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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135059	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin County Transitional Care	44 North 1st East Preston, ID 83263

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 07342 Based on policy review and staff interview, the facility failed to ensure their abuse policy included screening and training of employees, and protection for residents during an investigation. This failure placed all residents in the facility at risk for abuse if staff did not recognize abuse, report it, or put protection measures in place for a resident after an allegation of abuse. Findings include: The facility's policy, Freedom from Abuse, Neglect and Exploitation, dated 5/18/20, did not include screening requirements of staff to ensure or prevent abuse from occurring. The policy also did not include to whom, how and when to report incidents of abuse and neglect. The policy also did not include how the facility would protect a resident during an investigation of an allegation of abuse. During an interview with the Administrator on 5/17/24 at 9:40 AM, she confirmed the facility's abuse policy was lacking screening and training of employees, and protection of residents. She stated abuse training was completed annually for employees and covered all required topics, but the policy did not address all of them.

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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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20940 Based on record review and staff interview, it was determined the facility failed to ensure residents received gradual dose reductions (GDRs) of psychotropic medications or a stop date ordered for an as needed psychotropic medication unless clinically contraindicated. This was true for 3 of 5 residents (#8, #13, #18) reviewed for unnecessary medications. This failure created the potential for harm should residents receive medications that were unnecessary, ineffective, or used for excessive duration, or should residents experience adverse reactions from medications. Findings include: 1. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including anxiety and depression. A physician order, dated 1/25/22, documented to administer escitalopram (a medication used to treat depression and anxiety) 20 mg every day to Resident #8. Resident #8's care plan, documented he had a problem for behavior management with interventions including to monitor for depressive symptoms and behaviors towards staff. A Behavior Monitoring and Interventions Report, dated 5/1/24 to 5/17/24, documented Resident #8 did not display the identified problem behaviors. Resident #8's Psychotropic Medication Review Form documented no changes were recommended for 4/20/23, 6/15/23, 7/27/23, 9/21/23, 10/19/23, 11/16/23, 12/21/23, 1/25/24, 2/15/24, 3/21/24, and 4/18/24. Resident #8's record did not include GDR recommendations or dose reduction attempted after Resident #8 started on escitalopram, more than two years prior. 2. Resident #13 was admitted on [DATE], with multiple diagnoses including anxiety and depression. a. A physician order, dated 12/13/22, documented to administer Seroquel (an antipsychotic medication) 50 mg at bedtime to Resident #13. Resident #13's Psychotropic Medication Review Form documented on 1/19/23, the Seroquel dose was reduced to 25 mg, on 4/4/23 the dose was increased back to 50 mg, and on 7/12/23 the dose was increased to 75 mg. Resident #13's Record did not include GDRs for the Seroquel. b. A physician order, dated 1/9/23, documented to administer Celexa 40 mg every day to Resident #13 for the treatment of depression. The pharmacist notes on Resident 13's Psychotropic Medication Review Form documented no changes were recommended and Resident #13's moods were stable on 8/17/23, 9/21/23, 10/19/23, 11/16/23, 12/21/23, 1/25/24, 2/24/24, 3/21/24 and 4/18/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. A physician order, dated 11/27/23, documented to administer Ativan 0.5 mg every six hours as needed to Resident #13 as needed for anxiety. Resident #13's record did not include a stop date or reevaluation of his as needed Ativan after 14 days of use. 3. Resident #18 was admitted to the facility on [DATE], with multiple diagnoses including depression. Resident #18's record included the following physician orders: - Risperdal (an antipsychotic medication) 1.5 mg at bedtime for ataxia (movement disorder), dated 2/20/24 - Bupropion (an antidepressant) 150 mg daily for depression, dated 11/4/23 - Venlafaxine (an antidepressant) 150 mg daily for depression, dated 11/7/23 A pharmacy note, dated 4/18/24, documented Resident #18's moods were stable with no changes recommended during the 11/16/23, 12/21/23, 1/25/24, 2/15/24, and 3/21/24 reviews. Resident #18's care plan documented a Behavior Management Plan to address the use of psychoactive medications for the identified behaviors of depressive and anxiety symptoms. Resident #18's Behavior Monitoring and Interventions Report documented Resident #18 had not experienced behaviors in May of 2024. Review of the Social Services notes documented Resident #18 did not demonstrate depressive or anxiety symptoms since 11/8/23. Resident #18's record did not include a diagnosis of movement disorder or a psychotic disorder for the use of the Risperdal. Resident #18's record did not include GDRs were attempted for the Risperdal, Bupropion, and Venlafaxine. On 5/16/24 at 2:30 PM, the Medical Director with the Director of Nursing present confirmed the Consulting Pharmacist did not make GDR recommendations for Resident #3, Resident #13, and Resident #18. The Medical Director further confirmed there was no stop date for the as needed Ativan ordered for Resident #13.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20940 Based on record review and staff interview, the facility failed to ensure an antibiotic stewardship program was implemented to prevent continued use of antibiotics without a rationale. This was true for 2 of 5 residents (#8 and #13) reviewed for unnecessary medications. This deficient practice created the risk for Resident #8 and #13 to develop resistance to antibiotics resulting in ineffective or difficult treatment for infections. Findings include: 1. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including dementia, anxiety, skin picking disorder, and depression. Resident #8's record did not include documentation for a diagnosis of an infected hip wound. A physician order, dated 1/14/22, documented to administer Bactrim DS (an antibiotic) 800 mg to Resident #8 two times a day for an infected hip wound. Resident #8's record documented he received the antibiotic as ordered for more than two years. 2. Resident #13 was admitted to the facility on [DATE] with multiple diagnoses including anxiety, chronic kidney disease and depression. A physician order, dated 3/23/23, documented to administer Ciprodex Otic Suspension (an ear drop antibiotic) to Resident #13 every 12 hours as needed for a tympanic membrane (eardrum) perforation (rupture) for any drainage. Resident #13's record did not include documentation he had a history of a ruptured tympanic membrane. On 5/15/24 at 10:00 A.M, the Infection Preventionist (IP) confirmed Resident #8 continued to receive an antibiotic for an infected hip, however there was no documentation in his record he had an infected hip. The IP also confirmed Resident #13 continued to have an antibiotic ear drop for more two years and there was no documentation in his record of a ruptured eardrum.