STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135067	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradise Creek Health and Rehab of Cascadia	640 North Eisenhower Street Moscow, ID 83843

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, record review, and policy review, the facility failed to ensure a verbal grievance was documented, investigated, and the results were reported back for one out of 20 sampled residents (Resident (R) 8). This failure resulted in R8's grievance not being resolved timely. Findings include: Review of the facility's Complaints and Grievances policy dated 10/15/22 and provided by the facility revealed, The facility should make prompt efforts to resolve grievances the resident may have . Complaints/grievances may be written or verbal . Complaints/grievance are acknowledged, investigated, and the complainant apprised of progress toward a resolution and takes appropriate corrective action if the alleged violation is confirmed by the facility . Review of the undated Admission Record in the electronic medical record (EMR) under the Profile tab revealed R8 was admitted to the facility on [DATE] with a primary diagnosis of atherosclerotic heart disease. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/03/24 in the EMR under the MDS tab revealed R8 was intact in cognition with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS documented that R8 was frequently incontinent of urine. Review of the Resident Council Meeting Minutes dated 06/26/24 and provided by the facility revealed, Ask Activity Manager [name] or Social Services [name] for Grievance or Concern forms. Staff may assist in filling the forms out if needed. The form will be given to the appropriate department for review. Have forms filled out as soon as possible so a resolution can be reached in a timely manner. Paradise Creek has been keeping track of this process and has shown that this system is working to take care of concerns quickly/thoroughly. Review of Resident Council Meeting Minutes dated 07/31/24 and written by the Activity Manager (AM) revealed R8 raised a concern, [R8] says Dr [name] ordered large heavy briefs for him, but he hasn't got them. He is upset that his bed and clothes [are] always full of urine and he has a rash from it. He wants one of us to order those briefs for him . (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/27/24 at 4:10 PM, R8 stated he voided a large amount of urine frequently and wanted different incontinent briefs. R8 stated he frequently soiled his clothing and bedding due to the type of incontinent products not holding enough urine. R8 stated when he came to the facility, he had two boxes of incontinence pull up briefs and they had worked well. R8 stated that the Director of Nursing (DON) wanted him to continue to wear wrap around briefs and not the pull up briefs that worked for him previously. R8 stated he told the DON he would like to go back to the heavy duty large pull up briefs. During an interview on 08/28/24 at 11:16 AM, the AM stated she attended Resident Council Meetings and took the minutes. The AM stated she initiated grievances coming out of resident council and they went to the Social Services Manager (SSM). The AM stated she thought she initiated a grievance for R8's concern raised in the July 2024 resident council meeting; however, verified there was no grievance. The AM stated she thought R8's concern about his incontinence briefs had been resolved due to a different product being ordered. During an interview on 08/28/24 at 11:54 AM, Certified Nursing Assistant (CNA) 6 stated R8 required assistance with dressing and hygiene. CNA6 stated R8 struggled with fastening the tabs on the incontinence briefs; however, he could remove them. CNA6 stated R8 had some pull up briefs previously, but they were not currently being used. CNA6 stated R8 was incontinent of urine. CNA6 stated R8 preferred pull up briefs over the tab type of briefs that were currently in use. During an interview on 08/28/24 at 1:40 PM, the SSM stated no grievance had been initiated to address R8's concern about the type of incontinence brief he used and soiling his clothing/bedding. The SSM stated different incontinence products had been ordered for R8 and she thought the issue had been resolved. On 08/28/24 at 1:57 PM the SSM and surveyor went to R8's room. The SSM checked the supply of incontinence briefs in R8's room and there were the tab briefs in his closet. There were no pull up briefs in the room During an interview on 08/28/24 at 3:05 PM, the Central Supply Specialist (CSS) stated she ordered incontinence products and R8's concern regarding briefs was brought to her attention in July 2024. The CSS stated she ordered him a case of pull ups in two sizes (72 briefs in each case) to trial. The CSS stated she had not checked back with the resident after the second case was ordered and staff were to notify her if he ran out, which they had not done. During a follow up interview on 08/29/24 at 9:39 AM, R8 stated he was informed the staff ordered the pull up briefs yesterday. R8 stated he had not been provided with pull up briefs after bringing his concern to staff in July 2024. R8 stated the staff told him the wrap around briefs held more urine than the pull up briefs and that he should use the wrap around briefs. During an interview on 08/29/24 at 5:44 PM, the DON stated the tabs briefs (referred to as wrap around briefs by R8) held more urine than the pull up briefs. The DON stated the facility had provided a pull up brief to R8 after he expressed his concern but was unable to show documentation that the briefs were ordered and provided to R8.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on interview, observation, record review, and policy review, the facility failed to ensure two out of 20 sampled residents (Residents (R)30 and R43) were provided with adequate and or timely nursing care and services after: 1. R30 experienced a fall in which she sustained a significant laceration to her forehead and 2. R43's hospice orders were not implemented in a timely manner. The failure to send R30 to the emergency department (ED) timely resulted in harm when R30's laceration could not be sutured and then required debridement and continued treatment three weeks after the fall. Findings include: Review of the facility's Neurological Evaluation policy dated [DATE] revealed, Neurologic vital signs supplement the routine measurement of temperature, pulse rate, and respirations when a resident is suspected to have hit their head (e.g., a fall), has hit their head or has a traumatic brain and/or spinal cord injury . 1. Review of the undated Admission Record in the electronic medical record (EMR) under the Profile tab revealed R30 was admitted to the facility on [DATE] with diagnoses including congestive heart failure and muscle weakness. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] in the EMR under the Profile tab revealed R30 was moderately impaired in cognition with a Brief Interview for Mental Status (BIMS) score of 10 out of 15. Further review of this MDS revealed R30 was impaired in range of motion (ROM) to both sides of her upper and lower extremities, dependent on staff for toilet and tub transfers, and required substantial assistance for chair/bed to chair transfers. R30 experienced one fall with injury since the prior MDS assessment. R30 received hospice services. Review of the Care plan dated [DATE] in the EMR under the Care Plan tab revealed R30, had an actual fall with injury r/t [related to] impulsivity, confusion. Intervention in pertinent part included, Neuro-checks per policy and procedure. Review of a late entry Health Status Note, dated [DATE] at 10:40 PM, revealed Resident had a witnessed injury fall in the common area at 1900 [7:00 PM] hrs [hours]. Resident was observed to have leaned forward from her wheelchair and face planted onto the floor in a prone position. Resident had an abrasion to her forehead measuring 3 cm [centimeters] x [by] 1cm. Resident was asked how she ended to the floor and stated she was attempting to get up. Resident's granddaughter and emergency contact #1 [name] was notified, and so was the hospice nurse [name] and nurse manager on duty [name]. Hospice nurse [name] stated that resident should not be sent out to the hospital and that her nurse will be in tomorrow to f.u [follow up] with her. Resident's neuros are wnl [within normal limits] with no latent injuries noted. Resident assessed and was alert to her baseline, name, and place. First aid rendered to the abrasion site, resident transferred to her w.c. [wheelchair]. Resident continues to be on neuros. Resident c.o [complains of] pain and to her forehead and bilat [bilateral] knees and was administered prn [as needed] Tylenol 650 mg [milligrams] with therapeutic effect. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Neurological Record from [DATE] through [DATE], provided by the facility, revealed neuro checks were due on [DATE] at 10:00 PM, 11:00 PM, and on [DATE] at 12:00 AM and 4:00 AM. Sleeping was documented on the form for each of these times; neuros were not completed after 9:00 PM on [DATE] until 8:00 AM on [DATE]. The neuro checks completed at 8:00 AM on [DATE] were within normal limits. Review of the Hospice Notes, revealed no note written on [DATE] of a hospice nurse visit to R30. Review of the ED [Emergency Department] Provider Note dated [DATE] at 6:11 PM revealed, Pt [patient] feet caught in WC [wheelchair] last evening and fell forward on hard linoleum. Was not sent for eval from [name of facility] where witnessed event took place. Pressure dressing applied last evening . Pt reports mild forehead pain . Family notified last night after hospice and hospice nurse stated pt did not need to be sent. Granddaughter brought pt in and is POA [power of attorney] at bedside .Patient has a significant wound on her forehead as well as abrasions to her knees . Large skin tear and maceration on the forehead . The wound is too old to do any type of suture closure but we will irrigate the wound and dress as best as we can . Given the fact that the wound was not adequately treated for about 24 hours, we can discharge on Keflex [antibiotic] as a prophylactic . Review of the EMR Medication Administration Record (MAR), dated [DATE] revealed the Keflex antibiotic was not documented as administered. Review of the Order Summary, dated [DATE] through [DATE] and under the Orders tab in the EMR, revealed wound care to the forehead laceration one time a day every 3 days for cleanse wound, apply bacitracin [antibiotic ointment] and border foam dressing. Review of the Order Summary dated [DATE] in the EMR under the Orders tab revealed R30 received the following treatment to her forehead, initiated on [DATE], Bactine Max External Liquid ,d+[DATE].13 % (pain reliever), apply to affected area topically as needed for forehead wound cleansing prior to dressing changes, wound care to include wound washed/cleansed with Bactine Max. Place Adaptec [non-adherent dressing] in wound bed, calcium alginate [dressing used to manage moderate to heavy exudate fluid leaking out of blood vessels into nearby wounds, providing a moist healing environment, and supporting debridement (removal of dead, damaged or infected tissue to improve wound healing)] and then bordered foam to cover site, one time a day every 7 day(s) for wound to forehead. During an observation on [DATE] at 3:08 PM, R30 was observed in a recliner chair in her room sleeping. R30 had a large bandage covering most of her forehead. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 9:10 AM, Family Member (FM)3 stated R30 experienced a fall on [DATE] and the nurse had R30 up in a wheelchair ready to go to the hospital when she arrived in the facility that evening ([DATE] after the fall). FM3 stated the on-call hospice nurse made the decision not to transport R30 to the hospital. FM3 stated R30 had a pretty good gash on the head. FM3 stated she wanted R30 to go to the hospital and offered to take her, but was told a hospice nurse would come the next morning to assess the wound. FM3 stated the next morning she called the nurse on duty and was told the dressing was wet and the hospice would be coming to look at the wound. FM3 stated she arrived at the facility after 2:00 PM and the hospice nurse had not been into the facility. FM3 stated at 4:00 PM, the nurse on the evening shift took R30's dressing off and she saw the wound. FM3 stated it was a bad wound (laceration with some of the tissue separated and missing) and asked the nurse what she was going to do. The facility nurse then called hospice, reported no hospice nurse had been in to assess the wound, and hospice gave the order to send R30 to the ED. During an interview on [DATE] at 10:42 AM, the Director of Nursing (DON) stated the facility called to have R30 sent to the hospital on [DATE], but hospice declined to send her. The DON stated the nurse on duty at the time of the fall thought the wound was bad enough that it warranted R30 going to the ED. The DON stated if the hospice nurse did not come in on [DATE], the facility nurse on duty should have followed up. The DON stated neuro checks should be completed when residents were known to hit their head and they were important to detect a head injury. The DON stated sleeping was an inappropriate reason not to complete the neuro checks on [DATE] and education had been provided to the nursing staff after this incident. The DON stated by not completing the neuro checks, the facility had missed the opportunity to evaluate R30's status to detect a significant change in mental status. During an interview on [DATE] at 11:18 AM, R30's Hospice Nurse stated she was off duty on [DATE] when R30's fall occurred so the call went to the on-call hospice nurse. The Hospice Nurse stated a resident could go to the hospital with an acute injury. The Hospice Nurse stated she did not know if a hospice nurse assessed R30's wound on [DATE]. During an interview on [DATE] at 12:34 PM, the Resident Care Manager (RCM), Licensed Practical Nurse (LPN) stated he did not see R30's wound until [DATE]. The RCM stated there was a large, deep split with abraded skin on either side. The RCM stated when he saw the wound on [DATE] it was a laceration and not an abrasion. The RCM stated he consulted with R30's medical provider and stated R30 should have gone to the ED on [DATE]. 33865 2. Review of the facility's policy titled, Hospice Services, release date [DATE], revealed The hospice, nursing home, and resident/representative collaborates in the development of a coordinated care plan which includes, but is not limited to, the following .Interventions that address, as appropriate, the identification of timely, pertinent non-pharmacological and pharmacological interventions to manage pain and other symptoms of discomfort. Review of R43's Admission Record located in the EMR under the Profile tab revealed R43 was admitted on [DATE]. R43 expired on [DATE]. Diagnoses included malignant neoplasm of the brain, altered mental status, pain, anxiety, and other recurrent depressive disorders. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R43's admission MDS with an ARD of [DATE] and located in the EMR under the MDS tab, revealed a BIMS assessment was not conducted due to the resident being rarely/ never understood. The resident was identified as having cognitive skills as modified independence. Pain was marked as having occasional pain frequency. Review of R43's Care Plan located in the EMR under the Care Plan tab, initiated on [DATE], revealed R43 had a terminal prognosis. Interventions included administer medications per order .Integrate care with Hospice agency per resident/ resident advocate request. During an interview on [DATE] at 8:35 AM, the Family Member (FM) 1 stated she met with hospice and signed the hospice papers on [DATE]. FM1 stated orders were faxed by hospice to the facility on [DATE]. She stated she was told by a facility nurse that the orders were found on the nursing manager's desk on [DATE] and the order was not documented into the medical record until [DATE]. Review of the Order Summary Report located in the EMR under the Orders tab revealed the following orders prior to hospice services starting: Order date: [DATE] with end date: [DATE]: Lorazepam [anti-anxiety] oral concentrate 2 mg/ml [milligram/ milliliter] Give 1 mg by mouth every 4 hours as needed for severe anxiety for 14 days. Order date: [DATE]: Morphine [pain medication] Sulfate Solution 20mg/ml. Give 0.25ml by mouth every 2 hours as needed for moderate generalized pain/ dyspnea. Morphine Sulfate Solution. Give 0.5ml by mouth every 2 hours as needed for generalized pain/ dyspnea. Review of the hospice Visit Note located in the EMR under the Documents tab, dated [DATE], revealed Start of Care. The narrative revealed entering his first benefit period for terminal diagnosis of glioblastoma [brain tumor]. Review of the hospice Visit Note located in the EMR under the Documents tab, dated [DATE], revealed Is current pain management effective? Yes. The narrative revealed appears pt [patient] has declined since yesterday admit .whispered yes to being in pain. Requested facility administer PRN [as needed] morphine . New order to discontinue acetaminophen, Dulcolax, and Flomax capsules, and schedule 0.25mls of morphine Q4 [every 4] hours per hospice MD [physician]. Review of the Order Summary Report located in the EMR under the Orders tab, dated [DATE], revealed the following: Order date: [DATE]: Morphine Sulfate Solution 20mg/ml. Give 0.25ml by mouth every 4 hours for pain. Morphine Sulfate Solution. Give 0.5ml by mouth every 1 hour as needed for moderate to severe pain or dyspnea. This order was not added until two days after the hospice visit on [DATE]. Review of the hospice fax, provided by the facility and dated [DATE], revealed Discontinue current orders for lorazepam. Start lorazepam 2mg/dl oral concentrate, give 1mg (0.5ml) .every 1 hour as needed for anxiety or restlessness Further review of the EMR Order Summary Report revealed the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Order date: [DATE]: Lorazepam oral concentrate 1 mg/0.5ml. Give 0.5ml by mouth every 1 hour as needed for Anxiety and Restlessness. These changes in medications were not started until [DATE]. The fax was documented as received [DATE]. During an interview on [DATE] at 10:30 AM, Licensed Practical Nurse (LPN) 2 stated she came in that Friday/Saturday, talked with FM1, and hospice had come in that day. LPN2 stated she found the hospice orders on the manager's desk and confirmed the fax was dated [DATE]. During an interview on [DATE] at 1:06 PM, the Resident Care Manager (RCM) stated the resident was started on hospice care on [DATE]. He stated the changes in medication orders should have been put into place immediately. During an interview on [DATE] at 1:46 PM, the Director of Nursing (DON) stated the resident received hospice visits starting on [DATE] but that the medication changes were not added until [DATE]. She confirmed that although the resident was receiving pain management the hospice orders should have been put in immediately.

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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** 29728 Based on observations, record review, staff interview, and review of the facility policy, the facility failed to ensure interventions were put in place and followed to prevent additional falls for three of six residents reviewed for falls (Resident (R) 9, R33, and R42) out of a total sample of 20 residents. This failure increased the potential for additional falls and potential injury for residents with a history of falls. Findings include: Review of the facility's policy titled, Accidents and Supervision to Prevent Accidents, revision date [DATE], documented, The facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents . Avoidable Accident-an accident that 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; and/or .Evaluate/analyze the hazards and risks and eliminate them, if possible: and/or .Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible and if not, reduce the risk of an accident, and/or Monitor the effectiveness of the interventions and modify the care plan as necessary in accordance with current professional standards of practice. 1. Review of R9's Face Sheet, located in the electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE] with diagnosis of pelvic fracture, osteoporosis, dementia, macular degeneration, and cognitive communication deficit. Review R9's Annual Minimum Data Set (MDS), located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of eight out of 15 indicating R9 was moderately cognitively impaired. Review of the MDS revealed R9 was assessed for the use of a walker for mobility and was independent with chair/bed to chair transfers and independent for toileting. Review of R9's Care Plan, dated [DATE], located in the EMR under the Care Plan tab, revealed R9 was at risk for falls and was updated with additional interventions after the resident experienced several falls within the last year. During an interview with the DON on [DATE] at 1:58 PM, she stated the physician ordered a bed and chair alarm due to R9's cognitive history and desire to be independent increasing her risk for falls. Review of the EMR Orders tab revealed a Treatment Administration Record (TAR), for [DATE], that indicated the chair and bed alarm were ordered on [DATE]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on [DATE] at 5:20 PM revealed R9 was sitting on the side of her bed. Licensed Practical Nurse (LPN)3 entered the resident's room to respond to the silent alarm from the sensor pad on her bed and assisted the resident to her wheelchair. LPN3 was asked if there was an alarm in her wheelchair and she confirmed there was not an alarm in her wheelchair. LPN3 stated R9 had a bed alarm since most of her falls happen at night. During an interview with Certified Nursing Assistant (CNA) 6 on [DATE] at 11:00 AM, she stated the resident used a bed alarm but was not sure if she had a chair alarm. Observed the resident's wheelchair and CNA 6 verified there was not a chair alarm in use. During the interview with the DON on [DATE] at 01:58 PM, she stated the resident should have an alarm in her wheelchair and confirmed, there was not one in use. 2. Review of R 33's Face Sheet, located in the EMR under the Profile tab, revealed an admitted [DATE] with diagnoses including muscle weakness and dementia. Review of R33's quarterly MDS, located in the EMR under the MDS tab with an ARD of 06//,d+[DATE], revealed the resident had a BIMS score of four out of 15 indicating the resident was severely cognitive impaired. Further review of this MDS revealed R33 was also assessed as having impairment on upper and lower extremities and was dependent on staff for transfers from bed to chair. Review of the Care Plan located in the EMR under the Care Plan tab, dated [DATE], identified the resident as being at risk for falls due to weakness and confusion. An intervention to add a Dycem (anti-slip) pad and a comfort cushion to the seat of his wheelchair was added to the care plan on [DATE] to prevent falls. Review of the facility's Incident Packet Checklist, dated [DATE], provided by the DON, revealed R33 was in his wheelchair in dayroom and was observed by staff sliding out of the chair onto the floor. Staff could not reach him in time. Review of the Post Fall IDT Review revealed the resident had been restless in the wheelchair and had been self-propelling throughout the facility. He was previously adjusted by staff for comfort in the chair and was witnessed seated forward. As staff walked toward the resident to assist, R33 slid out of the wheelchair onto the floor on his buttocks. He was assessed for injury, pain, and assisted back in the wheelchair. Review of the 5 Why's Tool, included in the summary of the event indicated the Dycem pad was not under the resident in the wheelchair. Review of two additional Incident Packet Checklist, dated [DATE] and [DATE], revealed R33 slid out of his wheelchair onto the floor while in the dayroom. Staff witnessed the fall on [DATE] and [DATE] but could not reach the resident in time. The falls did not result in an injury. The Post Fall IDT Review for the fall on [DATE] revealed the root cause as weakness and follow up to place a cushion to assist for better position. Review of the Post Fall IDT Review for the [DATE] fall was to place comfort curve cushion in wheelchair for comfort and aid in position in the chair. During an interview with the DON on [DATE] at 3:15 PM, an observation was made of R33's wheelchair. She stated the cushion that was currently in use was the comfort cushion that had to be ordered after the falls on [DATE] and [DATE] even though the cushion was an intervention placed on the care plan on [DATE]. The DON confirmed that the Dycem mat was not placed in the chair when the resident fell on [DATE]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	33865 3. Review of R42's Admission Record located in the EMR under the Profile tab revealed R42 was admitted on [DATE]. R42 expired on [DATE]. Diagnoses included malignant neoplasm of upper lobe, left bronchitis or lung and muscle weakness. Review of R42's admission MDS with an ARD of [DATE] and located in the EMR under the MDS tab, revealed a BIMS score of 13 out of 15 which indicated the resident had intact cognition. Further review of this MDS revealed R42 required partial/ moderate assistance for putting on/ taking off footwear, and for rolling left and right. R42 was marked as having a fall within the past two-six months and a fracture related to a fall in the six months prior to admission. No falls were documented since admission. Review of R42's Care Plan located in the EMR under the Care Plan tab, initiated on [DATE], revealed the resident had impaired mobility with risk for falls .Interventions included Monitor for gait changes .Provide standard style of call light. Validate that it is in reach prior to leaving the room . Monitor resident position in bed . All initiated on [DATE]. Review of R42's Care Plan located in the EMR under the Care Plan tab, initiated on [DATE], revealed the resident had a terminal prognosis related to lung cancer with metastasis to the liver Interventions included administer medications per order .work with nursing staff to provide maximum comfort for the resident. a. Review of the fall investigation, provided by the facility and dated [DATE] at 1515 (3:15 PM) revealed the fall was unwitnessed. Immediate interventions included removed clutter and placed pillow under head, resident covered in urine from BSC [bedside commode] spilling. There was 4cm [centimeters] x 0.1cm, abrasion to the left knee, discoloration to right knee and back. The resident was found on the back lying next to the commode. The resident was self-transferring to the BSC, and the commode was unsteady related to a folding chair under the commode. The resident was marked as barefoot. Recommendations included check and offer toilet every two - three hours, staff educated to not leave resident unattended while on the commode. Neurochecks were not documented on [DATE] at 1530 (3:30 PM), 1545 (3:45 PM), 1600 (4:00 PM), 1715 (5:15 PM), 1815 (6:15 PM), 1915 (7:15 PM), and/or 2015 (8:15 PM). During an interview on [DATE] at 1:00 PM, the Director of Nursing (DON) stated for this fall, there was a commode stored on a chair and the resident tried to use the commode that was stored on top of the chair. She stated the commode should have been in a safe place and he should have been toileted with assistance. She stated the fall interventions included leaving the door open, and he was encouraged to use the call light. She stated the next fall happened the next day. b. Review of the fall investigation, provided by the facility and dated [DATE] at 2000 (8:00 PM) revealed the fall was unwitnessed. There was no injury. He was marked as barefoot. He was found on the floor, and resident stated, unsure of what happened. Interventions implemented included staff continuing to remind the resident to use a call light for assistance with transfers, proper footwear in place, use standby assistance for transfers and ambulation. He was found lying on the side next to the bed. Recommendations included staff to leave door open for observation for more frequent observation, encourage resident to use call light for assistance. (continued on next page)

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	135067	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradise Creek Health and Rehab of Cascadia	640 North Eisenhower Street Moscow, ID 83843

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:00 PM, the DON stated for this second fall, the resident was barefoot She stated the resident fell out of bed and there were no items in proximity. She stated the right footwear would have been shoes or non-skid socks. She stated Leaving the door open was not added to the care plan until [DATE]. c. Review of the fall investigation, provided by the facility and dated [DATE] at 2300 (11:00 PM) revealed the fall was unwitnessed. There was bruising-discoloration caused by impact. Bilateral bruising and left rib area redness. The resident was barefoot. The resident was found prone (face down) on the floor by the side of bed. Interventions included bed placed against wall and ensure in lowest position and mattress side propped to assist in resident not rolling off bed again. Increased weakness due to disease process. No defining bed edges. Recommendation included bed placed against wall, needs scoop mattress. During an interview on [DATE] at 1:00 PM, the DON stated for this third fall, he was found on the floor to the left side of the bed. She stated they recommended a scoop mattress to define the edges of the bed. She stated they recommended a bed against the wall and special mattress, but there was no indication if the door was open or closed. She stated the bolsters were added on [DATE] per care plan. d. Review of the fall investigation, provided by the facility and dated [DATE] at 0542 (5:42 AM) revealed the fall was unwitnessed. There were no injuries. The resident was barefoot. Interventions included neuros and elevation of mattress edge. The resident was found on the floor in a prone position beside bed. Recommendations included bolsters to be placed on mattress on AM shift. During an interview on [DATE] at 1:00 PM, the DON stated for this fourth fall, bolsters were on the care plan but were probably not on by that morning. She stated the bolsters were placed after this fall. Review of R42's Care Plan located in the EMR under the Care Plan tab, initiated on [DATE], revealed the resident had an actual fall with minor injury r/t [related to] disease process/ condition. Interventions included bolsters to be placed on mattress to reduce the risk for falls (initiated [DATE]) .Place bed against the wall to reduce risk for rolling out of bed on weaker left side (initiated [DATE]) .Staff to leave door open to room to observe more frequently to prevent falls (initiated [DATE]).

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 33865 Based on record review, interviews, and policy review, the facility failed to ensure annual performance reviews were completed for every nurse aide at least one review every 12 months for five of five (Certified Nursing Assistants (CNA) 1, CNA2, CNA3, CNA4, and CNA5) and failed to include no less than 12 hours of training per year for three of five (CNA) 1, CNA3, and CNA4) reviewed for education and reviews for 43 census residents. The failure had the ability to affect the current skillset and knowledge level in order to care for the residents. Findings include: Review of the facility's policy titled, Nurse Aide Staffing, release date 11/28/17, revealed Each nurse aide receives a performance review at least once every 12 months. Review of the undated document titled, Employee Seniority provided by the facility, revealed the following: -CNA1 had a hire date of 05/01/23. -CNA2 had a hire date of 05/01/23. -CNA3 had a hire date of 05/01/23. -CNA4 had a hire date of 06/06/23. -CNA5 had a hire date of 08/21/23. Review of undated Official Transcript provided by the facility, revealed CNA1 received 2.35 hours over the past year, CNA3 received seven hours of training over the past year, and CNA4 received 8.6 hours of training over the past year. Further review revealed that the training received did include abuse and dementia training, During an interview on 08/29/24 at 12:57 PM, Director of Nursing (DON) stated they only had five CNAs that had worked at the facility for over 12 months. She stated they had not conducted any performance reviews.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on interview, record review, and policy review, the facility failed to ensure the pharmacist made a written recommendation to the physician for a gradual dose reduction (GDR) for one of five residents reviewed for unnecessary medications (Resident (R) 16) out of a total sample of 20 residents. This failure increased the potential for R16 to be overmedicated. Findings include: Review of the facility's Drug Regimen Review policy dated 11/28/17 and provided by the facility revealed, The facility contracts with a pharmacy to complete monthly drug regimen review to identify irregularities and to identify clinically significant risks and/or actual or potential adverse consequences which may result from or be associated with medications . Any irregularities noted by the pharmacist during this review are to be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing . The attending physician documents in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. Review of the undated Admission Record in the electronic medical record (EMR) under the Profile tab revealed R16 was admitted to the facility on [DATE] with a diagnoses of dementia with mood disturbance and depression. Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/31/24 in the EMR under the MDS tab revealed R16 was severely impaired in cognition with a Brief Interview for Mental Status (BIMS) score of four out of 15. Further review of this MDS revealed R16 was identified as having verbal, physical, and other behavioral symptoms one to three days out of the assessment period (of seven days) and was administered an antipsychotic medication without a gradual dose reduction having been attempted. Review of the Order Summary Report from 05/25/23 through 08/28/24 in the EMR under the Orders tab revealed R16 was prescribed Seroquel (antipsychotic medication) Oral Tablet 25 milligrams (mg), give 12.5 mg by mouth at bedtime related to unspecified dementia with mood disturbance on 01/16/24. R16 continued on this dose during the survey; the Order Summary Report revealed no gradual dose reduction had been attempted. A request was made for all the pharmacist's medication recommendations of irregularities for R16. No pharmacy recommendations were provided. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/28/24 at 10:16 AM, the Director of Nursing (DON) stated R16 was started on Seroquel due to aggressive behaviors in January 2024. The DON stated on 04/15/24 the facility conducted a monthly summary review of R16s medications with the pharmacist and a psychiatric doctor. The DON stated a gradual dose reduction was discussed prior to when the gradual dose reduction (GDR) was due (six months after initiation); a formal written pharmacist recommendation had not been completed. A request was made for the psychiatric physician's rationale that a dose reduction not be implemented. The DON verified there was no documentation from the pharmacist or the psychiatric physician regarding a gradual dose reduction. A call to the pharmacist was made on 08/29/24 at 10:02 AM and a message was left but not returned. During an interview on 08/29/24 at 5:21 PM, the Director of Nursing (DON) verified there were no medication recommendations made by the pharmacist for R16 over the past 12 months.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 33865 Based on observation, record review, interviews, and facility policy review, the facility failed to ensure residents received meals that were palatable for five of 20 sampled residents (Resident (R) 19, R36, R22, R13, and R35) reviewed for palatability. This failure had the potential to affect resident meal intake. Findings include: Review of the facility's policy titled, Food Preparation, release date 11/28/17, revealed Food is prepared by methods that conserve nutritive value, flavor, and appearance .Food is stored, prepared, and held by methods that preserve the nutritive value of the food to the extent possible. 1. Review of R19's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/09/24 revealed a Brief Interview for Mental Status (BIMS) score of nine out of 15 which indicated the resident had moderately impaired cognition. During an interview on 08/26/24 at 10:41 AM, R19 stated the food had no flavor and no salt. 2. Review of R36's admission MDS with an ARD of 07/25/24 revealed a BIMS score of 15 out of 15 which indicated the resident had intact cognition. During an interview on 08/26/24 at 11:00 AM, R36 stated the food was ok for an institution but it was awful. She stated the menu sounded good but how could it taste so bad? During an interview on 08/28/24 at 12:17 PM, R36 stated the lasagna was warm to taste. She stated the salad was warm and Limpy. 3. Review of R22's annual MDS with an ARD of 06/14/24 revealed a BIMS score of 14 out of 15 which indicated the resident had intact cognition. During an interview on 08/26/24 at 11:26 AM, R22 stated she could eat the food, but it was not tolerable. 4. Review of R13's quarterly MDS with an ARD of 06/14/24 revealed a BIMS score of 14 out of 15 which indicated the resident had intact cognition. During an interview on 08/26/24 at 12:43 PM, R13 stated the meal with chicken and rice was a bit dry. 5. Review of R35's admission MDS with an ARD of 07/18/24 revealed a BIMS score of 15 out of 15 which indicated the resident had intact cognition. During an interview on 08/27/24 at 8:29 AM, R35 stated the food was cold and had no seasoning. He stated the water was not hot for cocoa, and they had no condiments. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During an observation on 08/28/24 at 11:15 AM, the temperatures of the food on the steam table were taken by Cook1. The lasagna was 192 degrees Fahrenheit (F), the salad was 39.6 degrees F, and the custard was 37.6 degrees F. During an observation and interview on 08/28/24 at 11:33 AM, a test tray was prepared from the steam table at 11:36 AM and placed on a cart. The cart left the kitchen at 11:48 AM. Staff started to pass trays from the cart at 11:55 AM. The last tray passed at 12:01 PM. An evaluation of a test tray was conducted at 12:01 PM, alongside the Registered Dietitian (RD). The lasagna was 118 degrees F, the salad containing ranch dressing was 89 degrees F. The salad was on the same plate as the lasagna. The custard was 54 degrees F. The RD confirmed the food temperatures and stated the hot food should have been in the 130 degrees F range and the cold food should have been around 50 degrees F by the time it was received by the resident. She stated the standard was to place the salad in a bowl with a packet of salad dressing on the side per resident choice. The test tray revealed the salad tasted watered down and soggy. The lasagna was slightly warm. During an interview on 08/29/24 at 10:00 AM, the RD and the Culinary Manager (CM) stated resident council touched on food. The RD stated they had not had a regular food committee group in a while. They stated they always put the salad in a separate bowl with dressing of choice on the side. The RD stated the lasagna may have been at the proper temperature if the salad had not been on the same plate.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33865 Based on observation, record review, interview, and policy review, the facility failed to ensure food was not expired, freezer temperatures were of proper parameters and thermometers were properly sanitized. This had the potential to affect food safety for the 41 residents served food from the kitchen. Findings include: Review of the facility's policy titled, Refrigerator & Freezer Temperature Monitoring, release date [DATE], revealed Freezers: Recommended temperature range is 0 F [degree Fahrenheit] +/-10 .Post a temperature log for each refrigerator and freezer at the beginning of the month. Review of the facility's policy titled, Food and Supply Storage, release date [DATE], revealed All food, non-food item, and supplies used in food preparation shall be stored in such a manner as to maintain safety and sanitation of the food or supply for human consumption .Expiration date: the last date that food should be eaten .Reject any unacceptable product and make note of return on the invoice. Review of the facility's policy titled, Food Preparation, release date [DATE], revealed When verifying food temperatures, staff should use a thermometer which is both clean, sanitized . During an observation and interview on [DATE] at 9:34 AM, the walk-in refrigerator had two five-pound containers of sour cream (one partial full and one full) with a best if used by date of [DATE]. The Culinary Manager (CM) confirmed the food was expired and stated he would dispose of the items. During an observation and interview on [DATE] at 9:37 AM, the walk-in refrigerator had one partially full 48-ounce container of potato salad with a use by date of [DATE]. The CM confirmed it was expired and stated it would be disposed of. During an observation and interview on [DATE] at 9:40 AM, the freezer had food that was not fully frozen. The CM stated the temperature was 28 degrees F. He stated they had been watching the freezer temperatures and that it was 1.2 degrees F the night before at 5:30 PM. During an interview on [DATE] at 8:38 AM, the CM stated all the walk-in freezer temperature logs included [DATE] ([DATE]-[DATE]); and [DATE] ([DATE]- [DATE]). He stated these were the only logs he had from [DATE] through [DATE]. The CM further stated that the food affected by the warm freezer temperatures was thrown away. During an observation and interview on [DATE] at 8:59 AM, the dry storage area contained two 32-ounce containers of honey thickened dairy liquids with a use by date of [DATE]. There were six 46-ounce containers of honey thickened liquids with best if used by date [DATE]. There was one 50-ounce can of chicken noodle soup with a received date of ,d+[DATE] and was dated [DATE]. The CM confirmed all the expired items. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on [DATE] at 9:48 AM, Cook1 was observed to have taken the temperature of one pan of lasagna. He proceeded to place the thermometer into a bucket of sanitizer water and wiped it with a rag from the sanitizer water. He placed the thermometer directly into the second pan of lasagna without letting the thermometer dry, resulting in the potential for chemical contamination. After he finished taking the temperature of the second pan of lasagna, he placed the thermometer in the sanitizer water and again wiped with a rag from the sanitizer water. At 10:23 AM, Cook1 stated he was in a rush and so he used the sanitizer bucket water instead of the thermometer wipes. The CM confirmed he should have used the thermometer wipes. The pan of lasagna that was temped with the improperly sanitized thermometer was disposed of. During an interview on [DATE] at 10:00 AM, the Registered Dietitian (RD) and the CM stated the freezer was currently working. They confirmed the expired foods observed during the kitchen tours.