STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135055	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Vista Care Center of Sandpoint	220 South Division Ave Sandpoint, ID 83864

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents' right to be treated with respect and dignity was upheld for 1 of 4 resident (Resident #1) who required assistance with their meals. This deficient practice resulted in a resident not being fed in a dignified manner. Findings include: The facility's Assistance with Meals policy, revised July 2017, documented residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example not standing over residents while assisting them with meals. Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including intracranial (brain) injury with loss of consciousness of unspecified duration. On 6/23/25 from 12:38 PM to 12:56 PM, LPN #4 was observed standing while feeding Resident #1 his meal. On 6/23/25 at 2:25 PM, LPN #4 stated he was standing when he assisted Resident #1 with his meal. LPN #4 stated he should have been sitting down while assisting Resident #1 with his meals.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview it was determined the facility failed to ensure residents exercised their right to formulate an Advance Directive. This was true for 2 of 15 residents (#37 and #38) whose records were reviewed. This failed practice created the potential for an adverse outcome if the resident's wishes were not followed. Findings include: The State Operation Manual (SOM), Appendix PP, defined an Advance Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. Physician Orders for Life-Sustaining Treatment (or POLST) paradigm form is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an advance directive. 1. Resident #37 was admitted to the facility on [DATE] with multiple diagnoses including dementia, post-traumatic stress disorder (PTSD), and depression. Resident #37's record did not include an advance directive for healthcare. Resident #37's record did not include documentation of resources offered for assistance with executing a healthcare advance directive. On 6/26/25 at 9:54 AM, the CCU Coordinator stated Resident #37 had a BIMS of 15 on admission in 2022. His sister facilitated admission and signed the financial power of attorney, but Resident #37 did not sign the power of attorney form. There was no documentation the facility followed up with Resident #37 about his healthcare advance directive options. The CCU Coordinator stated the facility focused on the POLST form during discussions at care conferences and did not discuss advance directives. 2. Resident #38 was admitted to the facility on [DATE] with multiple diagnoses including dementia, hallucinations, and depression. Resident #38's record did not include an advance directive for healthcare. Resident #38's record did not include documentation of resources offered for assistance with executing a healthcare advance directive. On 6/26/25 at 9:57 AM, the CCU Coordinator stated there was no documentation information or assistance executing an advance directive was offered to Resident #38's legal guardian.

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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 representative, and staff interview, it was determined the facility failed to ensure residents had a homelike environment. This was true for 1 of 1 resident's (Resident #16) whose room was observed to have a wall in disrepair. This deficient practice created the potential for psychosocial harm if Resident #16 was not provided a homelike environment. Findings include: The facility's Homelike Environment policy, revised February 2020, documented the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized and homelike setting. Resident #16 was admitted to the facility on [DATE] with multiple diagnoses including aphasia (inability to communicate verbally) after a stroke, right side weakness and paralysis, and dementia. On 6/24/25 at 9:39 AM, Resident #16's Representative stated she was concerned the baseboard area of his wall had exposed wood. On 6/25/25 at 3:19 PM, the base of the wall near the headboard of the resident's bed was observed with a long section of coving peeling away from the wall. Additionally, there were multiple long scratches on the board panel placed to protect the wall. On 6/25/25 at 3:25 PM, CNA #1 stated the coving and board on the wall near the resident's headboard needed to be repaired. On 6/26/25 at 10:50 AM, the Maintenance Assistant stated he was not aware Resident #16's room needed repairs to the wall until the previous evening. He added the wall had been repaired that morning.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview it was determined the facility failed to provide hospital transfer paperwork for 1 of 3 residents (Resident #18) when they were discharged to the hospital. This deficient practice created the potential for Resident #18 to experience harm if the receiving hospital was not provided current medical documentation when he was transferred for emergency medical care. Findings include: The CMS SOM Appendix PP, revised 4/25/25, documented when a facility transfers or discharges a resident the facility must ensure the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. Additionally, the facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility in a form and manner the resident can understand. Resident #18 was admitted to the facility on [DATE] with multiple diagnoses including stroke and left-side paralysis. Review of Resident #18's record documented he was transferred to the hospital on 4/19/25. Review of Resident #18's record did not document the hospital was provided his current medical documentation when he was transferred. On 6/25/25 at 2:50 PM, the DON stated she could not provide documentation the transferring hospital was provided Resident #18's current medical documentation when he was transferred.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure residents were provided notice of bed-hold and return policy and the Ombudsman advocate for residents was not informed of their transfer. This was true for 2 of 4 residents (#18, and #54) whose records were reviewed for discharge documentation. This failure placed the residents at risk for unnecessary psychosocial distress if they were unaware they could return to the facility following a hospitalization or therapeutic leave and the Ombudsman was not made aware a resident may require an advocate while out of the facility. Findings include: 1. Resident #54 was admitted to the facility on [DATE] with multiple diagnoses including a history of blood clots and kidney and bladder cancer. Resident #54's medical record documented he went to the hospital on 6/14/25 when his nephrostomy tube (a thin surgically placed tube from the kidney to a collection bag outside the body for urine) fell out. Resident #54's medical record did not include documentation a written bed-hold policy notification was provided to the resident or the Ombudsman was notified of his transfer to the hospital. 2. Resident #18 was admitted to the facility on [DATE] with multiple diagnoses including stroke and left-side paralysis. Review of Resident #18's record documented he was admitted to the hospital on [DATE] for lethargy, confusion, low blood oxygen levels on room air, and for refusing supplemental oxygen. Review of Resident #18's record did not document a written bed-hold policy notification was provided to him and did not document the Ombudsman was notified of Resident #18's transfer to the hospital. On 6/25/25 at 2:45 PM, the DON stated they had not provided bed-hold policy notification. She added on admission, resident's sign they understand the facility did not hold a bed for residents if they were discharged from the facility. On 6/25/25 at 3:05 PM, the CCU Coordinator stated, I notify the Ombudsman if I need her help, but I have not notified her when we have transfers or discharges.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident #27 was admitted to the facility on [DATE], with multiple diagnoses including intrahepatic (within the liver) bile duct (small tubes that transport bile to the small intestine) cancer. Resident #27's record documented a PASRR Level II was completed on 4/18/24. Resident #27's admission MDS assessment section A1500 dated 4/24/24, documented she did not have a PASRR Level II evaluation. Based on review of the Resident Assessment Instrument (RAI) Manual, record review, and staff interview, it was determined the facility failed to ensure residents' Minimum Data Set (MDS) Assessments included correct assessment information. This was true for 6 of 6 residents (#27, #35, #37, #38, #47, and #57) whose MDS records were reviewed for accuracy. This deficient practice had the potential for negative outcomes if residents were not assessed and/or monitored due to inaccurate assessments. Findings include: The RAI Manual, revised 10/1/2024, documented section A1500, PASRR (Preadmission Screening and Resident Review), was to be coded yes when a PASRR Level II screening determined a resident had a serious mental illness and/or intellectual disability, or related condition. 1. Resident #35 was admitted to the facility on [DATE] with multiple diagnoses including senile degeneration of the brain, PTSD, and an unspecified personality disorder. Resident #35's PASRR Level I, dated 6/9/22, documented he had a major mental illness diagnosis of anxiety disorder. Resident #35's PASRR Level II, dated 7/5/22, documented he had a current diagnosis of severe mental illness per PASRR criteria of anxiety disorder. Resident #35's Significant Change in Status MDS Assessment, dated 4/27/25, at A1500, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?, documented the answer no. 3. Resident #37 was admitted to the facility on [DATE] with multiple diagnoses including dementia, PTSD, and depression. Resident #37's updated PASRR level II, dated 4/30/24, documented he had a primary diagnosis of dementia with PTSD and depression. Resident #37's Annual MDS assessment, dated 9/23/24, documented under question A1500 he was not considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. 4. Resident #38 was admitted to the facility on [DATE] with multiple diagnoses including dementia, hallucinations, and depression. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #38's PASRR level II, dated 3/24/23, documented he had a primary diagnosis of dementia. Resident #38's Annual MDS assessment, dated 4/14/25, did not document at A1500 a PASRR Level II was completed. 5. Resident #47 was admitted to the facility on [DATE] with multiple diagnoses including neurocognitive disorder with Lewy Bodies (a progressive brain disorder characterized by dementia with fluctuating cognitive abilities, hallucinations, and parkinsonian motor symptoms), dementia with psychotic disturbance, PTSD, and depression. Resident #47's PASRR Level II, dated 1/15/25, documented he had a primary diagnosis of dementia and a secondary diagnosis of PTSD. Resident #47's Annual MDS assessment, dated 1/21/25, documented Resident #47 did not have a PASRR level II at A1500. On 6/25/25 at 10:12 AM, the MDS Coordinator stated, I interpreted the question incorrectly and marked no when it should have marked yes, at A1500 a PASRR level II was completed, for Resident #27, #35, #37, #38, and #47. 6. Resident #57 was admitted to the facility on [DATE], with multiple diagnoses including hypertension and chronic obstructive pulmonary disease. Resident #57's admission MDS assessment, Section P, dated 4/21/25, documented she was not using a wanderguard (a sensor for an alarm when a resident nears a building exit). On 6/24/25 at 9:44 AM, Resident #57 was observed to have a wanderguard attached to her left ankle. On 6/25/25 at 12:09 PM, the MDS Coordinator reviewed Resident #57's record and stated the MDS should have been coded yes.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and resident and staff interviews, it was determined the facility failed to provide a copy or summary of the baseline care plan to residents and/or their representative. This was true for 1 of 1 residents (Resident #115) reviewed for baseline care plan. This failure placed Resident #115 and/or his representative at risk of not being informed and having input in his care plan. Findings include: The facility's Care Plans - Baseline policy, revised December 2016 stated the resident and/or their representative will be provided a summary of the baseline care plan that includes but is not limited to: a. The initial goals of the resident. b. A summary of the resident's medications and dietary instructions. c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility, and d. Any updated information based on the details of the comprehensive care plan, as necessary. Resident #115 was admitted to the facility on [DATE], with multiple diagnoses including fracture of T(thoracic) 11 - T12 vertebra, ankylosing hyperostosis [NAME] (a non-inflammatory disorder characterized by calcifications and ossification (turns to bone) of spinal ligaments and entheses - places where tendons and ligaments connect to bones) and diabetes. An admission MDS assessment dated [DATE], documented Resident #115 was cognitively intact. On 6/24/25 at 9:58 AM, Resident #115 was in his room watching the television. When asked if he received a copy of his care plan, Resident #115 stated he was not sure if he had received a copy of his care plan or had a meeting with the staff about his care. Resident #115 stated he came from the hospital and there was no family member with him when he was admitted to the facility. A review of Resident #115's Baseline Care Plan did not include documentation a copy of his baseline care plan was provided to him and/or to his representative. On 6/25/25 at 9:43 AM, the DON stated she was unable to find documentation of Resident #115's Baseline Care Plan was provided to him and/or to his representative.

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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** Based on observation, record review, and staff interviews, it was determined the facility failed to ensure medications were administered according to physician's order and professional standards of practice. This was true for 2 of 5 residents (#23 and #41) whose medications administration were observed. This deficient practice created the potential for Resident #41 to develop a yeast infection when he did not rinse his mouth after using his inhaler. Resident #23 had the potential of not receiving the full benefit of his medication from incorrect dosage administration. Findings include: 1. The Wixela Inhub website: www.wixelahcp.com, accessed on 7/1/25, documented Candida albicans [a fungus] has occurred in patients treated with fluticasone propionate and salmeterol inhalation powder. Advise patients to rinse the mouth with water without swallowing following inhalations to help reduce the risk of oropharyngeal candidiasis [mouth and throat yeast infection]. Resident #41 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (COPD - a progressive lung disease characterized by increasing breathlessness) and dementia. A physician's order, dated 2/18/25 documented Resident #41 was to receive Advair Diskus inhalation (fluticasone-salmeterol) one inhalation orally two times a day for COPD, rinse mouth with water after each use. On 6/26/25 at 8:16 AM, LPN #1 handed the Wixela inhaler to Resident #41. Resident #41 took one inhalation of the Wixela and gave back the inhaler to LPN #1. LPN #1 did not instruct Resident #41 to rinse his mouth after taking one inhalation of the Wixela. On 6/26/25 at 8:40 AM, LPN #1 stated she did not offer Resident #41 to rinse his mouth after taking one inhalation of the Wixela. On 6/26/25 at 11:06 AM, the DON stated Advair Diskus and Wixela are two different names for the same fluticasone-salmeterol inhaled medication. The DON stated LPN #1 should have instructed Resident #41 to rinse his mouth after using the inhaler. 2. The WebMD website: www.webmd.com, accessed on 7/1/25, stated the seven rights of medication administration which included Right Dose. Along with giving the right medications comes giving the right dose. Resident #23 was admitted to the facility on [DATE], with multiple diagnoses including traumatic brain injury with loss of consciousness and quadriplegia (paralysis of both arms and legs). A physician's order dated 11/13/23, documented Resident #23 was to receive Vitamin B-12 oral tablet 1000 mcg, three tablets by mouth one time a day for vitamin deficiency. On 6/26/25 at 7:58 AM, LPN #1 was preparing Resident #23's oral medications to include Vitamin B-12. LPN #1 was observed to put one tablet of Vitamin B-12 to the medication cup. On 6/26/25 at 8:09 AM, LPN #1 administered Resident #23's medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/25 at 8:16 AM, LPN #1 reviewed Resident #23's physician's order and stated she gave Resident #23 one tablet of Vitamin B-12. LPN #1 stated she should have administered Resident #23 three tablets of Vitamin B-12.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, it was determined the facility failed to ensure physician's order to provide non-pharmacological intervention were offered to residents prior to administration of their as needed narcotic pain medications. This was true for 3 of 3 residents (#22, #54 and #115) reviewed for pain medications. This deficient practice created the potential for harm if the residents were overmedicated when their pain may have responded to nonpharmacological interventions. Findings include: The CDC website, www.cdc.gov, article titled, Overdose Prevention: Guideline Recommendations and Guiding Principles, accessed on 7/2/25, recommended clinicians should maximize use of nonpharmacological and nonopioid pharmacological therapies as appropriate for the specific condition and patient, and only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient. 1. Resident #22 was admitted to the facility on [DATE], with multiple diagnoses including low back pain and dementia. A physician's order, documented Resident #22 was to receive the following medications: - oxycodone (narcotic pain medication) hcl oral tablet, 2.5 mg every eight hours as needed for pain. - acetaminophen oral tablet 500 mg, one tablet every four hours as needed for pain. The physician's order also directed staff to offer Resident #22 non-pharmacological interventions for pain: rest, positioning, distractions, application of cold and heat packs as needed prior to administration of PRN pain medication. Resident #22's June 2025 MAR documented the following: - She was not administered the acetaminophen 500 mg every four hours PRN for pain. - She received oxycodone 2.5 mg on 6/6/25, 6/7/25, 6/9/25, 6/10/25, 6/13/25, 6/14/25, 6/15/25, 6/18/25, 6/22/25, 6/23/25 and 6/24/25. There was no documentation in Resident #22's record she was offered non-pharmacological interventions prior to administration of her pain medications. 2. Resident #115 was admitted to the facility on [DATE], with multiple diagnoses including fracture of T(thoracic) 11 - T12 vertebra, ankylosing hyperostosis [NAME] (a non-inflammatory disorder characterized by calcifications and ossification (turns to bone) of spinal ligaments and entheses - places where tendons and ligaments connect to bones) and diabetes. A physician's order, dated 6/5/25 documented Resident #115 was to receive the following medications: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- acetaminophen 500 mg, give one tablet by mouth every four hours as needed for pain level 1-5. - acetaminophen 500 mg, give two tablets by mouth every four hours as needed for pain level 6-10, not to exceed 3,000 mg per day. -oxycodone hcl 5 mg, give one tablet by mouth every six hours as needed for pain. The physician's order also directed staff to offer Resident #22 non-pharmacological interventions for pain: rest, positioning, distractions, application of cold and heat packs as needed prior to administration of PRN pain medication. Resident #115's June 2025 MAR documented the following: - He was not administered acetaminophen 500 mg every four hours as needed for pain - He received oxycodone 5 mg on 6/13/25, 6/14/25 and 6/18/25. There was no documentation in Resident #115's record he was offered non-pharmacological interventions prior to administration of his pain medications. 3. Resident #54 was admitted to the facility on [DATE] with multiple diagnoses including a history of blood clots, a history of substance use disorder, arthritis, and kidney and bladder cancer. Resident #54's physician orders documented the following: -Hydrocodone-Acetaminophen (a narcotic pain medication) tablet 7.5-325 mg, give 1 tablet by mouth every 6 hours as needed for severe pain, dated 3/24/25. -Prior to PRN medication offer nonpharmacological interventions for pain - rest, positioning, distractions, application of cold and heat packs, as needed. Resident #54's medication administration record for June 2025 documented he received the narcotic pain medication 69 times from June 1-24, 2025. The June 2025 medication administration record included documentation he had been offered nonpharmacological pain interventions 0 of the 69 times he received the narcotic pain medication. On 6/25/25 at 1:53 PM, the DON stated she was unable to find documentation Resident #22, #54, and #115 were offered non-pharmacological interventions prior to administration of their PRN narcotic pain medications. The DON stated Resident #22, #54, and #115 should have been offered the non-pharmacological interventions before giving their PRN narcotic pain medications.

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Valley Vista Care Center of Sandpoint	220 South Division Ave Sandpoint, ID 83864

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 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 resident was free from unnecessary medications. This was true for 1 of 5 residents (Resident #22) reviewed for unnecessary medications. Resident #22 was continually prescribed of cough medication without clear indication and in excessive duration. This deficient practice had the potential for harm if Resident #22 received medications that may result in negative outcomes without clear indication of need. Findings include: 1. Resident #22 was admitted to the facility on [DATE], with multiple diagnoses including chronic bronchitis, low back pain, and dementia. A physician's order, dated 1/30/25, documented Resident #22 was to receive guaifenesin ER (an expectorant-extended release) oral tablet 600 mg every 12 hours for congestion. Resident #22's March 2025, April 2025, May 2025, and June 1-26, 2025, documented Resident #22 was administered guaifenesin ER oral tablet 600 mg every 12 hours for congestion. A Nurse Practitioner's progress note dated 3/20/25, documented Resident #22 did not have cough or congestion and no shortness of breath. A Nurse Practitioner's progress note dated 4/25/25, documented Resident #22's lungs were clear on auscultation (listening with a stethoscope), no wheezing or rales (abnormal lung sounds) noted. A Nurse Practitioner's progress note dated 5/19/25, documented Resident #22 had no nasal congestion or nasal discharge, no dyspnea (difficulty of breathing), cough, congestion or wheezing. The note documented Resident #22's lungs were bilaterally clear to auscultation, no coughing, wheezing or rales. Resident #22 was observed on the following days with no cough or signs and symptoms of congestion or difficulty of breathing as follows: - 6/23/25 at 1:13 PM, she was sitting quietly on the couch by the nurse station. - 6/25/25 at 1:14 PM, she was lying in bed, eyes were closed. On 6/25/25 at 2:02 PM, when asked why Resident #22 was still taking guaifenesin when the Nurse Practitioner's progress dated 3/20/25, 4/25/25, and 5/19/25 documented she did not have congestion, the DON stated she was not sure why Resident #22 was taking guaifenesin. The DON stated it could be for prophylaxis (preventative), and added the order for guaifenesin needed to be clarified.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview, and policy review, it was determined the facility failed to ensure residents were routinely provided nourishing evening snacks. This was true for 5 of 7 resident's (#5, #26, #31, #56, and #115) who attended the resident council discussion with surveyors. This failure created the potential for residents to experience hunger between meals, increased fatigue, weight loss, and poor quality of sleep. Findings include: The CMS SOM, Appendix PP, updated 4/25/25, documented no more than 14 hours between a substantial evening meal and breakfast the following day should elapse, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. The SOM defines a nourishing snack as items from the basic food groups (protein, grain, dairy, fruit, and vegetables), either singly or in combination with each other. On 6/25/25 at 10:33 AM, Resident #5, #26, #31, and #115 stated they were provided snacks when asked, but the snacks were not very big or filling. Resident #56 stated he was unaware he could ask for snacks after dinner. The residents added they were unaware they could ask for more than one snack. A review of the facility meal hours documented there were 15 hours between dinner and breakfast. On 6/26/25 at 2:55 PM, the CDM stated she was aware there were more than 14 hours between dinner and breakfast, and it was determined the snacks available were considered nourishing and appropriate for the residents. She was unaware of any resident group agreement to the meal hours as they were changed in 2020. The CDM stated the nursing staff should offer snacks to the residents between meals. On 6/27/25 at 10:50 AM, the DON stated nursing staff offered snacks available from the snack cart and whenever a resident asked for one. She was unaware if they were routinely offered between dinner and breakfast. On 6/27/25 at 11:15 AM, LPN #4 stated residents are always offered snacks between meals if they are care planned for staff to do so, or if a resident asks for a snack, but he was unaware if staff routinely offered snacks between dinner and breakfast for all residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined the facility failed to ensure the resident's refrigerators were cleaned, and expired spices were discarded. These deficiencies had the potential to affect the 59 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: The FDA Food Code Section 3-501.17 Ready-to-Eat, TCS (time/temperature control for safety) food, date marking, documented marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded. 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. On 6/26/25 at 2:25 PM, it was observed the following spices were expired in the spice rack next to the cook preparation area: Fajita (expired 12/24), Chili Powder (expired 6/24), and Onion Powder (expired 4/24). On 6/26/25 at 2:30 PM, the CDM stated she was unaware the spices were expired and they should have been thrown out. On 6/24/25 at 1:45 PM, and on 6/26/25 at 2:45 PM, it was observed the resident's refrigerators located in the Lodge, the Village, and the Kitchen were not clean, with food residue located on the interior shelves. On 6/26/25 at 3:50 PM, the CDM stated there is a cleaning schedule documenting what is cleaned and when; however, she was unable to find documentation a cleaning schedule had been followed in June 2025.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. Based on license and certification review and staff interview, it was determined the facility failed to ensure nursing staff were licensed/certified within the state where they provided care. This was true for 1 of 3 nursing staff (Staff #1) whose licenses/certification were reviewed and had the potential to affect all 61 residents in the facility. This failure created the potential for harm if residents received inappropriate care due to a nursing staff lacking the credentials to provide nursing care. Findings include: On 6/25/25 at 3:18 PM, licenses and certification of three nursing staff were reviewed with the HR personnel. Staff #1 who was hired as a CNA on 3/26/25 did not have a certification to work as a CNA in this state. The HR personnel stated she was recently hired in the facility as the HR when Staff #1 was hired, and would look further for the certification of the Staff #1. On 6/26/25 at 2:01 PM, the HR personnel stated she reached out with the previous HR personnel and was told Staff #1 had certification as a nursing assistant when she was hired in the facility. The HR personnel also stated she called Staff #1 and asked her to provide a copy of her certification, but Staff #1 stated she did not have a copy of her certification. The HR personnel stated she was unable to find Staff #1 certificate. The HR personnel stated Staff #1 would not be allowed to work in the facility if she could not provide proof of her certification and her employment was immediately terminated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, policy review, and staff interview, it was determined the facility failed to ensure infection control and prevention practices were maintained when the facility failed to offer hand hygiene to residents before their meals were served. This was true for 7 of 9 residents (#6, #9, #36, #37, #46, #47, and #50) eating in the Lodge dining room and 3 of 6 resident's (#12, #38, and #39) observed eating in their rooms. This failed practice had the potential for negative outcomes by exposing residents to the risk of infection and cross-contamination. Findings include: The CMS SOM, Appendix PP, revised 4/25/25, documented hand hygiene should be offered to residents before meals. The facility's Hand Hygiene Policy, revised October 2023, documented hand hygiene should be practiced helping to prevent the spread of infections, and offered to residents, family members, and/or visitors. On 6/23/25 at 12:04 PM, the following was observed in the Lodge dining room: 1. Residents #6, #9, #37, #46, #47, and #50 were not offered hand hygiene before being provided their beverages and meals. 2. Resident #36 was observed sitting at the dining table coughing into his hands and then rubbed his face after sneezing. Staff did not offer hand hygiene before serving his meal or after he sneezed into his hands. 3. Residents #12, #38, and #39 were not offered hand hygiene before being offered their meal trays. On 6/23/25 at 12:35 PM, LPN #2 stated she had not offered hand hygiene to residents #12, #38, and #39, and she should have. On 6/23/25 at 12:40 PM, LPN #3 stated we should be offering hand hygiene before their meals and after a resident sneezes.