on her face. The facility's investigation report concluded that it was suspected [Resident #130] slapped [Resident #18]. The report documented the facility had taken measures to ensure that contact between the two residents was limited and any activities would be supervised by staff. Both residents agreed to a set schedule for smoking. [Resident #18] would smoke during the even hours and [Resident #130] would smoke during the odd hours. On 10/11/24 at 11:43 AM, the Administrator together with the ADON stated he was the facility's abuse coordinator and stated all suspected residents' abuse/neglect are to be reported and investigated. The ADON stated Resident #130 denied slapping Resident #18, but later on she acknowledged that she did slap Resident #18. The ADON stated the two residents were put on different smoking schedules. 5. Physical abuse by CNA #3 directred at Resident #18. A review of an investigative summary report uploaded to the State's Long-Term Care Reporting Portal, dated 2/27/24, documented [Resident #18] was fearful of a CNA #3. [Resident #18] was interviewed on 2/26/24, [Resident #18] stated a staff came to wake her up and pushed her bad hip. She reported the staff seemed upset that she had diarrhea and needed to be cleaned up. [Resident #18] stated CNA #3 told her if she could go out to smoke, she could get up to go to the bathroom. [Resident #18] reported CNA #3 grabbed her right wrist and left ankle and flipped her onto her back forcefully. She stated CNA #3 was very angry and aggressive towards her. [Resident #18] stated she asked CNA #3 to stop and to leave her alone multiple times but, CNA #3 did not stop holding her down. [Resident #18] complained of right wrist injury from the incident. She was found to have 3.5 cm x 3.5 cm reddened area on the top surface of her wrist. On the palm side of her wrist were three small circular bruises each measuring 1.25 cm x 1.5 cm. [Resident #18] stated she was afraid of CNA #3 and does not want her to ever take care of her or be near her. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	The facility's investigation report concluded the allegation of abuse by CNA #3 to [Resident #18] was substantiated due to the presence of physical bruising and redness on her wrist which were not present prior to the cares provided by CNA #3. The facility's investigation report, documented CNA #3 was terminated from her employment via phone conversation on 2/26/24 at 12:34 PM. On 10/11/24 at 11:48 AM, the Administrator stated because of the bruises sustained by Resident #18 during cares, CNA #3 was terminated from her employment. The Administrator also stated the facility had a float pool of staff and hire them at corporate level with long-term contracts, usually 13 weeks, to better care for the residents.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on review of facility policy, record review, document review, and interviews, the facility failed to ensure allegations of abuse were thoroughly investigated. This was true for 2 of 8 residents (#4, and #46) reviewed for abuse and neglect. This deficient practice created the potential for psychosocial, verbal, and physical harm whose abuse allegations were not investigated thoroughly, and measures taken to protect resident during the investigation, which placed all residents in the facility at risk of abuse. Findings include: The facility's Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property Policy, dated 8/22, documented a resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The policy defined Verbal and Mental abuse as oral, written, or gestured language that includes disparaging and derogatory terms to the resident or their families or within their hearing distance regardless of their age, ability to comprehend or disability, that would demean or humiliate, resulting in pain or mental anguish. Mental abuse can be verbal or non-verbal. It includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation. 1. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and chronic, hypertensive kidney disease. On 10/08/24 at 11:39 AM, Resident #4 stated, I don't feel safe with [Resident #61]. He came into my room, yelling at me, and I spoke back to him. He left. I see him around the facility, and I don't make eye contact. I look down or towards the wall. A review of progress notes from 8/5/24 documented an SBAR where Resident #61 entered multiple rooms but did not identify which rooms or which residents were involved. Review of facility's Grievances, SBARS, and I&A reports were reviewed for 2024. No reports were found. 2. Resident #46 was admitted to the facility on [DATE] with multiple diagnoses including acute and chronic respiratory failure with hypoxia (a condition in which there is a deficiency of oxygen in the body's tissues), pulmonary embolism, diabetes, and congestive heart failure. On 10/08/24 at 10:23 AM, Resident #46 stated, Resident #61 used to live across the hall from me and would wander into my room and yell at me. I didn't feel safe. I know he doesn't like women. They moved him, and it's been better, but I still don't know if I should fear him as I can't move, and [staff] don't come very quickly when I press the call light. I also think about what I have nearby to pick up and defend myself if he does come back. On 10/11/24 at 11:01 AM, LPN #2 stated she provided a grievance form to Resident #46 when Resident #61 yelled at her outside of her room. She stated this incident happened within a few months of Resident #61coming into the facility. LPN #2 also stated residents were affected by the incident. They were provided grievance forms, but I don't know if they filled them out. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 8/5/24, documented [Resident #61] is disruptive, aggressive, and requires more attention than this facility can provide, he requires a behavior unit. Additionally, it was documented [Resident #61] continued to have outbursts of agitation and was being intrusive by going into other residents' rooms. He was extremely aggressive, loud, and difficult to redirect. A psychiatric evaluation and medication change was asked for. A review of facility grievances for 2024, did not show any complaints regarding this incident. A review of I&A reports for 2024, did not show any documentation regarding this incident. An SBAR report, dated 8/5/24, documented that Resident #61 entered other resident's room, but did not identify which rooms or residents who were involved. On 10/11/24 at 11:23 AM, the Administrator and DON stated Resident #61 was moved to a different room after the incidents in the hallway, but they are not sure if a report was filed. They were unaware Resident #61 was entering residents' room.

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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** 50603 Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure resident care plans were revised to reflect current needs and interventions. This was true for 2 of 23 residents (#4, and #17) whose care plans were reviewed. This placed residents at risk of adverse outcomes if care and services were not provided due to care plans not being revised as residents' needs changed. Findings include: The facility's Care Planning Process policy, revised 5/19/23, documented the care plan must be reviewed and revised according to the RAI (Resident Assessment Instrument) process at a minimum upon admission, quarterly, and with significant change in condition and services provided or arranged much be consistent with each resident's written care plan. 1. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and chronic, hypertensive kidney disease. Resident #4's care plan, dated 6/29/22, relating to renal failure, directed staff to monitor her for signs or symptoms of hypo/hypervolemia, and to monitor/document/report her for signs and symptoms of acute failure: oliguria, and increased BUN and Creatinine. A review of the MAR/TAR for September through October 2024, failed to document any hypo/hypervolemia monitoring. On 10/11/24 at 11:45 AM, the DON verified she did not see anything in Resident #4's EHR record related to hypo/hypervolemia monitoring. She stated there was no blood work being tracked; however, Resident #4 is up for an MDS review in December and her file will open next month to be updated. 2. Resident #17 was admitted to the facility on [DATE], with multiple diagnoses including rib fractures, chronic obstructive pulmonary disease, and diabetes. On 10/08/24 at 9:13 AM, Resident #17 stated in a follow-up interview per resident's request, he stated he is trying to lose weight and he has started to take the weekly shot. A physician's order, dated 9/24/24, documented Semiglutide (an anitdiabetic medication used for the treatment of type 2 diabetes and an anit-obesity medication used for long-term weight management) administration, with weekly weights taken. A review of Resident #17's care plan, dated 9/5/24, and revised on 9/19/24, did not include any weight management interventions. On 10/11/24 at 11:46 AM, a review of Resident #17's record, with the DON, verified Resident #17's care plan was not updated with a weight management program. On 10/10/24 at 10:30 AM, during a resident requested follow-up interview, Resident #17 stated he was supposed to have CPAP machine on every night, but no one had come in to help him. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Ridge Care	210 West Lacrosse Avenue Coeur D'Alene, ID 83814

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #17's care plan, dated 9/5/24 and revised 9/19/24, does not show use of CPAP machine. A physician's order, dated 10/2/24, documented: Hook Patient up to Home CPAP with 2 LPM (liters per minute) of Oxygen continuously through device. Increase Oxygen if Pulse Oximetry Level is below 88%. A review of the MAR, for October 2024, documented beginning 10/2/24 at 7:00 PM, the CPAP mask was being placed on Resident #17. However, Resident #17 was adamant no one had helped him put the mask on before bed. On 10/11/24 at 10:45 PM, the DON stated she would investigate what happened with the CPAP mask. She verified the O2 tubing should be dated. The DON confirmed the care plan was not updated.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43353 Based on interview, record review, and review of facility policy, the facility failed to provide activities of daily living (ADL) care for 1 of 4 dependent residents (Resident #19) who required extensive assistance with personal hygiene/showers out of a total sample of 32 residents. This deficient practice created the potential for Resident #19 to have a decrease in their quality of life. Findings include: Resident #19 was admitted to the facility on [DATE], with multiple diagnoses including multiple sclerosis. A Quarterly MDS assessment, dated 8/28/24 documented Resident #19 was cognitively intact and required assistance with bathing/showers/hygiene. Resident #19's Shower Sheets for the past 30 days documented he received two showers a week, except for two, one he refused, and one he was unavailable. During an interview on 10/07/24 at 4:12 PM, Resident #19 stated he only received one shower a week. He said his shower days were Sundays and Wednesdays and he always received a shower on Sunday, but not on Wednesday. By Sunday, my hair is always greasy and in bad shape and I need a really good shave by then. They don't say why they don't give me my Wednesday shower, but I really want my showers. I know they put I refuse a lot, but that is not the case. The resident was noted with approximately 1/4 inch of beard growth and oily unkempt hair. During a follow up interview on 10/11/24 at 1:10 PM, Resident #19 stated, I asked if I could get my shower two days ago, on Wednesday, but I never received it, as usual. I don't get bed baths, and they never tell me why. During an interview on 10/11/24 at 1:20 PM, LPN #1 stated, Resident #19 got a partial bed bath on Wednesday. I know on Sundays he gets a shower. On Wednesday he got a partial bed bath because we only had one aide on the floor that day. During an interview on 10/11/24 at 1:30 PM, the DON said Resident #19 was care planned to receive two showers a week. Everyone should have two showers a week. Review of the facility policy titled, Personal Needs, dated 12/20/22 revealed Policy: The center strives to promote a healthy environment and prevent infection by meeting the personal care needs of the residents. The center also provides the needed support when the resident performs their activities of daily living (ADLs) . The Care Plan will address the individual needs and preferences of the resident. Personal care and ADL support will be provided according to the resident's Care Plan. Compliance with care delivery needs and interventions will be determined by observation of care delivery and not through the utilization of care delivery flow record (Point of Care). Personal care and support include but is not limited to the following: bath/shower, grooming/dressing, shampoo, shave .

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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** 36193 Based on observation, record review, policy review and staff interview, it was determined the facility failed to ensure resident-centered care were provided in accordance with professional standards of nursing practice and residents' comprehensive care plans. This was true for 3 of 23 residents (#4, #17, and #22) 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 #22 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses chronic respiratory failure with hypercapnia (increase level of carbon dioxide in your blood), myotonic (muscles are unable to relax after they contract) muscular dystrophy (a progressive muscle loss) and paroxysmal (uncontrolled) atrial fibrillation (irregular heartbeat). A physician order, dated 3/30/24, documented monitor Resident #22's bilateral lower extremities edema and notify the physician if change is noted. A care plan, revised 4/15/24, directed staff to monitor/document/report Resident #22's any signs and symptoms of CAD (coronary artery disease) such as dependent edema, changes in capillary refill, and color/warmth of her extremities to the physician. On 10/7/24 at 3:03 PM, Resident #22 stated to the surveyor her legs were red and big. CNA #1 then removed the sheet and Resident #22's right and left leg were observed to be swollen, and looked dry with flaky skin. The middle portion of her right leg was noted to be slightly red in color. A Nursing Note, dated 10/1/24 at 4:24 PM, documented, Resident has large slightly red area to BLE. Not red [warm] to touch but painful when pressure is applied. Legs have 2-3+ edema in BLE as well. Resident #22 was encouraged to wear her TED hose or other compression garment, but Resident #22 stated it would make her uncomfortable. Resident #22 was also educated to take her diuretic medication, but Resident #22 stated she didn't care and would not talk to the nurse anymore. There was no documentation in Resident #22's record the 2-3+ edema to her BLE, which was painful when pressure was applied, was referred to the physician. On 10/10/24 at 10:48 AM, the DON reviewed Resident #22's record. The DON stated Resident #22 should have been referred to the physician and she was not. 50603 3. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and chronic, hypertensive kidney disease. Resident #4's care plan, dated 7/15/22, directed staff to monitor her Hypo/Hypervolemia, and to notify the physician of irregularities. Resident #4's record did not include monitoring for Hypo/Hypervolemia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/24 at 11:45 AM, the DON verified that the physician's orders were not being followed as Resident #4 did not have any monitoring system in place for Hypo/Hypervolemia. The DON stated if there were notifications to the physician, they might be recorded separately, after the physician signs off on the notification. Notifications are usually recorded in progress notes, but she was unable to find any relating to Hypo/Hypervolemia or Edema. A physician's order dated 5/8/23, documented to monitor for edema using the BLE (bilateral, lower extremity) Edema Scale weekly, and to notify the physician if a change in edema is noted. A review of the MAR and TAR for October 2024, documented the following BLE Edema Scale: -9/19/24: An increase from grade 2 to grade 3 -9/21/24: No recorded measurement -9/23/24: An increase from grade 1 to grade 2 -10/5/24: An increase from grade 2 to grade 3 -10/6/24: A decrease from grade 3 to grade 2 -10/7/24: A decrease from grade 2 to grade 1 -10/9/24: An increase from grade 1 to grade 2 -10/10/24: A decrease from grade 2 to grade 1 No notifications to the physician were found in the resident's record. On 10/11/24 at 11:45 AM, the DON verified that the physician's orders were not being followed. She also confirmed notifications to the physician for the changes in edema were not available. 4. Resident #17 was admitted to the facility on [DATE], with multiple diagnoses including rib fractures, chronic obstructive pulmonary disease, and diabetes. On 10/7/24 at 4:15 PM, it was observed in Resident #17's room, no date was on the O2 tubing, and the CPAP machine mask was on the floor. A physician's order, dated 9/8/24, documented to change O2 tubing, label and date, every night shift, every Sunday. A review of the TAR for September and October 2024, documented O2 tubing was changed, labeled, and dated every night shift on Sunday's. On 10/10/24 at 1:30 PM, with dayshift LPN #1 present, he verified there was no date on the O2 tubing. He stated O2 tubing should be dated by the evening staff who take care of this.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **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 residents received proper treatment to maintain foot health. This was true for 2 of 5 residents (#22 and #48) reviewed for foot care. This deficient practice created the potential for harm should residents experience complications related lack of proper foot care. Findings include: 1. Resident #22 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses chronic respiratory failure with hypercapnia (increase level of carbon dioxide in your the blood), myotonic (muscles are unable to relax after they contract) muscular dystrophy (a progressive muscle loss) and paroxysmal (uncontrolled) atrial fibrillation (irregular heart beat). A care plan, initiated on 1/4/24, directed staff to refer Resident #22 to a podiatrist/foot care nurse to monitor/document foot care needs and to cut her long nails. A Nurse Practitioner (NP) progress note, dated 8/20/24 documented, Candidiasis [fungal infection] of skin and nail. A Quarterly Nursing Evaluation, dated 9/22/24, documented Resident #22's toenails were yellow. A September 2024 TAR, directed staff to check Resident #22's foot every week and notify the physician if skin issue was noted. On 10/7/24 at 3:03 PM, Resident #22's toenails were observed to be long, thick and yellowish in color. The right big toe was noted to have blackened area on its side. There was no documentation in Resident #22's record she was seen by a podiatrist or was referred to the physician regarding the condition of her toenails. On 10/10/24 at 10:19 AM, the ADON with the DON present was asked if Resident #22 was seen by a podiatrist, the ADON reviewed Resident #22's record and stated she was unable to find documentation Resident #22 was seen by a podiatrist. 2. Resident #48 was admitted to the facility on [DATE], with multiple diagnoses including respiratory failure with hypercapnia (increase level of carbon dioxide your blood), diabetes and chronic obstructive pulmonary disease. A physician order, dated 2/8/24, documented, Diabetic Foot checks every week on skin check day. Notify MD [if] skin issue is noted. A care plan initiated on 2/14/24, directed staff to refer Resident #48 to a podiatrist/foot nurse to monitor/document foot care needs and to cut long nails. A Quarterly Nursing Evaluation dated 8/24/24, the section was blank regarding the assessment on C. Skin Integrity #3 Toenails. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A September 2024 TAR, directed staff to check Resident #48's foot every week and notify the physician if skin issue was noted. On 10/8/24 at 3:55 PM, Resident #48 was in bed and his toenails were observed to be thick and long. There was no documentation in Resident #48's record she was seen by a podiatrist or was referred to the physician regarding her toenails condition. On 10/10/24 at 10:19 AM, the ADON, with the DON present, was asked if Resident #48 was seen by a podiatrist, the ADON reviewed Resident #48's record and stated she was unable to find documentation Resident #48 was seen by a podiatrist.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on policy review, record review, and staff interview, it was determined the facility failed to ensure a resident with mental disorders received appropriate treatment and behavioral services. This was true for 1 of 1 resident (Resident #61) reviewed for mental and behavioral health care. This failure created the potential for the resident to experience compromised physical and psychosocial well-being. Findings include: Resident #61 was admitted to the facility on [DATE], with multiple diagnoses including autistic disorder, dementia with agitation, and adult personality and behavior disorder. A social services progress noted, dated 4/19/24, documented Resident #61's previous primary care provider stated he was becoming increasingly more demented, and he may have a schizotypal personality disorder. Social services stated Resident #61 might need a psychiatric evaluation. Resident #61's care plan, dated 4/26/24 and revised on 5/3/24, documented a history or potential to demonstrate, verbal abusive behaviors such as aggressive cursing, threatening, and yelling at staff, ineffective coping skills, mental/emotional illness, and poor impulse control. The care plan directed staff to document observed behavior, and if resident became agitated, to intervene before escalation, guide away from source of distress, and if aggressive, to have staff walk away to approach later. A preadmission PASSR I was completed on 5/9/24, identifying unspecified dementia, autism, and substantial limitations in learning, self-care, capacity for living independently, and self-direction. A PASSR II evaluation was recommended. An abbreviated PASSR II was completed on 5/9/24 and 5/10/24, documenting a diagnosis of autism and stating that no specialized services were required, as Resident #61's needs would be met by the receiving facility. On 5/18/24 Resident #61 was sent to the hospital due to increasing lethargy, confusion, and decrease appetite and thirst. Resident #61 was admitted to the hospital on 5/18/24 for a consultation regarding lithium management related to his increasing lethargy, confusion, and decrease in appetite and thirst. On 5/21/24, a hospital admission history and physical, documented Resident #61 had past medical diagnoses of autism with combative behavior and dementia. A Social Services progress note, dated 6/28/24, documented Resident #61's behavior in the facility was not appropriate and his dementia had worsened. Social Services stated the safety of other residents and staff in the facility could be at risk and Resident #61 was no longer appropriate for this environment. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Social Services progress note, dated 8/1/24, documented social services was looking for alternative placement due to [Resident #61's] ongoing behavior and autism diagnosis. IDT felt that [Resident #61] might be overstimulated, and a smaller setting would be more appropriate to meet his current needs. An SBAR, dated 8/5/24, documented Resident #61 needs a psychiatric evaluation as Resident #61's medication had already been adjusted. On 9/13/24, Resident #61 was seen for a Psychiatric Initial Consultation related to assaultive/violent behaviors and crisis stabilization. The physician's report documented patient was loud and made verbal threats to staff. The report stated facility staff had reported Resident #61's behavior had been escalating, becoming loud, making threats, and frightening other residents. Although, [Resident #61] had not been physically aggressive, the report stated, [Resident #61] would kill the kitchen staff, and the facility would not be accepting him back. There was no record found where Resident #61 was seen by a psychiatrist regarding schizotypal personal disorder, or behavioral aggression prior to 9/13/24. On 10/11/24 at 1:31 PM, the Administrator stated, We have had to send Resident #61 to the hospital to get psych evaluations. No one was available to see him here as our facility is not set up for these types of evaluations. The Administrator stated the facility had been working to get Resident #61 placed into an appropriate facility to care for his specific diagnoses.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on observation, policy review and staff interview, it was determined the facility failed to ensure medications were disposed properly. This was true for one of one staff (LPN #2) observed disposing the medications in the regular trash can. This deficient practice created the potential for harm if resident pick up and take the medication. Findings include: The facility's Destruction of Controlled Substance procedure, undated, documented under the section Disposal of Drugs - Drug Buster Drug Disposal System Remove discontinued, expired, contaminated or unusable medication from original prescription container or packaging and dispose of by placing into Drug Buster container. On [DATE], three pills were observed on top of LPN #2's medication cart and LPN #2 was looking at the computer. There was no barrier between the medication cart and the three pills. When LPN #2 saw the Surveyor, she immediately pick up the three pills and threw them in the trash can which was located on the side of her medication cart. When asked what the pills were, LPN #2 stated they were all over the counter medications and can be thrown in the regular trash can. LPN #2 also stated, if they were narcotics medications she would dispose them in the drug buster. When asked again about the names of the pills, LPN #2 stated they were ASA, metoprolol (antihypertensive) and gabapentin (anticonvulsant). [DATE] 04:26 PM, the DON stated the medications should have disposed in the drug buster and not in the regular trash can. The Drugs.com website, accessed on [DATE], stated gabapentin and metoprolol are prescription medications.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review, review of the State Long-Term Care Reporting Portal, I&As, review of facility policies and procedure, and staff interview, it was determined the facility failed to ensure residents were free from significant medication errors. This was true for 4 of 4 residents (#3, #126, #127 and #129) reviewed for medication administration. Resident #129 was harmed when he experienced dizziness and low blood pressure and needed to be sent to the hospital due to his hypotension. Findings include: The facility's Medication Administration procedure, undated, directed the licensed nurse to check the following to administer the medication: - Right medication - Right dose - Right dosage form - Right route - Right resident - Right time 1. Resident #129 was admitted to the facility on [DATE], with multiple diagnoses including heart failure, hypertension, and atrial fibrillation (irregular heartbeat). A facility Investigative Summary Report, dated 8/13/24 at 11:00 AM, documented Resident #129 took a cup of pills which was intended for another resident. Resident #129 complained of being dizzy, his blood pressure was taken, and it was 74/38. The provider was notified, and an order was received to send Resident #129 to the hospital. Resident #129 was informed the provider wanted him to go to the hospital for evaluation but, Resident #129 did not want to go to the hospital and stated he felt like he would be fine. When his chair was sat-up from a tilt position, Resident #19 was getting dizzy again. After 5-10 seconds Resident #129 head fell to his chest, his eyes rolled back, and his tongue fell out of his mouth. The nurse tried sternal rubbing to arouse him,and he did not respond. Resident #19 was laid down back in chair. After five seconds, Resident #129 came to and asked what happened. He was told that he crashed and would be sent to the hospital. Resident #129's blood pressure at this time was 80/42 mmHg. EMS was called and Resident #142 was taken to the hospital. The Investigative Summary Report, documented Resident #129 was wrongly administered the following medications by the float nurse at 11:00 AM on 8/13/24: - ASA 81 mg - irbesartan (anti-hypertensive) 75 mg (milligram) (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Pantoprazole (decreases the amount of acid produced in the stomach) 20 mg - Metformin (anti-diabetic)500 mg - Senna Plus (laxative) 8.6-50 mg A Hospital progress note, dated 8/13/24, documented Resident #129 received irbesartan 75 mg which was prescribed for another resident, and he would be admitted due to persistent hypotension (low blood pressure). On 10/10/24, the DON who just started in the facility two weeks prior, reviewed the Investigative Summary report and stated the float nurse did not follow the six rights of medication administration. The DON stated the nurse should make sure the right medications were administered to the right resident. 2. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and hypertension. A I&A report, dated 2/29/24, documented Resident #3's blood sugar was not checked and did not receive her 6 units of Novolog. An interview with the day shift nurse stated she was very busy and did not have time to complete the blood sugar check or give insulin. When asked why she did not ask for assistance from RCM or another nurse, the day shift nurse stated, I was too busy. The I&A documented the day shift nurse did not complete an incident report, nor did she return to work her next shift. The day shift nurse was subsequently terminated on 3/4/24. On 10/10/24 at 1:30 PM, the DON who just started in the facility two weeks prior, reviewed the I&A and stated the nurse should have checked Resident #3's blood sugar if it's supposed to be done during her shift and administered the medication as ordered by the physician. The DON also stated nurses on the floor should have asked the RCM for assistance as needed. 3. Resident #125 was admitted to the facility on [DATE], with multiple diagnoses including anoxic (a complete loss of oxygen supply in your body or brain) brain damage and persistent vegetative state. An I&A report, dated 4/24/24, documented Resident #125 was administered Norco (opioid pain medication) 5/325 mg and Clonazepam (antianxiety) 0.5 mg via is PEG tube at 5:00 PM from the day shift nurse, and received the same medications again at 6:00 PM from the evening shift nurse. Resident #125 was monitored and no changes in condition was noted. The I&A documented the nurse who administered the second medications was a travel agency contract nurse and was educated on the process for checking out all medications on the MAR to ensure they are not given too soon and how to look for the last dose given on the MAR. On 10/10/24 at 1:45 PM, the DON who just started in the facility two weeks prior, reviewed the I&A and stated the medication error was committed by the travel nurse and was educated on the importance of medication administration. The DON also stated the facility is now contracting nurses on a long-term basis so they have time to get to know the facility as well as the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135042	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Ridge Care	210 West Lacrosse Avenue Coeur D'Alene, ID 83814

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #127 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including respiratory failure, diabetes, and liver cirrhosis (severe scarring of the liver that can be caused by many diseases and conditions, such as hepatitis or alcoholism). An I&A report, dated 7/7/24, documented Resident #127 did not receive his Novolog sliding scale prior to his lunch. The report documented the 6:00 AM to 12:00 PM nurse told the oncoming nurse that she had not given the insulin to the residents requiring sliding scale insulin on the 500 Hall. The oncoming nurse stated she thought the 6:00 AM to 12:00 PM nurse told her all insulins were given. Both nurses were educated on the requirements for shift-to-shift hand over of residents' medications. Resident #127's blood sugar was monitored, no signs and symptoms of hypoglycemia or hyperglycemia noted. On 10/10/24 at 1:55 PM, the DON who just started in the facility two weeks prior, reviewed the I&A report and stated Resident #127 did not receive his sliding scale insulin due to miscommunication between the two nurses. The DON stated 6:00 AM to 12:00 PM nurse should have stayed to complete the medication administration or wrote down the name of residents she was unable to give the sliding scale of insulin for the oncoming nurse.

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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. 50603 Based on observation and staff interview, it was determined the facility failed to ensure the kitchen equipment and environment was maintained, clean, and food was stored in a safe and sanitary manner. These deficiencies had the potential to affect the 69 residents who consumed food prepared by the facility. This placed residents at risk for potential contamination of food and adverse health outcomes, including food-borne illnesses. Findings include: FDA Food Code Section 3-303.12 documented packaged food may not be stored in direct contact with ice or water if the food is subject to the entry of water because of the nature of its packaging, wrapping, or container or its positioning in the ice or water. The FDA Food Code Section 6-501.12 Cleaning, Frequency and Restrictions, documented cleaning of the physical facilities is an important measure in ensuring the protection and sanitary preparation of food. A regular cleaning schedule should be established and followed to maintain the facility in a clean and sanitary manner. Primary cleaning should be done at times when foods are in protected storage and when food is not being served or prepared. 1. The initial kitchen inspection was conducted on 10/7/24 at 11:45 AM, with the CDM (Certified Dietary Manager). The following was observed - Condensation icicles from the cooling fans in the walk-in freezer were observed falling and accumulating on the following food items located below the cooling fans: cardboard boxes of frozen vegetables. - An accumulation of ice about 2.5 inches thick, was around the pipe behind the condenser above the cardboard boxes of vegetables. 2. A second kitchen inspection was conducted on 10/10/24 at 3:15 PM with the CDM. The following was observed: - Condensation icicles from the cooling fans in the walk-in freezer were observed falling and accumulating on the following food items located below the cooling fans: cardboard boxes of frozen vegetables, opened packages of frozen hamburgers. - An accumulation of ice about 2.5 inches thick, was around the pipe behind the condenser above the cardboard boxes of vegetables. On 10/10/24 at 3:20 PM, CDM stated that facility maintenance is responsible for cleaning the refrigerators and walk-in freezers. She stated she was not sure when the pipe behind the condenser was last looked at, but it had been during this past summer. The CDM also stated that a drip pan is usually below the condenser to catch any water droplets that fall. She was not sure why the drip pan was not there but acknowledged the food below the ice droplets had been contaminated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/11/24 at 10:30 AM, the Maintenance Director confirmed that a deep cleaning of the refrigerator and walk-in freezer had been completed over the summer. However, it was the responsibility of the kitchen staff to spot clean in between, especially if there is ice build-up. The Maintenance Director confirmed the pipe behind the condenser should be fixed as the ice build-up on the pipe was not the kitchen staff's responsibility. On 10/11/24 at 2:33 PM, the CDM provided a kitchen cleaning schedule documenting daily breakdown of staff responsibilities to include cleaning the interior of the refrigerator and walk-in freezer. She could not explain why there had been a large buildup of ice in the walk-in refrigerator.

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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** 43353 Based on observation, interview, review of facility policy, and review of facility training document, the facility failed to ensure that staff wore appropriate Personal Protective Equipment (PPE) for one of three residents (Resident #173) observed for enhanced barrier precautions (EBP) when providing care out of a total sample of 32 residents. This had the potential for the resident to have an increase for infection. Findings include: Review of Resident #173's Admission Record in the Profile tab of the electronic medical record (EMR) revealed an admitted [DATE]. The Admission Record revealed a diagnosis of malignant neoplasm (cancer) of endometrium (tissue of the uterus). Review of Resident #173's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/28/24, located in the EMR MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated the resident was moderately cognitively impaired. During observation and interview 10/08/24 at 9:26 AM revealed Resident #173 had a STOP Enhanced Barrier Precautions (EBP) signage on the door frame and an isolation cart outside the doorway. The Certified Nurse Aide (CNA) was observed to empty the urine from the foley catheter drainage bag. The CNA was observed with only gloves on. The CNA confirmed they only had gloves on and the resident was on EBP and should have worn a gown. During an interview on 10/08/24 at 9:30 AM, Resident #173 stated, The staff usually wore gowns and gloves when taking care of them. During an interview on 10/08/24 at 9:47 AM, the Administrator stated, All staff were aware of when to use EBP and for which residents require it. During an interview on 10/10/24 at 2:52 PM, the Infection Preventionist (IP) stated, All staff are trained on when and who to use EBP for. I go over this training each time we have a new admission it applies to and with each new infection or new occurrence when it's needed. I don't know why CNA didn't wear EBP, but he was educated again. Review of the facility policy titled, Enhanced Barrier Precautions (EBP) Policy and Procedure, dated 04/2024 revealed Policy: Enhanced barrier precautions (EBP) will be used for novel or targeted MDROs [Multidrug-resistant organisms] . Enhanced Barrier Precautions (EBP): The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and for indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's training check-off document titled, Personal Protective Equipment Skills Checklist, dated 09/18/21 with attached undated document defining EBP requirements in detail, Type of Precaution: Enhanced Barrier Precautions (EBP); Applies to: All residents with any of the following: Infection or colonization with an MDRO when contact precautions do not otherwise apply. Wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status; When to Use PPE: During high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator; PPE Use: Gloves and gown prior to the high-contact care activity, change PPE before caring for another resident, don before room entry, doff before room exit, face protection may also be needed; Restriction: None.