

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2025
NAME OF PROVIDER OR SUPPLIER Silverton Health and Rehabilitation of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 405 West Seventh Street Silverton, ID 83867	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, review of the State Agency's Long-Term Care Reporting Portal, and review of I&As, it was determined the facility failed to ensure residents are free from abuse. This was true for 3 of 3 residents (Resident #9, #30, #51) whose records were reviewed for abuse. This created the potential for harm when Residents #9, #30, and #51 were struck by Resident #8. Findings include:</p> <p>The facility's Abuse policy revised 10/15/22, documented residents will remain free from abuse, neglect, misappropriation of resident property, and exploitation. Including but not limited to corporal punishment.</p> <p>Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including dementia with psychotic disturbances and major depressive disorder.</p> <p>1. Physical abuse directed by Resident #8 to Resident #30.</p> <p>Resident #30 was admitted to the facility on [DATE], with multiple diagnoses including muscle weakness, pain, and dementia.</p> <p>On review of the State Agency's Long-Term Care Reporting Portal accessed on 6/24/25, a facility report was identified indicating Resident #8 had a physical altercation with Resident #30.</p> <p>On review of the facility's, I&A's a resident-to-resident investigation dated 11/10/24, documented Resident #8 was in the common area when she self-propelled her wheelchair to Resident #30 and began to kick her multiple times. Resident #30 informed a CNA of the incident and both Resident #8 and Resident #30 were separated and assessed for injuries.</p> <p>The I&A documented Resident #8 was the aggressor, and the following interventions were to be implemented for her:</p> <ul style="list-style-type: none"> - Medication changes - Non-pharmacological interventions - Continue to monitor Resident #8 in line of sight while in the day room. - Divert Resident #8 with activities or with 1 on 1 conversation and provide less stimulation. <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #8's care plan revised on 11/9/20, directed staff to intervene as necessary to protect the rights and safety of others.</p> <p>A physician order dated 6/28/23, directed staff to document behaviors of verbal and physical aggression as well as refusal of cares.</p> <p>On review of Resident #8's behavior monitor dated 11/1/24 through 11/13/24, Resident #8 displayed physical aggression on the following days with no interventions:</p> <ul style="list-style-type: none"> - 11/3/24 during day shift - 11/3/24 during night shift - 11/4/24 during day shift - 11/4/24 during night shift - 11/10/24 during night shift - 11/13/24 during day shift - 11/13/24 during night shift <p>On 6/26/25 at 3:45 PM, the DON stated Resident #8 had a medication change to her Risperdal (an antipsychotic medication). However, it is unclear why interventions were not documented.</p> <p>2. Physical abuse directed by Resident #8 to Resident #51.</p> <p>Resident #51 was admitted to the facility on [DATE], with multiple diagnoses including weakness, major depressive disorder and dementia.</p> <p>On review of the State Agency's Long-Term Care Reporting Portal accessed on 6/24/25, a facility report was identified indicating Resident #8 had a physical altercation with Resident #51.</p> <p>On review of the facility's, I&A's a resident-to-resident investigation dated 12/17/24, documented Resident #51 was wheeling herself to the nurse's station when she encountered Resident #8. Resident #8 than slapped Resident #51 and called her a name. Resident #51 than slapped Resident #8 in return. Staff than separated both residents. The report documented both residents were assessed for injuries, but no injuries were identified. Upon conclusion of the investigation Resident #8 was identified as the aggressor and Resident #51 as the victim.</p> <p>The I&A report documented the following interventions for Resident #8:</p> <ul style="list-style-type: none"> - Review of current medications with increase in dose - <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Staff educated to implement 1 on 1 when Resident #8 presents with agitation.</p> <p>Resident #8's care plan revised 12/17/24, directed staff if Resident #8 appeared agitated to implement a 1 on 1 supervision and take resident into a quiet place away from environmental triggers.</p> <p>The I&A also documented the facility made the decision to send referrals to 2 behavioral health facilities in the state to best meet the needs of Resident #8.</p> <p>On 6/25/25 at 3:55 PM, the DON stated Resident #8 was given her own room to provide a low stimulation environment when she became overwhelmed. She also stated staff were directed to immediately initiate 1 on 1 care when Resident #8 became agitated.</p> <p>3. Physical abuse directed by Resident #8 to Resident #9.</p> <p>Resident #9 was readmitted to the facility on [DATE], with multiple diagnoses including bipolar disorder, pain, muscle weakness, and anxiety.</p> <p>On review of the State Agency's Long-Term Care Reporting Portal accessed on 6/24/25, a facility report was identified indicating Resident #8 had a physical altercation with Resident #9.</p> <p>On review of the facility's, I&A's report a resident-to-resident investigation dated 5/19/25, documented Resident #9 was ambulating back to her room with her walker and Resident #8 was self-propelling in her wheelchair. When Resident #9 arrived at the doorway of her room Resident #8 then kicked Resident #9 striking her on her right lateral calf and told her to get in her room. A CNA observed the situation and immediately separated the two residents and notified the nurse. The report documented both residents were assessed for injuries and no injuries were identified. It also documented the facility determined the incident occurred because of Resident #8's agitation. The report directed staff to continue to monitor Resident #8 closely in line of sight when out of her room and around others.</p> <p>Resident #8's care plan revised on 5/19/25, directed staff to keep resident in line of sight at all times due to aggressive behaviors, and to continue to use already care planned interventions with 1 on 1 interventions as needed.</p> <p>On review of Resident #8's behavior monitor dated 5/1/25 through 5/31/25, one episode of physical aggression was documented on 5/5/25 with interventions implemented however, the record was unclear if the interventions were effective.</p> <p>Resident #8's record did not include documentation of the physical aggression that occurred on 5/19/25 during the resident-to-resident incident.</p> <p>On 6/26/25 at 5:00 PM, the DON stated, Resident #8's medications were increased in dose. She also stated when resident #8 became agitated she would make rude verbal comments and would walk around the facility aimlessly. The DON stated, However, that day the staff missed the need for interventions.</p> <p>On 6/26/25 at 5:25 PM, the Administrator stated the incidents that occurred on 11/10/24, 12/17/24, and 5/19/25 were all substantiated for abuse with Resident #8 being the aggressor.</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interview, it was determined the facility failed to ensure Residents were monitored adequately to ensure residents were free from chemical restraints. This was true for 1 of 5 residents (Resident #23) whose records were reviewed for unnecessary medication. This failure caused the potential for more than minimal harm when Resident #23 was not able to participate in activities of daily living. Findings include:Resident #23 was admitted to the facility on [DATE], with multiple diagnoses including bipolar disorder, dementia, and insomnia.Resident #23's care plan revised 4/28/23, directed staff to monitor, document, and report to the MD changes in cognitive function such as difficulty expressing herself, level of consciousness, and mental status.A physician order dated 3/17/24, directed staff to monitor for the following side effects:1. Over-sedation / Lethargy2. Restless agitation3. Increased confusion/ poor concentration4. Mental status change5. Visual disturbances6. Change in gait/ mobility7. Behavior changes8. Nausea or vomitingOn review of resident #23's records the following physician orders were implemented:- Trazadone (a sleep-aid) 50 mg (milligrams) by mouth at bedtime for insomnia initiated on 11/14/24.- Depakote (an anticonvulsant medication used to treat manic episodes) delayed release 500 mg three times a day for bipolar disorder initiated on 3/26/25.- Risperdal (an antipsychotic medication) 0.25 mg by mouth at bedtime for bipolar disorder initiated on 5/13/24.- Risperdal 0.25 mg by mouth one time a day for bipolar disorder initiated on 5/14/25.On 6/23/25 at 10:50 AM, Resident #23 was observed falling asleep and leaning over a table in the common area during activities.On 6/23/25 at 11:39 AM, Resident #23 was observed in the dining room for lunch. Her lunch was placed in front of her and special eating utensils were provided. Resident #23 was observed taking two bites from her meal before she placed her hands in front of her on the table and began to fall asleep using her hands to support her head. Shortly after she asked staff if she can leave the dining room and was escorted out.On 6/25/25 at 10:55 AM, Resident #23 was observed leaning on the doorway of her room as she closed her eyes. Her hair was noted to be unkempt, and her clothing appeared to be disheveled and slept in. Resident #23 remained leaning on the doorway of her room until staff were able to assist her.On 6/26/25 at 10:53 AM, Resident #23 was noted sleeping in bed.A review of Resident #23's MAR dated 6/1/25 - 6/25/25, the record did not include documentation of Resident #23 experiencing sedation or lethargyOn 6/26/25 at 2:30 PM, on review of Resident #23's record the DON stated staff are not documenting Resident #23's condition and therefore it is unclear if medication adjustments need to be made.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 1 of 3 residents (Resident #39) 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:</p> <p>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 determines a resident had a serious mental illness and/or intellectual disability, or related condition.</p> <p>Resident #39 was admitted to the facility on [DATE], with multiple diagnoses including post-traumatic stress disorder (PTSD, a mental health condition triggered by experiencing or witnessing a traumatic event), stimulant abuse and panic disorder.</p> <p>Resident #39's Annual MDS assessment dated [DATE], documented under A1500 in Section A, no for the question, 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? However, there was a PASRR Level II observed in his electronic medical record, dated 3/13/25.</p> <p>On 6/26/25 at 2:21 PM, the MDS Coordinator stated Resident #39's MDS assessment was coded that the resident did not receive a PASRR Level II, and it should have been coded yes.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**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' care plans were revised according to their needs. This was true for 1 of 13 residents (Resident #8) whose records were reviewed for care plan timing and revisions. This failure created the potential for harm when residents' needs were not identified and or met. Findings include:</p> <p>Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including dementia with psychotic disturbances and major depressive disorder.</p> <p>Resident #8's care plan revised on 11/14/24, directed staff to investigate and identify potential triggers of target behaviors. The care plan also directed staff to use non-pharmacological interventions to reduce target behavior. Resident #8's care plan also directed staff to keep her within line of sight due to aggressive behaviors.</p> <p>The care plan did not include documentation of what triggered Resident #8 to become aggressive with others around her.</p> <p>On 6/26/25 at 3:21 PM, the DON stated Resident #8 becomes agitated when she is over stimulated with loud sounds or too many activities around her. She also stated that Resident #8 will begin to aimlessly ambulate around the facility making rude comments towards others. When asked how staff will know what triggers her behaviors, she stated based on the care plan they wouldn't because the care plan does not include what triggers her aggressive behaviors only interventions.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**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 professional standards of practice were followed for 5 of 5 residents (#4, #7, #26, #40, and #41) reviewed for bowel and bladder care. This failed practice created the potential for each of these residents to experience discomfort when their medications were not administered according to the physician's order. Findings include:</p> <p>1.) Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including dementia, muscle weakness, and constipation.</p> <p>An Annual MDS assessment dated [DATE], documented Resident #4's decision making was poor, and she needed cues and/or supervision.</p> <p>A physician's order documented Resident #4 was to receive the following medications:</p> <p>-Milk of Magnesia (MOM) suspension 1200 milligram (mg) /15 milliliters (ml), give 30 ml orally as needed for no bowel movement (BM) for two days. Give 1 dose. If no results within 24 hours, see Dulcolax suppository order.</p> <p>-Dulcolax suppository 10 mg, insert 1 suppository rectally as needed for bowel care. Give if no results from MOM. If no results in 24 hours, see Fleets Enema order.</p> <p>-Fleet Enema, insert 1 unit rectally as needed for bowel care. Give if no results from MOM and subsequent Dulcolax suppository. Complete bowel assessment and notify MD if no results.</p> <p>Resident #4's Bowel Movement Records, dated 5/15/25 through 6/15/25, documented she did not have a bowel movement from 5/29/25 through 6/1/25 (4 days).</p> <p>Resident #4's Medication administration record (MAR), dated 5/15/25 through 6/15/25, documented she did not receive any bowel care medications when she did not have a bowel movement for 4 days.</p> <p>On 6/26/25 at 1:15 PM, the DON reviewed Resident #4's record and stated Resident #4 should have been offered a bowel medication when she hadn't had a bowel movement on the evening of 5/31/25.</p> <p>2.) Resident #7 was admitted to the facility on [DATE], with multiple diagnoses including chronic pain, muscle weakness, and constipation.</p> <p>A Quarterly MDS assessment dated [DATE], documented Resident #7 was cognitively intact.</p> <p>A physician's order documented Resident #7 was to receive the following medications:</p> <p>-Bisacodyl oral tablet delayed release 5mg, give 10 mg by mouth as needed for constipation daily.</p> <p>-Bisacodyl laxative rectal suppository, insert 1 unit rectally every 72 hours as needed for constipation may give every 3 days if no BM.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Milk of Magnesia suspension 400 mg/5 ml, give 30 ml by mouth as needed for constipation. If resident does not have a bowel movement for three days, administer milk of magnesia per physician order on day four.</p> <p>-Miralax Powder, give 0.5 dose by mouth every 24 hours as needed for constipation mix with 4 oz of liquid of choice.</p> <p>Resident #7's Bowel Movement Records, dated 6/1/25 through 6/24/25, documented he did not have a bowel movement from 6/3/25 through 6/8/25 (6 days) and from 6/10/25 through 6/14/25 (5 days).</p> <p>Resident #7's MAR, dated 6/1/25 through 6/24/25, documented he did not receive any bowel care medications when he did not have a bowel movement for 6 days and 5 days respectively.</p> <p>On 6/24/25 at 3:30 PM, Resident #7 stated he frequently gets constipation and has to ask the nurse for a bowel medication when it gets bad.</p> <p>On 6/26/25 at 1:20 PM, the DON reviewed Resident #7's record and stated Resident #7 is cognitively intact and can ask for bowel medications when needed. She further stated the nurse should have been tracking his bowel movements and offered medications when Resident #7 had not had a bowel movement on the evening of 6/6 or the morning of 6/7 and again when he had not had a bowel movement on the evening of 6/12 or the morning of 6/13.</p> <p>3.) Resident #26 was admitted to the facility on [DATE], with multiple diagnoses including dementia, muscle weakness, and constipation.</p> <p>A Quarterly MDS assessment dated [DATE], documented Resident #27's decision making was poor, and she needed cues and/or supervision.</p> <p>A physician's order documented Resident #27 was to receive the following medications:</p> <p>-Milk of Magnesia suspension 400 mg/5 ml, give 30 ml by mouth as needed for constipation. Give daily as needed. Contact provider if there is three days without significant BM.</p> <p>-Dulcolax suppository 10 mg, insert one suppository rectally as needed for constipation. Contact provider if there is three days without significant BM.</p> <p>-Fleets Enema, insert one dose rectally as needed for constipation. Give if no results from MOM and subsequent Dulcolax suppository. Complete bowel assessment and notify provider if no results.</p> <p>Resident #26's Bowel Movement Records, dated 6/1/25 through 6/24/25, documented she did not have a bowel movement from 6/13/25 through 6/16/25 (4 days).</p> <p>Resident #26's MAR, dated 6/1/25 through 6/24/25, documented she did not receive any bowel care medications when she did not have a bowel movement for 4 days.</p> <p>On 6/26/25 at 1:25 PM, the DON reviewed Resident #26's record and stated Resident #26 should have been offered a bowel medication when she did not have a bowel movement on the evening of 6/15 or the morning of 6/16.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4.) Resident #40 was re-admitted to the facility on [DATE], with multiple diagnoses including long term antibiotic use, muscle weakness, and constipation.</p> <p>An admission MDS assessment dated [DATE], documented Resident #40's decision making was moderately impaired.</p> <p>A physician's order documented Resident #40 was to receive the following medications:</p> <ul style="list-style-type: none"> -Milk of Magnesia suspension 1200 mg/15 ml, give 30 milliliters orally as needed for no BM for 72 hours, give 1 dose. If no results within 24 hours, see Dulcolax suppository order. -Dulcolax suppository 10 mg, insert 1 suppository rectally as needed for bowel care after MOM administration with no results. Give if no results from MOM. If no results in 24 hours, see Fleets Enema order. -Fleet Enema, insert 1 unit rectally as needed for bowel care after 24 hours of suppository with no results, give if no results from MOM and subsequent Dulcolax suppository. Complete bowel assessment and notify MD if no results. <p>Resident #40's Bowel Movement Records, dated 6/1/25 through 6/24/25, documented he did not have a bowel movement from 6/17/25 through 6/21/25 (5 days).</p> <p>Resident #40's MAR, dated 6/1/25 through 6/24/25, documented he did not receive any bowel care medications when he did not have a bowel movement for 5 days.</p> <p>On 6/26/25 at 1:30 PM, the DON reviewed Resident #40's record and stated Resident #40 should have been offered a bowel medication when he had not had a bowel movement on the evening of 6/19 or the morning of 6/21.</p> <p>5.) Resident #41 was admitted to the facility on [DATE], with multiple diagnoses including psychotic disturbance, muscle weakness, and constipation.</p> <p>A Quarterly MDS assessment dated [DATE], documented Resident #41's decision making was poor, and she needed cues and/or supervision.</p> <p>A physician's order documented Resident #41 was to receive the following medications:</p> <ul style="list-style-type: none"> -Milk of Magnesia suspension 1200 mg/15 ml, give 30 milliliters orally as needed for no BM for two days. Give 1 dose. If no results within 24 hours, see Dulcolax suppository order. -Dulcolax suppository 10 mg, insert 1 suppository rectally as needed for bowel care, give if no results from MOM. If no results in 24 hours, see Fleets Enema order. -Fleet Enema, insert 1 unit rectally as needed for bowel care. Give if no results from MOM and subsequent Dulcolax suppository. Complete bowel assessment and notify MD if no results. <p>Resident #41's Bowel Movement Records dated 5/15/25 through 6/15/25, documented she did not have a bowel movement from 5/29/25 through 6/1/25 (4 days).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of incident and accidents (I&A), staff interview, and The State Operation Manual, it was determined the facility failed to ensure adequate supervision was provided to prevent falls. This was true for 1 of 1 resident, (Resident #8) whose record was reviewed for falls. This had the potential to cause more than minimal harm to resident #8. Findings include: The State Operation Manual, Appendix PP, defined Avoidable Accident as an accident occurred because the facility failed to: Identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including muscle weakness, difficulty in walking, and history of falls. Resident #8's care plan revised on 8/27/23, directed staff to place personal items and assistive devices within reach. An I&A report dated 4/11/25 at 4:00 PM, documented a CNA assisted Resident #8 to transfer to the couch in the common area. After the transfer the CNA proceeded to place the wheelchair near Resident #8 when the nurse interrupted her and instructed her to remove the wheelchair and place it behind the couch so Resident #8 would not attempt to self-transfer. The report documented Resident #8 attempted to self-transfer and lost her balance causing her to fall on her right side and hit her head. It also documented Resident #8 was 5-7 feet away from a transfer area. The I&A report also documented Resident #8 obtained a goose egg on the right side of her head, the provider was notified and ordered the facility to send Resident #8 to the hospital for further evaluation. The fall investigation included statements from two CNA's documenting the removal of the wheelchair from Resident #8 resulted in the fall. On 6/25/25 at 2:50 PM, during an interview with the DON and Administrator the DON stated education was provided to staff on placement of wheelchairs.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, resident and staff interview, it was determined the facility failed to ensure respiratory services were provided. This was true for 1 of 1 resident (Resident #14) whose record was reviewed for respiratory services. This failure created the potential for harm when Resident #14's continuous positive airway pressure (CPAP) machine (a non-invasive ventilation machine) was not applied at bedtime. Findings include:</p> <p>Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including obstructive sleep apnea and muscle weakness.</p> <p>Resident #14's care plan revised 7/4/24, directed staff to see the administration record for the application schedule.</p> <p>A physician order dated 3/30/25, directed staff to apply the CPAP machine at bedtime and remove in the morning.</p> <p>On 6/24/25 at 1:53 PM, Resident #14's CPAP machine was observed on a night stand next to her bed with no water in it. The mask was located directly on the floor near Resident #14's bed.</p> <p>On 6/25/25 at 9:39 AM, Resident #14 stated she had not used her CPAP machine in a month because it doesn't work. She stated, that's why I have been using this during the night and pointed at the oxygen cannula on her nose.</p> <p>On 6/25/25 at 4:58 PM, the DON stated Resident #14's CPAP machine has not worked in two weeks. She also stated she notified the provider on 6/21/25 and he directed her to place Resident #14 on 2 liters of oxygen via nasal cannula while she sleeps. However, neither her nor the provider discussed putting the order for the CPAP machine on hold until it was resolved.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure nursing staff were educated on identifying mood, behaviors, and side effects. This failure created the potential for adverse outcomes when residents' records were not accurately reflecting residents' current condition. Findings include:</p> <p>On 6/26/25 at 1:45 PM, during a record review with the DON, she stated the facility had identified some concerns with resident documentation for mood, behavior, and side effects and had provided several opportunities for education with the staff.</p> <p>On 6/26/25 at 1:47 PM, a request for staff education was made and the following was provided:</p> <ul style="list-style-type: none"> -On 3/26/24, the agenda listed CNA's were to be educated on notifying the nurse of behaviors for proper documentation however, no proof of education was provided. - On 6/5/25, the agenda listed documenting behaviors but no proof of education was provided. -On 11/7/24, the agenda listed documentation for behavior charting but no proof of education was provided. <p>On review of the staff education provided no specific mood, behavior, or side effects were documented.</p> <p>On 6/26/25 at 2:05 PM, the DON stated the staff are not identifying abnormal behaviors and she believed they should provide further staff education.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on record review and staff interview it was determined the facility failed to ensure a registered nurse (RN) was on-site for 8 consecutive hours a day, for 7 days a week, to provide care to the residents. This was true for 3 of 21 days reviewed for sufficient staffing. This failure placed all residents at risk for harm if their routine and/ or emergency needs could not be met without the care of a registered nurse. Findings include:</p> <p>On review of the nursing staff hours worked, dated 6/1/25 through 6/21/25 the facility did not provide 8 consecutive hours of registered nurse coverage on 6/1/25, 6/14/25, and 6/15/25 (3 of 21 days).</p> <p>On 6/24/25 at 10:02 AM, the Administrator stated the facility did not have an RN for 8 consecutive hours on 6/1/25, 6/14/25 and 6/15/25.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure (a) food was stored in a safe and sanitary manner and (b) drink wear was maintained in sanitary conditions. This deficient practice created the potential to affect 49 of 49 residents who consumed food and drinks prepared by the facility. This placed residents at risk for adverse outcomes, including food-borne illness. Findings include:</p> <p>a. On 6/23/25 at 10:10 AM, during a initial kitchen inspection a large brown box was observed in the dry goods pantry. The box contained large yellow onions noted with a green fuzzy substance on the surface of multiple onions.</p> <p>On 6/23/25 at 10:11 AM, when asked if the onions were in a safe condition to serve the Dietitian stated obviously we would not serve them to anyone.</p> <p>b. On 6/24/25 at 2:15 PM, during a in-depth kitchen inspection a bread toaster was identified sitting on a counter. The toaster was observed to contained a thick layer of black encrusted particles. Also, during the inspection multiple purple coffee cups were identified in a clean storage cabinet to have a layer of brown substance along the inside of the cup.</p> <p>On 6/24/25 at 2:32 PM, During an interview with the Administrator and Kitchen Aid #1, the Administrator stated the toaster is not in a clean condition and will be replaced. Kitchen Aid #1 stated in his opinion the cups were also not in sanitary condition.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**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 Resident records contained accurate documentation. This was true for 2 of 2 residents (Resident #8 and #14) whose records were reviewed for accuracy. This failure had the potential for adverse outcomes and harm when Resident #8's record documents an inaccurate weight and when Resident #14's record documented inaccuracy of administration of continuous positive airway pressure (CPAP) machine (a non-invasive ventilation machine) use. Findings include:</p> <p>1. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including dysphagia, lactose intolerance, and vitamin D deficiency.</p> <p>Resident #8's record documented the following weights:</p> <ul style="list-style-type: none"> - On 1/7/25 her weight was 145 lbs. - On 2/12/25 her weight was 147 lbs. - On 3/4/25 her weight was 133 lbs. - On 4/25/25 her weight was 130.5 lbs. - On 5/13/25 her weight was 140 lbs. - On 6/ 3/25 her weight was 127 lbs. <p>A Quarterly Nutritional assessment dated [DATE], documented Resident #8's weight was calculated using the weight documented on 5/13/25 of 140 lbs.</p> <p>A Quarterly MDS assessment dated [DATE], documented Resident #8 had a weight of 140 lbs. Section K question 0300 labeled weight loss, asked did the Resident have a 5% weight loss or more in the last month or 10% or more in the last 6 months. The question was answered No or Unknown.</p> <p>Resident #8's record documented the weight on 5/13/25 of 140 lbs. was crossed out as inaccurate on 6/12/25, 30 days after the weight was entered.</p> <p>On 6/25/25 at 10:35 AM, the DON stated the Quarterly Nutritional Assessment and the Quarterly MDS both reflected a weight that was inaccurately documented.</p> <p>2. Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including obstructive sleep apnea and gastro-esophageal reflux.</p> <p>Resident #14's Care Plan revised on 7/4/24, directed staff to cleanse her mask and tubing daily and replace tubing weekly.</p> <p>A physician order dated 7/6/24, directed staff to cleanse the CPAP mask nightly.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #14's Medication Administration Record (MAR) dated 6/1/25 through 6/24/25, documented the following orders were signed off as completed:</p> <ul style="list-style-type: none"> - Wipe CPAP mask daily every night shift. - Remove mask from head gear and clean mask and cushion with warm soapy water or with CPAP wipe. <p>On review of Resident #14's record the following order to assist with CPAP placement was not signed off as completed on the following dates:</p> <p>6/9/25, 6/10/25, 6/15/25, 6/20/25, 6/21/25, 6/22/25, 6/23/25, 6/24/25</p> <p>On 6/25/25 at 4:45 PM, when asked if she cleaned the CPAP machine for Resident #14 LPN # 1 stated No I do not touch it only night shift. LPN #1 was asked to verify her credentials and asked why her credentials indicated she had cleansed the CPAP machine she stated I guess we all have a lot to learn.</p> <p>On 6/25/25 at 4:58 PM, the DON stated the CPAP machine had not worked for the last two weeks and she did not know why the staff were inaccurately documenting in the MAR.</p>

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>Based on record review and staff interview it was determined the facility failed to ensure the Quality Assessment and Performance Improvement (QAPI) committee took action to identify and resolve systemic problems. This failure affected 49 of 49 residents residing in the facility. The deficient practice resulted in failure to identify resident mood, behaviors, and side effects for adverse outcomes when residents' record were not accurately documenting the residents current condition. Findings include:</p> <p>The facility's QAPI plan revised on 06/04/24, directed the QAPI committee to perform the following:</p> <ul style="list-style-type: none"> - Meet at a minimum on a quarterly basis - Coordinating and evaluating QAPI program activities - Developing and implementing appropriate plan of action to correct identified deficiencies - Regularly review and analyze data collected under QAPI program and data resulting from drug regimen review and acting on available data to make improvements. - Determine areas for Performance Improvement Plans (PIP) for rapid improvement projects. <p>On 6/26/25 at 2:05 PM, the DON stated she has been educating the nursing staff on mood, behaviors, and side effects for several months.</p> <p>On 6/27/25 at 8:43 AM, The administrator stated the QAPI committee met monthly and have discussed pharmacy concerns. When asked if the team had identified inaccuracy for documentation for mood and behaviors he stated yes. When asked why the concerns was not deemed necessary to implement as a PIP he stated he cannot speak to why the team did not implement a PIP to correct the deficient practice.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, CDC recommendation review, and staff interview, it was determined the facility failed to ensure infection control and prevention practices were maintained. This failure had the potential to impact all residents in the facility by placing them at risk for cross contamination and transmission of infection. Findings include:</p> <p>The Centers for Disease Control and Prevention (CDC) web page titled, Clinical Safety: Hand Hygiene for Healthcare Workers, updated 2/27/24, documented hand hygiene should be performed:</p> <ul style="list-style-type: none"> -Immediately before touching a patient. -Before performing an aseptic task such as placing an indwelling device or handling invasive medical devices. -Before moving from work on a soiled body site to a clean body site on the same patient. -After touching a patient or patient's surroundings. -After contact with blood, body fluids, or contaminated surfaces. -Immediately after glove removal. <p>The following was observed for hand hygiene and Personal Protective equipment (PPE):</p> <p>On 6/24/25 at 2:50 PM, CNA #1 and CNA #2 were observed entering Resident #6's room to provide peri-care. Both CNAs sanitized their hands and donned gloves and positioned Resident #6 on her side. CNA #1 was providing peri-care for Resident #6 when she removed her soiled gloves. She then reached into her shirt pocket and pulled out a pair of gloves, paused, put them back into her pocket and pulled a pair of gloves from a box in the residents' bathroom. CNA #1 then donned the new gloves. No hand hygiene was observed. She proceeded to complete Residents #6's care by donning her new brief and positioning her comfortably in her bed. Both CNAs removed their gloves and performed hand hygiene prior to leaving Resident #6's room.</p> <p>On 6/24/25 at 3:05 PM, CNA #1 stated she should have performed hand hygiene after removing the dirty gloves and before donning the new gloves and continuing resident care.</p> <p>On 6/26/25 at 10:10 AM, the DON stated the expectation for direct care staff would be that they wash their hands between glove changes.</p>