STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135064	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Care & Rehabilitation	1224 Eighth Street Rupert, ID 83350

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on record review, interviews, and policy review, the facility failed to thoroughly investigate an injury of unknown origin for one resident (Residents (R)20) out of two residents reviewed for abuse out of a total sample of 14 residents. This failure created the potential for residents to be, or to continue to be, abused/neglected. Findings include: The facility's Abuse, Neglect and Exploitation Policy dated 12/03/21 read, in pertinent part, It is the policy of the facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property; and Investigation of Alleged Abuse, Neglect and Exploitation: A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Review of R20's Admission Record, dated 09/19/24 and found in the electronic medical record (EMR) under the Admissions tab, indicated the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease. Review of R20's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 07/30/24 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. Review of R20's Progress Notes, dated 08/29/24 and found in the EMR under the Notes tab, revealed [R20] with scattered bruising to the back of her right hand. [R20] does not know how she bruised her hand, un-witnessed injury. The facility's Incident/Accident Log, dated 01/01/24 through 09/17/24, was reviewed and indicated R20's 08/29/24 bruising was an injury of unknown origin. The facility's incident report related to R20's 08/29/24 injury of unknown origin indicated the injury was not witnessed and R20 was not able to tell staff how the bruising occurred. The form's Level of Pain, Mental Status, Predisposing Environmental Factors, Predisposing Physiological Factors, and Predisposing Situation Factors Sections were not complete. The facility was not able to provide an investigation into R20's 08/29/24 injury of unknown origin. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator in Training (AIT) on 09/17/24 at 2:24 PM, she confirmed no investigation had been done related to R20's injury of unknown origin. She stated her expectation was a thorough investigation should be done into any injury of unknown origin reported/experience by any resident in the facility.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on record review, observations, interviews, and review of the National Institute of Health (NIH) guidance, the facility failed to ensure professional standards of care were met for one resident (Residents (R)14) of one resident observed receiving medication through a gastrostomy (G) tube out of a total sample of 14 residents. This failure created the potential for R14 to have unwanted complications related to administration of her medication. The findings include: The facility's policies and procedures related to the administration of medication via G-Tube were requested by the survey team on 09/18/24. During an interview with the Administrator in Training (AIT) on 09/18/24 at 1:04 PM, she stated the facility did not have a policy to address the administration of medication via G-Tube. Review of the National Institutes of Health (2021) guidance on how to administer enteral (G-Tube) medication revealed, Prepare each medication individually in its own cup. Crush pills, open capsules, and pour liquid medication into a medication cup. Dilute the medication in 5 to 10 mL of water; and Elevate the head of the bed at least 30-45 degrees to prevent aspiration. NIH.org Review of R14's Admission Record, dated 09/19/24 and found in the electronic medical record (EMR) under the Admissions tab, indicated the resident was admitted to the facility on [DATE] with diagnoses including anoxic brain damage and quadriplegia. Review of R14's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 06/18/24 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) assessment was not able to be conducted due to the resident's poor cognition. The assessment indicated R14 had both short and long-term memory deficits and indicated the resident had a G-Tube in place through which she received all of her nutrition and medication. Review of R14's Order Summary Report, dated 09/19/24 and found in the EMR under the Orders tab, indicated orders for the resident to receive Baclofen (a muscle relaxant) 10 MG (milligrams) per her G-Tube four times daily, Famotidine (an acid reducing medication) 20 MG per her G-Tube twice daily, and Sertraline (an antidepressant medication) 25 MG per her G-Tube every morning. Further review of the Orders revealed no orders for checking placement, to have the head of bed (HOB) elevated while administering medications, administering medications separately, and/or water flushes before, between medications, and after medication administration. Licensed Practical Nurse (LPN1) was observed administering R14's medications on 09/18/24 at 9:53 AM. LPN1 crushed all three medications together and mixed them with water for administration. LPN1 then pushed water into the resident's stomach via her G-Tube prior to checking placement of the tube and administered the medications all at one time while the head of the resident's bed was elevated approximately 20 degrees. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LPN1 on 09/18/24 at 10:16 AM, she stated she thought she was supposed to push water into the resident's stomach with the plunger and then pull back to check residual to ensure proper placement of the tube. She stated she had never been told to crush medications separately and administer individually with a water flush between each medication. During an interview with the Administrator in Training (AIT), who was the former Director of Nursing (DON), on 09/18/24 at 1:04 PM, confirmed medications were to be crushed individually and given separately with a water flush in between each medication, placement of the G-Tube was expected to be done by checking residual without pushing water into the resident's stomach first, water and all medications were to be given through a G-Tube via gravity rather than using a plunger to push them into the stomach cavity, and the head of a resident's bed was to be elevated at least 30 degrees when administering medication through a G-Tube.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on record review, interviews, and review of facility policy, the facility failed to ensure one resident (Resident (R) 14) of seven residents reviewed for accidents had been assessed for the use of side rails, had risk and benefits discussed with her representative, and/or obtained informed consent for the use of side rails out of a total sample of 14 residents This failure created the potential for the resident to experience negative effects/risks associated with the use of the rails unnecessarily. Findings include: The facility's undated Proper Use of Bed Rails Policy, dated 2024 read, in pertinent part, It is the policy to utilize a person centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails; and The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs. The resident (Bed Rail) assessment must also assess the resident's risk from using the bed rails; and Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of the bed rails; and Upon obtaining informed consent, the facility obtain a physician's order for the use of the specified bed rail and medical diagnosis, condition, symptom, or functional reason for the use of the bed rail. Review of R14's Admission Record, dated 09/19/24 and found in the electronic medical record (EMR) under the Admissions tab, indicated the resident was admitted to the facility on [DATE] with diagnoses including anoxic brain damage and quadriplegia. Review of R14's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 06/18/24 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) assessment was not able to be conducted due to the resident's poor cognition. The assessment indicated R14 had both short and long-term memory deficits and indicated the resident was dependent upon staff to move in her bed as well as for transfers in and out of her bed. The assessment indicated R14 was not using side rails on her bed. Review of R14's Order Summary Report, dated 09/19/24 and found in the EMR under the Orders tab, indicated orders for May use side rails on bed based on admission/quarterly assessment. Review of R14's comprehensive care plan, dated 08/13/24 and found in the EMR under the Care Plan tab, indicated Side rails per side rail assessment. Bilateral upper rails. Review of R14's EMR revealed no Bed Rail Evaluation, risks and benefits, or signed informed consent for the use of the side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R14 was observed lying in her bed with bilateral half side rails in the raised position at the head of her bed on 09/16/24 at 11:02 AM, and on 09/17/24 at 9:37 AM, 12:02 PM, and 2:15 PM. During an interview with the Administrator in Training (AIT) on 09/17/24 at 12:05 PM, she confirmed R14 was not able to move in her bed independently and was not able to grasp her side rails due to her severely contracted upper extremities. During a follow-up interview with the AIT on 09/17/24 at 2:20 PM, she confirmed R14 should not have bed rails on her bed since there was no rationale for the use of the rails.

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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. 39411 Based on observations, interviews, and policy review, the facility failed to properly sanitize the thermometer used to take temperatures of the food. These failures had the potential to increase the risk of foodborne illnesses and infection for all residents receiving food from the facility kitchen. Findings include: Review of the facility's undated policy titled, Taking Accurate Temperatures, indicated that the probe should be cleaned, rinsed, sanitized, and air-dried before taking temperatures and immediately cleaned and re-sanitized after taking the temperature of each food. During an observation of the tray line on 09/18/24 at 11:30 AM, Cook1 was observed to take the thermometer out of her pocket and take the temperature of the food without sanitizing the thermometer before use. Cook1 was observed to use an alcohol swab to clean the thermometer after taking the temperature of the first item and re-use the same alcohol swab after taking the temperature of the next two food items. Cook1 then placed the thermometer back into her pocket. Cook1 then removed the thermometer and took the temperature of the next two food items without sanitizing the thermometer first and then using the same alcohol swab to sanitize the thermometer between taking the temperature of the next two food items. During an interview on 09/18/24 at 11:37 AM [NAME] 2 stated that they usually clean the thermometer before use and between testing each food item. During an interview on 09/18/24 at 11:40 AM Cook1 stated that she knew her pocket would contaminate the thermometer, and she should have cleaned the thermometer before using it. During an interview on 09/18/24 at 12:20 PM the Food Service Supervisor (FSS) stated that the thermometers need to be cleaned before and after each use. The FSS stated that she would expect the staff to follow the sanitizing requirements.