STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135056	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln County Care Center	511 East Fourth Street Shoshone, ID 83352

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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 - Some	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, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with a clean, safe, homelike environment. This was true for all residents who resided in the facility whose environment were observed. This deficient practice created the potential for harm if residents were embarrassed by and/or felt the disrepair in the facility was unacceptable, disrespectful, or undignified or residents were injured due to unsafe areas in the facility. Findings include: The facility's Homelike Environment policy, revision date February 2021, documented residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible.The following areas were observed: a) On 4/12/26 at 10:30 AM, observed in room [ROOM NUMBER]-B on the wall behind bed, four strips with missing paint, with 4 holes in each strip. Multiple small holes were observed in the wall. The ceiling by the curtain railing observed an approximately 1 x 2 and approximately 1 x 3 area with the paper part of the sheetrock missing. b) On 4/12/26 at 11:09 AM, observed in room [ROOM NUMBER]-B approximately 1.5 x 2.5 part of the bottom right corner of windowsill missing. The lower part of the rebar was exposed. c) On 4/14/26 at 6:42 AM, observed the vent in the dining room covered with a black substance. d) On 4/14/26 at 11:03 AM, observed the large light fixture above nurse's station without a cover and two long, thick cobwebs hanging from the light fixture frame. On 4/14/26 at 11:38 AM, the Maintenance Supervisor stated the walls are concrete and it is hard to replace the walls around the window in the resident's room when the beds keep breaking pieces off and the resident in room [ROOM NUMBER]-B just moved into that room and he has not had time to fix the wall behind her bed. He also stated the cobwebs on the light at the nurse's should have been cleaned up by housekeeping and the vent in the dining room should have been cleaned by housekeeping.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, policy review, and staff interview, it was determined the facility failed to ensure medications available for residents were labeled, dated, and stored appropriately. This was true for 1 of 1 medication rooms and 1 of 1 medication carts audited for labeling and storage of medication. This failure created the potential for residents to have missed doses of medication, to receive expired medications with decreased efficacy, and residents to receive the wrong medication due to the medication label being illegible. Findings include:The facility's Storage of Medication policy revision date April 2019, documented:- discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.- Scheduled II-V controlled medications are stored in separately locked, permanently affixed compartments.The EVENCARE ProView operator's manual documented:- Record the date on the bottle when you open a new bottle of test strips. Discard any unused test strips three months after opening.- Test strips are good three months after opening or until the last day of the month of expiration, whichever comes first.On 4/13/26 at 10:15 AM, a medication storage audit was completed of the medication room with LPN #1 present. The following was observed: - a bottle of liquid lorazepam (an antianxiety medication) 2mg/ml was observed in the medication refrigerator. The label was illegible on the bottle and on the box. On 4/13/26 at 10:17 AM, LPN #1 stated she was able to read part of the label on the bottle of lorazepam, but she did not know if the bottle should be in the refrigerator to be used. - observed a vial of tuberculin purified protein derivative with an open date of 11/24/25. On 4/13/26 at 10:20 AM, LPN #1 stated she was not sure how long the bottle was good after it was open. - observed a Hepatitis B vaccine syringe with an expiration date of 7/7/25. On 4/13/26 at 10:27 AM, LPN #1 stated the Hepatitis B vaccine should not have been in the refrigerator. - observed a metal box with a lock on it. On 4/13/26 at 10:29 AM, LPN #1 stated the metal box had insulin and narcotics from the pharmacy in it. She stated the metal box was not permanently attached to the refrigerator and was too big to lock it in the lock box on the bottom of the refrigerator. LPN #1 also stated the narcotics could not be removed from the metal box and placed in the lock box of the refrigerator because the narcotics had to be assigned to a resident and the nurse would need to get the key to the box from the pharmacy. On 4/13/26 at 2:21 PM, the DON stated the metal box in the refrigerator, in the medication room had narcotics in it and it should have been permanently attached to the refrigerator and had not been. On 4/13/26 at 2:25 PM, the Regional Nurse Consultant stated the bottle of lorazepam should have been replaced since you could not read the resident's whole name and 30 days after the Tuberculin testing solution was opened the bottle should have been thrown out. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/13/26 at 10:32 AM, the following was observed in the west hall medication cart: - on the right side, second drawer observed 3 small round, unlabeled, white pills - on the left side, second drawer, observed 1 duloxetine HCl 60 mg tablet, 1 Lasix 20 mg tablet, 1 Atorvastatin Calcium 40 mg tablet, 1 Divalproex sodium 250 mg tablet, 1 Atorvastatin Calcium 20 mg tablet, 1 Atorvastatin Calcium 10 mg tablet, 1 pantoprazole sodium 40 mg tablet, and 1 Quetiapine 50 mg tablet. On 4/13/26 at 10:39 AM, LPN #1 stated the loose pills should not have been in the medication cart. On 4/13/26 at 2:29 PM, the Regional Nurse Consultant stated the nurses should have destroyed the loose pills in the medication cart. On 4/14/26 at 10:58 AM, observed RN #1 remove a glucometer strip from the Evencare Proview glucose strip bottle to be used to check Resident #18's blood sugar. The bottle of glucose test strips did not have an open date. On 4/14/26 at 11:00 AM, RN #1 stated the bottle of glucose test strips should have had an open date but she was not sure how long the strips were good for after they were opened. On 4/12/26 at 9:37 AM, an unattended medication cart was observed across from the nurses station with one round white pill lying on the ground near the corner of the medication cart. On 4/12/26 at 9:45 AM, LPN #1 stated she had dropped the medication that morning but could not find it. On 4/12/26 at 9:47 AM, LPN #1 stated she should have moved the medication cart when looking for the lost medication and destroyed the medication but had not.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **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 informed consent was obtained prior to initiation of psychotropic medications for 2 of 3 residents (#1 and #35) reviewed for unnecessary medications. This deficient practice placed residents at risk of receiving medications without knowledge of the reason why medications were prescribed, the expected benefits, and the risks associated with the medications. Findings include:The facility's Medication Therapy policy, version 1.1, documented 1. Each resident's medication regimen shall include only those medications necessary to treat existing condition and address significant risks. 2. Medication use shall be consistent with an individual's condition, prognosis, values, wishes, and responses to such treatments.Resident #1 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including heart failure and anxiety.A physician order dated 3/1/26, documented Citalopram Hydrobromide oral tablet 20 mg by mouth one time per day. On 4/13/26 at 4:09 PM, the RNC stated Resident #1 did not have a signed Informed Consent for Use of Antidepressant Medications for the ordered Citalopram Hydrobromide.Resident #35 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including stable fracture of lumbar vertebra (the back), depression, and repeated falls.A physician order dated 4/1/26, documented Sertraline HCl oral tablet 200 mg by mouth at bedtime.On 4/13/26 at 1:30 PM, Resident #35's medical record included an Informed Consent for Use of Antidepressant medication for the prescribed Sertraline signed and dated 4/10/26.On 4/13/26 at 4:10 PM, the RNC stated the Informed Consent for the Sertraline should have been signed before Resident #35 received the medication but had not been.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, resident and staff interviews, policy review and record review, it was determined the facility failed to ensure residents were initially assessed to determine if they were safe to self-administer medications for 1 of 1 resident (Resident #35). This failure created the potential for adverse effects if residents self-administered medications inappropriately. Findings include:The facility's Self-Administration of Medications policy, revised date February 2021, documented, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so.if it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. On 4/12/26 at 9:47 AM, observed Resident #35 had Calcitonin nasal spray on her overbed table. Resident #35 stated, she keeps it in her room for use when she needs it and had used it before she came to the facility.Resident #35's medical record had no documentation of an IDT patient assessment for self-administration of medications and no documentation in her care plan to allow self-administration of medications.On 4/13/26 at 2:27 PM, the Regional Nurse Consultant stated, Resident #35 should not have had Calcitonin nasal spray in her room and had not been assessed by IDT for self-administration of medications.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, record review, and staff interview, it was determined the facility failed to ensure a resident's call light was within reach for 2 of 12 residents (#12 and #35) reviewed for residents' rights. This deficient practice had the potential to cause harm if the resident could not call for assistance when needed or experienced an adverse medical event that required attention. Findings include: The facility's Answering the Call Light policy, version 1.3, documented. The purpose of this procedure is to ensure timely responses to the resident's requests and needs.Ensure that the call light is accessible to the resident. Resident #12 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (disease process which causes decreased ability of the lungs to function) and dementia. On 4/12/26 at 9:59 AM, observed Resident #12 lying in bed with his call light plugged into the wall and hanging down the wall and under the foot of his bed and not within his reach. Resident #12 unable to independently reach call light. On 4/12/26 at 10:25 AM, CNA #1 stated Resident #12's call light should be within reach and had not been. Resident #35 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including stable fracture of lumbar vertebra (the back) and repeated falls. On 4/12/26 at 10:09 AM, observed Resident #35 sitting in her recliner in her room with her call light draped over the overbed table that was pushed against the bed on the other side of the room and not within reach. Resident #35 stated, staff pushed her table against the bed this morning after removing her breakfast tray from her room and she cannot reach her call light. On 4/12/26 at 10:27 AM, CNA #1 stated Resident #35's call light should be within reach and had not been. On 4/13/26 at 10:48 AM, the RNC stated residents' call light should be within reach and had not been.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure the MDS assessment accurately reflected resident's status. This was true for 2 of 12 residents (#11, and #15) whose MDS assessments were reviewed. This deficient practice had the potential for negative outcomes if the residents were not monitored properly due to inaccurate assessments. Findings include:Resident #11 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including epilepsy and dementia.On 4/12/26 at 11:20 AM, observed Resident #11 in his wheelchair. No restraints were observed in his wheelchair or in his bed.Resident #11's Quarterly MDS dated [DATE], documented in section P0100. Physical Restraints, Other used daily, for restraint.Resident # 15 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including diabetes and acquired absence of the left leg above the knee.On 4/12/26 at 11:14 AM, observed Resident #15 lying in his bed with a trapeze bar over his bed to assist him with repositioning. No restraints were observed in his bed or in his wheelchair.Resident #15's admission MDS dated [DATE], documented in section P0100. Physical Restraints, Other used daily, for restraint.On 4/13/26 at 10:12 AM, the DON & the MDS coordinator stated the MDS was coded incorrectly. Resident #11 does not have a restraint and neither does Resident #15. Restraints should not have been coded on the MDS.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and staff interview, it was determined the facility failed to refer residents for further evaluation when residents were diagnosed with a major mental illness. This was true for 1 of 3 residents (Resident #4) reviewed for Pre-admission Screening and Resident Review (PASRR) level 2 evaluations. This deficient practice had the potential to cause harm if residents' specialized services for mental health needs were not evaluated by an appropriate state-designated authority. Findings include: The facility's Resident Assessments PASRR Screening Coordination policy, dated 4/25, documents 3. PASRR Level I and Level II screenings, when needed, will be conducted prior to the resident being admitted to the facility. 4. The facility will utilize Level II evaluation reports when conducting assessments of the resident, developing care plans. The State Operation Manual, Appendix PP revised on 7/23/25, documents a positive Level I screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as PASRR Level II, which must be conducted prior to admission to a nursing facility. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including Chronic Obstructive Pulmonary Disorder (a progressive lung disease that restricts airflow), Bipolar Disorder (a chronic mental health condition characterized by extreme mood swings), and Post-Traumatic Stress Disorder (a mental health condition triggered by experiencing or witnessing terrifying events). Resident #4's care plan dated 8/18/24, documented Resident #4 meets PASRR Level II of determination secondary to serious mental illness diagnoses including: Anxiety, Bipolar Disorder, and Long Term Care Stay. Resident #4's medical record documented a PASRR Level I screening was completed on 4/15/25 (over 8 months after admission). The PASRR Level I screening documented Resident #4 had major mental illnesses of Depressive Disorders, Anxiety Disorders, Bipolar Disorders, and Post-Traumatic Stress Disorder and instructed that the PASRR Level I be forwarded to the states-designated authority for a PASRR Level II evaluation. On 4/14/26 at 8:17 AM, Resident #4's medical record had not documented a PASRR Level II evaluation had been completed. On 4/14/26 at 8:41 AM, the RNC stated the facility did not have a PASRR Level II for Resident #4 and should have had one.

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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, and staff interview, it was determined the facility failed to provide a resident's baseline care plan to the resident or his/her representative for 3 of 5 residents (#10, #30, and #35) reviewed for baseline care plan. This failure placed residents and their representatives at risk of not being informed and having input in their care plan. Findings include:The facility's Care Plans - Baseline policy, version 1.2, documented 3. The resident and/or representative are provided a written summary of the baseline care plan (in a language that the resident/representative can understand). 5. Provision of the summary to the resident and/or representative is documented in the medical record.Resident #10 was admitted to the facility on [DATE], with multiple diagnoses including muscle wasting (the loss of muscle mass) and respiratory failureResident #10's medical record had not documented that a baseline care plan was provided and discussed with him or his resident representative.Resident #30 was admitted on [DATE], with multiple diagnoses including Parkinson's disease (a chronic nervous disease characterized by fine slowly spreading tremor) and malignant neoplasm of prostate (cancerous tumor).Resident #30's medical record had not documented that a baseline care plan was provided and discussed with him or his resident representative.Resident #35 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including stable fracture of lumbar vertebra (the back) and repeated falls.Resident #35's medical record had not documented that a baseline care plan was provided and discussed with her or her resident representative.On 4/14/26 at 8:40 AM, the RNC stated there was no documentation that the residents or their representatives had received a copy of their baseline care plans.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure care was provided for 1 of 1 resident (Resident #3) per professional standards of practice. Findings include:Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including end stage renal disease and diabetes.Resident #3's care plan dated 5/13/25, documented she needed hemodialysis related to end stage renal disease and the listed following interventions:- administer medications as ordered-encourage Resident #3 to go for the scheduled dialysis appointments. Resident receives dialysis on (TUESDAY, THURSDAY, SATURDAY)Resident #3's physician's order dated 3/19/26, documented Amlodipine Besylate (calcium channel blocker used to treat hypertension), give 10 mg by mouth one time a day every Mon, Fri, Sun related to hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease. Hold for SBP less than 100 or pulse less than 60.Review of Resident #3's medical record did not contain dialysis communication forms for Tuesday 3/17/26, and Saturday 3/21/26.Resident #3's Dialysis communication form dated 3/19/26, documented: decrease Amlodipine to 5mg every day. On 4/13/26 at 9:11 AM, review of Resident #3's medical record did not document the decrease in the dose of her Amlodipine as ordered.On 4/13/26 at 2:30 PM, the DON stated Resident #3's Amlodipine dose was not correct and was not sure why it had not been changed. On 4/14/26 at 8:44 AM, the Regional Nurse Consultant stated Resident #3's dialysis communication sheets for 3/19/26, and 3/21/26, were missing. She also stated Resident #3's Amlodipine dose was clarified with the doctor, and it should have been 5 mgs every day and had not been.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure nurse staffing information was accurate and posted daily for each shift. This failed practice had the potential to affect all residents residing in the facility and their representatives, visitors, and others who wanted to review the facility's staffing levels. Findings include: The facility's Staffing, Sufficient and Competent Nursing policy, revision date April 2025, documented. Direct care daily staffing numbers (the number of nursing personnel responsible for providing direct care to residents) are posted in the facility for every shift.On 4/13/26, the daily postings of licensed and unlicensed nurse staffing were reviewed between 11/1/25 - 4/11/26. There were no adjustments to the posted staffing when the scheduled hours did not match the actual hours worked.On 4/13/26 at 11:37 AM, the RNC and DON stated the facility does not make adjustments to the daily postings with actual hours worked, they only adjust the time on the daily assignment sheets.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, resident and staff interview, and food test tray evaluation, it was determined the facility failed to ensure resident meals were palatable and maintained safe and appetizing temperatures to the residents. This had the potential to affect the 26 residents who resided in the facility who consumed meals prepared in the facility's kitchen. This failed practice had the potential to negatively affect the residents' nutritional status and psychosocial well-being. Findings include: The 2022 FDA Food Code states hot food will be maintained at 135 degrees F or above and cold food will be maintained at 41 degrees F or below. On 4/13/26 at 10:42 AM, during the Resident Council meeting, 6 of 6 residents stated the food served was often cold, tasteless, and not nutritious. The residents stated there are no condiments on the meal tray, especially when trays are delivered to their room, and the dinner meal is usually the worst meal of the day. On 4/14/26 at 11:27 AM, observed the lunch meal service with the following observations: - The menu documented the main entree was roast beef/gravy, scalloped potatoes, seasoned green beans, roll with margarine, coconut cake, and beverage. -The meal served was roasted pork with gravy, scalloped potatoes, green beans, roll with margarine, white cake, and beverage. - There were no garnishes or condiments served with the meal. On 4/14/26 at 12:06 PM, the last tray from the meal cart was presented to the surveyor for testing the serving temperature, taste, and presentation with the following observations: - Scalloped potatoes were served at 135 degrees F and tasted bland. - Gravy was bland and tasteless. - [NAME] beans were served at 128 degrees F and should have been 135 degrees F, tasted bland, and mushy in texture. - No beverage served on the tray. On 4/14/26 at 1:12 PM, the Dietary Manager stated the facility used frozen food and often the food did not have much flavor, and the green beans should have been at 135 degrees F. On 4/14/26 at 1:16 PM, the Dietary Manager stated the Dietary department has only one staff member scheduled for the dinner meal service each day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135056	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln County Care Center	511 East Fourth Street Shoshone, ID 83352

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on the FDA Food Code, observation, and interview, the facility failed to ensure food was appropriately stored, distributed, and labeled, and cleaning logs were properly documented. This deficient practice had the potential to affect all residents who received meals prepared in the facility's kitchen. This placed residents at risk for potential contamination of food and adverse health outcomes including food-borne illnesses. Findings include:The FDA Food Code 2022, 3-501.17 documented, Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking . refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.On 4/12/26 at 9:41 AM, observed the following:- the walk-in refrigerator contained one large, opened package of provolone cheese with no use by date. - the pantry contained three bags of cookies dated 4/8/26, with use by date 4/11/26, and one bag of sliced cake not dated.- the walk-in freezer contained an opened box of enchiladas dated 3/24/26, and no use by date.On 4/12/26 at 11:48 AM, observed dietary trays being delivered to resident rooms. The dietary tray included an uncovered bowl of gelatin dessert. On 4/14/26 at 11:24 AM, observed dietary trays being delivered to resident rooms with an uncovered plate of sliced cake.On 4/14/26 at 11:35 AM, the [NAME] stated she was not aware that all food on the dietary trays delivered to resident rooms must be covered.On 4/14/26 at 1:40 PM, observed the daily cleaning log marked completed (with an X) for Sunday through Saturday.On 4/14/26 at 1:42 PM, the Dietary Aide stated she did not have a new cleaning log so she continued to use the same one.On 4/14/26 at 1:44 PM, the Dietary Manager stated the daily cleaning log should have been replaced with a new daily cleaning log for the current week and had not been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135056	A. Building B. Wing	04/15/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 prevention practices were maintained to provide a safe and sanitary environment. These failures had the potential to impact all residents in the facility by placing them at risk for cross contamination and infection. Findings include:The facility's Handwashing/Hand Hygiene Policy Revised date March 2022, documented use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water before and after eating or handling food.The facility's Homelike Environment policy revision date February 2021, documented the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a clean, sanitary, and orderly environment.The following was observed for hand hygiene:On 4/12/26 at 12:04 PM, observed 14 residents served their meals in the dining room. The residents were not offered hand hygiene before eating their meals.On 4/12/26 at 12:12 PM, CNA #1 stated the resident's hands should have been sanitized before they started eating.On 4/13/26 at 2:44 PM, the DON stated the residents in the dining room should have been offered hand hygiene using the hand sanitizer from the bottle before eating their meals.The following was observed for infection control:On 4/14/26 at 6:53 AM, the housekeeper was observed carrying clean gowns down the hallway, uncovered.On 4/14/26 at 6:56 AM, the housekeeper stated she should have covered the gowns.On 4/14/26 at 8:36 AM, with the housekeeper present, the following was observed in the laundry room:-Behind the small, personal washing machine on the pipes observed a white, hard substance and a grey fuzzy substance.-By the entrance to the laundry room observed a tube of wires covered with a fuzzy grey substance.-Behind the large washing machine, observed on the water pipes a teal-colored substance and a fuzzy grey substance.-On the cover of the chemical dispenser of the large washing machine observed a layer of white substance.-On the wall and on the wires by the bucket of washing chemical observed a grey fuzzy build up on the chemical buckets and walls.On 4/14/26 at 8:41 AM, the housekeeper stated there was no cleaning schedule, but they do sweep every day.