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	05/29/2025

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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 51121 Based on record review, policy review, document review, and staff interview, it was determined the facility failed to ensure residents and their representatives received assistance to exercise their right to formulate an Advance Directive. This was true for 6 of 25 Residents (#3, #5, #8, #9, #10, and #22) whose records were reviewed for advance directives. This deficient practice created the potential for harm or adverse outcomes if the residents' wishes were not followed or documented regarding their advance care planning. Findings include: The facility's TCU Advanced Directives policy dated [DATE], documented the following under Procedures; - 1. Upon admission the resident/representative will be given the form Your right's as a patient to make medical treatment decisions. After reading this form they will be ask(ed) to sign that they have read and received the form and to declare if they already have advanced directives and what kind. - 4. If the resident already has made advanced directives, the admitting nurse will invite them to bring copies of the advanced directives to the facility to be placed in the residents' chart. - 5. If they have not established advanced directives but wish to, they will be referred to social services to have the option to create a (1) Living Will/Durable Power of Attorney for Health Care (2) POST, or (3) declare CPR status. - 6. Advanced Directives will be reviewed and discussed with the resident/representative upon the residents annual admitted by social services or as often as the resident/representative desire. The facility's Your Rights As A Patient To Make Medical Treatment Decisions document only contained information pertaining to living will and durable power of attorney for health care, and had not contained documentation declaring the status of an Advance Directive. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including dementia and depression. On [DATE], Resident #3's medical record had not contained documentation of Advance Directives and no documentation that the facility had offered to assist her with formulating an Advance Directive. (continued on next page)

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:28 AM, the DON stated the facility had Resident #3 document if she wanted CPR or not and that was the extent of their Advance Directives. On [DATE] at 10:30 AM, the Social Worker stated during annual admitted review with Resident #3, there was no documentation that Advanced Directives were discussed or confirmed. Resident #5 was admitted to the facility on [DATE], with multiple diagnoses including chronic kidney disease and chronic respiratory disease. On [DATE], Resident #5's medical record had not contained documentation of Advance Directives and no documentation that the facility had offered to assist her with formulating an Advance Directive. On [DATE] at 10:28 AM, the DON stated they had Resident #5 document if she wanted CPR or not and that was the extent of their advance directives On [DATE] at 10:30 AM, the Social Worker stated during annual admitted review with Resident #5, there was no documentation that Advanced Directives were discussed or confirmed. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including depression and chronic obstructive pulmonary disease (a progressive lung disease characterized by airflow limitations and chronic respiratory symptoms). On [DATE], Resident #8's medical record had not contained documentation of Advance Directives and no documentation that the facility had offered to assist her with formulating an Advance Directive. On [DATE] at 10:28 AM, the DON stated they had Resident #8 document if she wanted CPR or not and that iwas the extent of their advance directives. On [DATE] at 10:30 AM, the Social Worker stated during annual admitted review with Resident #8, there was no documentation that Advanced Directives were discussed or confirmed. Resident #9 was admitted to the facility on [DATE], with multiple diagnoses including dementia and depression. On [DATE], Resident #9's medical record contained a POST document but had not contained documentation of Advance Directives and no documentation that the facility had offered to assist him with formulating an Advance Directive. On [DATE] at 10:28 AM, the DON stated they had Resident #9 document if he wanted CPR or not and that was the extent of their advance directives. On [DATE] at 10:30 AM, the Social Worker stated during annual admitted review with Resident #9, there was no documentation that Advanced Directives were discussed or confirmed. Resident #10 was admitted to the facility on [DATE], with multiple diagnoses including anoxic brain damage (an injury that caused the brain to not receive oxygen) and diabetes. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE], Resident #10's medical records had not contained documentation of Advance Directives and no documentation that the facility had offered to assist him with formulating an Advance Directive. On [DATE] at 10:28 AM, the DON stated they had Resident #10 document if he wanted CPR or not and that was the extent of their advance directives On [DATE] at 10:30 AM, the Social Worker stated during annual admitted review with Resident #10, there was no documentation that Advanced Directives were discussed or confirmed. Resident #22 was admitted to the facility on [DATE], with multiple diagnoses including chronic viral hepatitis (infection that causes liver inflammation and damage) and dementia. On [DATE], Resident #22's had not contained documentation of Advance Directives and no documentation that the facility had offered to assist her with formulating an Advance Directive. On [DATE] at 10:28 AM, the DON stated they had Resident #22 document if she wanted CPR or not and that was the extent of their advance directives. On [DATE] at 10:30 AM, the Social Worker stated during annual admitted review with Resident #22, there was no documentation that Advanced Directives were discussed or confirmed. 52524

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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** 51121 Based on observation, interview, and record review, it was determined the facility failed to ensure the MDS assessment accurately reflected resident's status. This was true for 1 of 12 residents (Resident #21) whose MDS, care plan, and nursing assessments were reviewed. This deficient practice had the potential for negative outcomes if the resident was not assessed and cared for or monitored due to inaccurate assessments. Findings include: Resident #21 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and stroke. Resident #21's MDS height measurement were documented as follows: - 7/3/24, documented his height at 66 inches. - 10/2/24, documented his height at 63 inches. - 12/31/24, documented his height at 66 inches. - 4/2/25, documented his height at 63 inches. On 5/28/25 at 10:29 AM, the Administrator stated she was not sure why Resident #21's height discrepancies were put into the MDS assessments.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52524 Based on record review, policy review and staff interview, it was determined the facility failed to ensure residents care plans were revised and updated. This was true for 2 of 12 residents (#1 and #19) whose care plans were reviewed. This created the potential for harm when residents' care plans were not revised to reflect care or fall prevention needs. Findings include: The facility's Care Plan policy, revised September 2022, documented the care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The facility's Risk Assessment for Accidents, Falls, and Care Planning policy dated 2/24/25, documented care plans will be specifically developed for each resident to mitigate the risk of falls utilizing the TCU care planning regarding falls procedure. Monitoring is the process of evaluating the effectiveness of care plan interventions. Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks. a. Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (a progressive lung disease characterized by airflow limitations and chronic respiratory symptoms) and depression. On 5/27/25, Resident #1's record documented falls on 12/2/24, 12/12/24, 1/27/25, 2/11/25, and 4/20/25. Resident #1's care plan had not addressed fall interventions related to each fall occurrence. The following dates identifies each fall and the facility's Fall Committee documentation. - 12/2/24 - Resident #1 considered a high fall risk, was found sitting on the floor after a fall and the following interventions had previously been implemented - move resident's room closer to nurses station, frequent rounding, touch call light, repeated education, urinal at bedside. - 12/12/24 - Resident #1 fell as CNA was walking into his room. Plan - staff have been reminded to ensure the urinal is within his reach and to keep it empty. - 1/27/25 - Resident #1 fell out of bed due to oxygen tubing. Plan - Given shorter tubing. - 2/11/25 - Resident #1 slipped off his bed, stating his shoe slipped off. No plan noted. - 4/20/25 - Resident #1 slipped off his bed, stating his feet slipped. Plan - Staff to ensure non-skid footwear is on resident prior to leaving room. None of the facility's Fall Committee documented interventions for Resident #1 were care planned following each fall incident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/25 at 2:24 PM, the DON stated Resident #1's care plans should have been updated to address each fall related issue but were not. The fall committee did investigate and commented on each fall but this information did not get transferred into Resident #1's care plans. b. Resident #19 was admitted to the facility on [DATE], with multiple diagnoses including dementia and hypertension (high blood pressure). On 5/28/25, Resident #19's care plan had not documented resident wandering incidents or interventions to address wandering. On 5/28/25 at 8:58 AM, review of progress note, dated 5/16/25, documented Resident #19 was very agitated and wandered outside of the facility and was walked back inside. Additional progress notes dated, 3/18/25, 4/2/25, and 4/6/25, documented Resident #19 wandering about the facility. The MDS admission assessment, dated 3/24/25, documented Resident #19 had experienced wandering experiences 1-3 times. On 5/28/25 at 10:30 AM, the Social Worker and DON stated care plans are to be updated and had not been. 51121

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on observation, State Operations Manual, and interviews, it was determined the facility failed to ensure safe water temperatures in resident rooms. This was true for 2 of 5 resident rooms (12 and 15) whose water temperatures were checked. This deficient practice placed residents at risk for harm when using room sink water. Findings include: State Operations Manual Appendix PP, 483.25d, Table 1 illustrates damage to skin in relation to the temperature of the water and the length of time exposure. Table 1. Time and Temperature Relationship to Serious Burns Water Temperature Time Required for a 3rd Degree Burn to Occur 155 F 1 second 148 F 2 seconds 140 F 5 seconds 133 F 15 seconds 127 F 1 minute 124 F 3 minutes 120 F 5 minutes 100 F Safe Temperatures for Bathing NOTE: Burns can occur even at water temperatures below those identified in the table, depending on an individual's condition and the length of exposure. Resident #17 was admitted to the facility on [DATE], with multiple diagnoses including pneumonia and hemiplegia and hemiparesis following stroke (Hemiplegia refers to complete paralysis on one side of the body, while hemiparesis refers to weakness on one side of the body). On 5/27/25 at 1:26 PM, Resident #17 stated his room (12) water temperature was very hot. The following resident room water temperatures were found to be above 120 degrees Fahrenheit (F). - On 5/27/25 at 1:28 PM, the sink water temperature was 125 degrees F in room [ROOM NUMBER]. - On 5/27/25 at 1:42 PM, the sink water temperature was 126 degrees F in room [ROOM NUMBER]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/25 at 2:12 PM, the Administrator stated the maintenance department verified the water was too hot and found the boiler setting at 122 degrees F which has been corrected.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on observation, record review and staff interview, it was determined the facility failed to ensure licensed nurses performed tasks which they had the knowledge, skills, and competencies. This was true for 4 of 15 licensed nurses. This had the potential for adverse effects to all residents who are assessed for oxygen therapy. Findings include: Resident #20 was admitted to the facility on [DATE], with multiple diagnoses including anxiety disorder and dementia. Resident #20's physician order dated 3/5/25, documented O2 via nasal cannula 2-3L to keep SATS greater than 90%. The following had been documented when Resident #20's oxygen saturations (SATS) were lower than the physician's oxygen order and no documented nursing interventions occurred. - On 5/14/25 at 7:25 AM, SpO2 was 89% with oxygen per LPN #1. - On 5/13/25 at 4:54 AM, SpO2 was 86% with oxygen per LPN #2. - On 5/7/25 at 4:16 AM, SpO2 was 89% with oxygen per LPN #2. - On 5/5/25 at 5:14 AM, SpO2 was 89% with oxygen per LPN #2. - On 5/3/25 at 4:38 AM, SpO2 was 89% with oxygen per LPN #2. - On 5/1/25 at 7:37 AM, SpO2 was 89% with oxygen per LPN #1. Addressed by LPN #1 telling resident to take deep breaths. - On 4/28/25 at 3:42 PM, SpO2 was 89% with oxygen per LPN #1. - On 4/27/25 at 4:34 AM, SpO2 was 89% with oxygen per LPN #2. - On 4/26/25 at 4:15 AM, SpO2 was 89% with oxygen per LPN #2. - On 4/14/25 at 5:49 AM, SpO2 was 88% with oxygen per RN #1. - On 3/15/25 at 11:54 PM, SpO2 was 89% with oxygen per RN #2. - On 3/15/25 at 2:30 PM, SpO2 was 88% with oxygen per LPN #1. - On 3/15/25 at 12:54 AM, SpO2 was 89% with oxygen per RN #2. - On 3/10/25 at 5:02 AM, SpO2 was 88% with oxygen per RN #1. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 3/7/25 at 8:32 AM, SpO2 was 84% on room air per LPN #1. On 5/28/25 at 3:25 PM, the DON stated nursing staff should have documented intervention when each low SpO2 was found on Resident #20 but did not.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 52524 Based on record review and staff interview, it was determined the facility failed to ensure controlled medications were tracked and kept secure from potential theft and/or diversion. This was true for 1 of 2 medication carts reviewed. This failure created the potential for undetected misuse and/or diversion of controlled medications and had the potential to affect all residents who received controlled medication in the facility. Findings include: On 5/28/25 at 1:53 PM, during Hall B medication cart audit, observed the narcotic accountability record, dated 5/18/25 to 5/28/25, with 2 licensed nurse signatures not documented. On 5/28/25 at 1:58 PM, LPN #3 stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart. On 5/29/25 at 11:04 AM, the DON stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52524 Based on observations, review of the State Operations Manual, and staff interviews it was determined the facility failed to ensure controlled medications were stored and kept secure, and biologicals were labeled when opened. This was true for the facility. These deficient practices created the potential for theft and/or diversion and use of expired biologicals. Findings include: The State Operations Manual, Appendix PP, updated [DATE], Schedule II-V medications must be maintained in separately locked, permanently affixed compartments. 1. The following was observed for controlled medications. - On [DATE] at 1:31 PM, a box of lorazepam (Schedule IV controlled medication) stored on the medication refrigerator shelf. On [DATE] at 1:35 PM, LPN #3 stated the medication refrigerator and the medication cabinet are locked. There is no other locked compartment inside the medication refrigerator for controlled medications. 2. The following was observed for biologicals. - On [DATE] at 8:18 AM, one set of glucose test solutions were not dated when opened. On [DATE] at 8:20 AM, LPN #3 stated glucose test solution was not dated when opened and should have been. On [DATE] at 2:08 PM, the DON stated glucose test solution bottles should be dated when opened and were not.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51121 Based on observation, interview, policy review, and review of the Idaho Food Code, the facility failed to appropriately store, distribute, and label foods. 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 and use of spoiled foods, and adverse health outcomes including food-borne illnesses. Findings include: The Idaho Food Code, revised February 2021, stated, 3-501.17 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. The facility's TCU Resident Food Storage policy dated 11/8/23, documented residents may have food brought in from home sources or gardens from family or friends with the provision that they are marked with the resident's full name, the date opened, and that the goods are checked for safety when brought in to the facility, i.e. sealed jars, expiration dated, etc. On 5/27/25 at 9:00 AM, with Dietary Coordinator present, observed in the walk-in freezer, the following food storage related issues. - One bag of biscuits was not sealed and opened to room air, - One large Ziploc bag of sandwiches was not dated. - Large amounts of ice build up on floor and fans in the walk-in freezer unit. On 5/27/25 at 9:15 AM, the Dietary Coordinator stated the ice buildup needed to be addressed, food items should be properly sealed and properly dated and were not. On 5/29/25 at 10:03 AM, with the assistant Dietary Coordinator present, observed the following issues in the nourishment room refrigerator which contained resident refrigerated food items. - Opened relish container with no open date or name of resident, - Opened container of homemade jelly/jam with 2024 date documented on the lid and no name of resident, - Ziploc bag of sliced cheese with no date. On 5/29/25 at 10:05 AM, the assistant Dietary Coordinator stated refrigerated resident food items must be dated and have resident names or be disposed of.