

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Cove of Cascadia, The		STREET ADDRESS, CITY, STATE, ZIP CODE 620 North Sixth Street Bellevue, ID 83313	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603</p> <p>Based on observation, record review, policy review, review of the State Survey Long-Term Care Reporting Portal and interviews, it was determined the facility failed to ensure residents were free from abuse and neglect. This was true for 1 of 2 residents (Resident #8) reviewed for abuse and neglect. Resident #8 experienced physical and verbal abuse from another resident. This failure placed all residents at risk of ongoing abuse, potential physical and psychosocial harm. Findings include:</p> <p>The facility's Abuse policy, revised 8/1/23, documented the facility respects residents' rights to be free from abuse, neglect, misappropriation of resident property, and exploitation. The policy identified residents who are at most risk of neglect and abuse have dementia, or who have psychosocial, interactive, and/or behavioral dysfunction such as verbally aggressive behaviors and/or physically aggressive behavior. Additionally, residents are identified at risk for abusing other residents through family interviews, chart review, behavior monitoring, and mood and behavior triggere.</p> <p>Resident #8 was admitted to the facility on [DATE] with multiple diagnoses including pneumonia, diabetes, chronic obstructive pulmonary disease, and brain injury.</p> <p>A quarterly MDS assessment, dated 9/23/24, documented Resident #8 was cognitively intact.</p> <p>Resident #26 was admitted to the facility on [DATE] with multiple diagnoses including brain hemorrhage, and dementia.</p> <p>A quarterly MDS, dated [DATE], documented Resident #26 was severely cognitively impaired.</p> <p>Resident #8 and Resident #26 share a Suite which includes rooms adjacent to each other sharing a common bathroom and entry way, but each have private room space.</p> <p>A review of I&A reports investigated by the facility, and reported on time to the State LTC portal documented Resident #8 experienced physical and verbal abuse from Resident #26 as follows:</p> <p>Incident 1: On 5/23/24, Resident #26 was yelling at Resident #8. Resident #26 hit Resident #8 four times with a cup.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing progress note, dated 5/23/24, documented Resident #8 left her cup by a common area sink. When Resident #8 returned, her cup was missing and she asked if Resident #26 took it, to which Resident #26 responded, no. Resident #8 saw her cup on Resident #26's bedside table and reclaimed the cup. The residents began yelling at each other and calling each other curse words. Resident #26 hit Resident #8 four times with a different cup.</p> <p>According to Resident #8's statement, dated 5/24/24, Resident #26 hit her four times on the head with a different cup.</p> <p>The investigative summary, dated 5/24/24, documented that Resident #8 stated Resident #26 hit her in the head with the cup and called her a bitch. Resident #8 put her hands up to protect herself from Resident #26 slapping her before staff intervened. Resident #8 was offered another room to prevent a recurrence, but declined stating she likes her room and view. Resident #8 also stated Resident #26 would not remember the incident. Staff did not see any physical altercation between the residents, and no injuries were documented.</p> <p>Incident 2: On 7/29/24, Resident #26 threw juice on Resident #8 as she was rolling away in her wheelchair.</p> <p>The investigative summary, dated 8/2/24, documented Resident #26 was waiting at the kitchen window asking for juice when Resident #8 came to the window to ask for coffee. Resident #8 received her coffee first as the juice was not available at the same time. Resident #26 was verbally aggressive with Resident #8, who rolled away in her wheelchair. Resident #26 then threw her juice on Resident #8's back. No physical or mental injuries were identified. Resident #8 has no recollection of the incident. The facility stated they would continue to monitor. It was unclear what the facility would continue to monitor.</p> <p>A nursing progress note, dated 7/29/24, documented Resident #8 understood Resident #26 has cognition deficits, and Resident #8 was not distraught or wanting to move rooms after the incident.</p> <p>Incident 3: On 9/4/24, Resident #8 was rolling away from a verbal fight with Resident #26 and bumped into Resident #26. Resident #26 then punched Resident #8 in the shoulder three times.</p> <p>Resident #8 and Resident #26 were passing each other in the hallway going opposite directions. Words were exchanged between the two residents, and a nurse overheard Resident #26 calling Resident #8 a Fat Cow. Resident #8 turned her wheelchair around, hitting Resident #26 who claimed her foot had been run over. Resident #26 then hit Resident #8 in the shoulder/arm area three times. Nursing checked Resident #8's arm and noted there was a red area where Resident #26 hit her. Both Resident #8 and Resident #26 were inspected for skin injuries and bruising, and none were noted on Resident #26's foot or Resident #8's arm.</p> <p>The investigative summary, dated 9/10/24, documented the medication for both Resident #8 and Resident #26 was adjusted, and the facility would monitor changes in behavior, anger, anxiety, and depression. It was also recommended on moving one of the resident's when a room becomes available.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/25/24 at 8:45 AM, the Administrator and DON stated there had been no further incidents regarding Resident #8 and Resident #26 after their medication was adjusted. No comment was made as to why the residents were still in rooms adjacent to each other or why Resident #26 was not moved to another building of the facility.</p> <p>The facility's investigation concluded Resident #8 and Resident #26 have had several interactions of resident-to-resident abuse.</p> <p>The facility took the following actions:</p> <ul style="list-style-type: none"> - They offered a change in room location to Resident #8. - They modified the medication of both Resident #8 and Resident #26. - They monitor the behavior of both residents of increases in anger, anxiety, and depression. - Staff training regarding resident-to-resident abuse on 9/10/24. <p>These findings represent past non-compliance with this regulatory requirement. There was sufficient evidence the facility corrected the non-compliance as of 9/10/24, and there have been no further occurrences reported between Resident #8 and Resident #26, although they remain in adjacent rooms. At the time of this survey the facility was in substantial compliance and therefore does not require a plan of correction.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193</p> <p>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 (Resident #6 and Resident #32) whose care plans were reviewed. This created the potential for harm if cares and/or services were not provided appropriately due to inaccurate information on the care plan. Findings include:</p> <p>The facility's Care Plans policy, revised [DATE], documented a team of qualified persons monitors the resident's condition and effectiveness of the care plan interventions, revising the care plan quarterly, annually, with a significant change assessment or more frequently as needed with the input by the resident and/or the representative, to the extent possible.</p> <p>1. Resident #6 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including personal history of traumatic brain injury and dysphagia (difficulty in swallowing).</p> <p>A care plan, revised [DATE], documented Resident #6 was a smoker and required supervision while smoking. Resident #6's care plan also documented he used cigarette extenders due to burning his fingers because he chose to smoke cigarettes down to the filter and refused to let staff put them out any sooner.</p> <p>On [DATE] at 9:12 AM, Resident #6 was observed in the smoking area with NA#1 standing next to him. Resident #6 was holding the cigarette with no extender.</p> <p>On [DATE] at 2:39 PM, the CNO stated Resident #1 no longer need the cigarette extender. The CNO stated the cigarette extender should have been taken out from his care plan and it was not.</p> <p>50603</p> <p>2. Resident #32 was admitted to the facility on [DATE] with multiple diagnoses including major depressive disorder with psychotic symptoms, dementia with agitation, mental disorders, brain injury, and parkinsonism.</p> <p>A quarterly MDS assessment, dated [DATE], documented Resident #32 was severely cognitively impaired.</p> <p>A review of Resident #32's care plan, dated [DATE] and revised on [DATE], documented an Advance Directive was in place and a full code was requested.</p> <p>On [DATE] at 9:26 AM, a review of Resident #32's record documented the following:</p> <p>- A POST (Physician Orders for Scope of Treatment), dated [DATE], signed by Resident #32, documented his code status was Full Code.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A physician's progress note, dated [DATE], documented the physician spoke to the guardian about Resident's #32's condition, and she stated she did not want CPR, as aggressive interventions would increase Resident #32's distress without prolonging life.</p> <p>- A POST, dated [DATE], signed by the physician, documented Resident #32's code status of DNR (Do Not Resuscitate).</p> <p>On [DATE] at 3:55 PM, the CNO verified the updated POST from [DATE] was not added to Resident #32's care plan. She confirmed the care plan should have been updated, as needed, to reflect the change from full code to DNR and it was not.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603</p> <p>Based on record review and staff interview, it was determined the facility failed to provide adequate supervision and functioning devices to prevent elopement and fall. This was true for 1 of 6 residents (Resident #29) reviewed for accidents and elopement. This deficiency created the potential for physical harm (Resident #29 was harmed) if residents were not supervised or assistive devices not functioning when residents at risk for elopement left the facility. Findings include:</p> <p>Resident #29 was admitted to the facility on [DATE], with multiple diagnoses including fractures of the right hip and pubic bone, prostate and bone cancer, and dementia.</p> <p>A quarterly MDS assessment, dated 8/23/24, documented Resident #29 was severely cognitively impaired.</p> <p>Resident #29's care plan, initiated on 1/14/24, documented the resident was at risk for wandering and elopement. His care plan was updated on 4/21/24, 6/26/24, 7/8/24, and 9/19/24, directing staff to provide the following interventions: Distract Resident #29 from wandering by offering pleasant diversions, structured activities, food, conversation, television, books; Provide structured activities; Place Wander Alert on Wheelchair; and Document number of aimless wandering episodes.</p> <p>A physician's order, dated 1/14/24 and 6/29/24, directed staff to place a Wander Alert on Resident #29's wheelchair. A consent was signed on 11/20/23, and 6/9/24.</p> <p>A nursing progress noted, dated 8/15/24, documented Resident #29 attempted to get out the front door and set off the wander alarm. He had been wandering for 22 days previously.</p> <p>An I&A report, dated 8/31/24, documented Resident #29 was found in the parking lot of the facility trying to get off the floor and into his wheelchair. Resident #29 was noted to have 0.5 cm by 2.8 cm laceration to his right temporal area, and abrasions to his right elbow and right pinky toe. The provider was notified and gave an order to send Resident #29 to the hospital. The I&A also documented the emergency exit alarm was turned off.</p> <p>An investigation report, dated 9/5/24, documented Resident #29 exited the facility using the emergency exit door with delayed egress. It appeared Resident #29 propelled his wheelchair on the sidewalk and two of his wheelchair wheels fell off the curb and potentially tripped his chair forward causing him to fall and hit head on the ground. The I&A documented Resident #29 was sent to the hospital.</p> <p>A hospital report, dated 8/31/24, documented Resident #29 had a right parietal scalp laceration roughly 3 cm long without contamination and no pulsatile bleeding. Resident #29 received laceration repair with four staples, to return in 5-7 days to have them removed.</p> <p>A nursing note, dated 9/10/24, documented Resident #29 had the staples removed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/25/24 at 9:56 AM, the CEO and CNO, stated the Wander Alert is set for the front door as it doesn't lock during the day. A Wander Guard would have locked the front doors and an alarm at the front door would have alerted staff. However, the alarm guards are not set to the side doors. Resident #29 exited the side door and the fire alarm on that door did not sound. The CEO and CNO stated, they do not know why the side door alarm was not activated, but it is now checked twice per day to ensure the alarm is activated.</p> <p>The facility's investigation concluded Resident #29 the exterior [side] door alarms were not set. Resident #29 did have a wandering device placed on his wheelchair. Resident #29 propelled himself in his wheelchair outside the door and when his wheels fell off the curb, he lost his balance and fell out of his wheelchair.</p> <p>The facility took the following actions:</p> <ul style="list-style-type: none"> - Monitoring the side door alarms at least twice per day per shift (up to four times per day). - Checking to ensure the Wander Guard is functional. <p>These findings represent past non-compliance with this regulatory requirement. There was sufficient evidence the facility corrected the non-compliance as of 9/5/24, and there were no further occurrences Resident #29 wandered out of the facility. At the time of this survey the facility was in substantial compliance and therefore does not require a plan of correction.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure nutrition was administered as ordered by the physician for 1 of 2 residents (Resident #6) whose nutritional needs were reviewed. This deficient practice created the potential for harm when Resident #6 was not provided with physician ordered nutrition. Findings include:</p> <p>The International Dysphagia Diet Standardisation Initiative (IDDSI), documented the dental diet was previously known as Mechanical Diet. It was designed to provide a texture modification of the regular diet for patients without dysphagia who are in need of a texture modification. Meats are in ground form or small bit-size, moist, and mashable or flakable. All hard foods are omitted, or their form is altered.</p> <p>Resident #6 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including personal history of traumatic brain injury and dysphagia (difficulty in swallowing).</p> <p>A physician's order, directed staff to provide Resident #6 with dental/mechanical soft texture diet with thin consistency, extra sauce, and gravy on meals on scoop plate and built-up utensils for all meals.</p> <p>On 10/22/24 at 12:19 PM, Resident #6 was served ground chicken with mushrooms cut into slices, green beans, and pasta. Resident #6 started eating, when suddenly he started coughing.</p> <p>LPN #1 and AD quickly assisted Resident #6. LPN #1 was heard asking Resident #6 if he would like to be brought back to his room. Resident #6 responded yes, and LPN #1 and AD pushed his wheelchair back to his room.</p> <p>On 10/22/24 at 12:30 PM, the CDM stated Resident #6 was on mechanical soft diet. Resident #6's meal card did not indicate he was on mechanical soft diet. The CDM stated Resident #6's meal card should indicate what type of diet he was on, but it was not. The Surveyor then asked the CDM to bring Resident #6's meal to the Nurse's station. The ground chicken, green beans and pasta were easily mashed with a fork but not the mushrooms slices. When asked if the mushrooms were fresh mushroom or canned mushrooms. The CDM stated they were fresh mushrooms. The smallest mushroom slice noted was about 1 cm (centimeter) by 1 cm in size. The CDM stated the mushrooms were cut small but not small enough and should have been put into the food processor together with the chicken.</p> <p>On 10/22/24 at 1:20 PM, the [NAME] stated she knew Resident #6 was on mechanical diet. She stated she put the chicken and mushrooms into the food processor, and it was finished. The [NAME] stated she added some gravy to make it moist. The [NAME] stated when she ladled some gravy, she did not notice that some mushrooms came with it.</p> <p>On 10/22/24 at 4:17 PM, the CNO stated Resident #6 was on mechanical diet and should be indicated in his meal card. The CNO stated she did not know why Resident #6's diet information was not in his meal card.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/24/24 at 12:03 PM, the RD stated the mushroom should have been put in the food processor together with the chicken or been finely chopped.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure the kitchen equipment and environment was maintained, clean, and food was stored in a safe and sanitary manner. Additionally, the facility failed to ensure food was not exposed to cross-contamination while raw food was defrosting over cooked food. These deficiencies had the potential to affect the 69 residents who consumed food prepared by the facility. This placed residents at risk for potential contamination of food and adverse health outcomes, including food-borne illnesses. Findings include:</p> <p>The FDA (Food Drug Administration) Food Code Section ,d+[DATE].11 Preventing Food and Ingredient Contamination/Packaged and Unpackaged Food - Separation, Packaging, and Segregation. (A) Food shall be protected from cross-contamination by: .Separating raw food animal foods during storage, preparation, holding, and display from: (b) Cooked ready-to-eat food.</p> <p>The FDA Food Code Section ,d+[DATE].17 Ready-to-Eat, TCS (time/temperature control for safety) food, date marking, states marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded.</p> <p>FDA Food Code Section ,d+[DATE].14 (A) documented cleaning ventilation systems intake and exhaust air ducts shall be cleaned so they are not a source of contamination by dust, dirt, and other materials.</p> <p>The facility's Food and Supply Storage policy, dated [DATE], documented all food, non-food items, 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 as set forth in the FDA code, state regulations, and city/county health codes.</p> <p>- Guidelines for food storage: Section 9: In refrigerators, store cooked foods about fresh foods to prevent cross contamination. All raw meat, poultry, and fish should be stored on bottom shelves in coolers/refrigerators and in pas deep enough to contain any juice from products.</p> <p>- Labeling and rotating food supply: Section 1: For food products that are opened and completely used or prepared at the facility and stored, the product should be labeled as to its contents and use-by dates.</p> <p>The facility's Sanitizing Stationary Food Service Equipment and Food Contact Surfaces policy, dated [DATE], documented proper cleaning and sanitizing station food service equipment (e.g., mixers, slicers, and other equipment that cannot be readily immersed in water) and food contact surfaces minimizes the growth of microorganisms that may result in food contamination. The cleaning and sanitation tasks are established on a cleaning schedule; assigned by employee position by shift and frequency.</p> <p>The initial kitchen inspection was conducted on [DATE] at 3:15 PM. The following was observed:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- In the [NAME] Kitchen Refrigerator raw chicken was defrosting above packaged ready-to-eat hardboiled eggs.</p> <p>- In both [NAME] and [NAME] kitchen refrigerators, there was a build-up of hanging dust particles on the ceiling fans.</p> <p>A follow-up kitchen inspection was conducted on [DATE] at 11:15 AM with the CDM. The following was observed:</p> <p>- In both [NAME] and [NAME] kitchen refrigerators, there was a build-up of hanging dust particles on the ceiling fans.</p> <p>- Lettuce, dated [DATE], was in the [NAME] refrigerator.</p> <p>- Expired spices were found in the cabinet with the following expiration/use-by dates: Thyme leaves, ([DATE]); Garlic powder ([DATE]); Thyme powder - no date; Lemon pepper ([DATE]); Celery seed ([DATE]); Tarragon ([DATE]); Dill weed ([DATE]); Ground white pepper ([DATE]); Whole celery seed ([DATE]); undated chili powder; chicken seasoning ([DATE]); Poppy seed ([DATE]); nutmeg ([DATE]); Johnny's season salt - no date. breadcrumbs - no date; cayenne pepper ([DATE]). Spices stored in cabinet with temperature recorded at 81 degrees F.</p> <p>A review of the kitchen cleaning schedule for September and [DATE] documented the main refrigerator and freezer were not cleaned on [DATE], [DATE], and [DATE].</p> <p>On [DATE] at 3:45 PM, the CDM confirmed the spices in the cabinet should have been thrown away by the expiration or use-by date. She also stated morning and afternoon cooks will clean the refrigerators at the end of each shift. The CDM was not sure why there was a build-up of dust on the ventilation cooling fans.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Cove of Cascadia, The		STREET ADDRESS, CITY, STATE, ZIP CODE 620 North Sixth Street Bellevue, ID 83313	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193</p> <p>Based on observation, record review, resident and staff interviews, it was determined the facility failed to ensure residents were provided with appropriate devices to support their body positioning while sitting in their wheelchair. This was true for 1 of 1 resident (Resident #11) reviewed for positioning. Resident #11 was at risk of neck and back discomfort when his head and neck were not supported while he was sitting in his wheelchair. Findings include:</p> <p>Resident #11 was admitted to the facility on [DATE] and readmitted 11//18/20, with multiple diagnoses including schizoaffective disorder, anemia, and benign prostatic hyperplasia (enlargement of the prostate gland).</p> <p>Resident #11 was observed as follows:</p> <ul style="list-style-type: none"> - On 10/21/24 at 5:10 PM and on 10/22/24 at 12:21 PM, he was in the dining room sitting at the table together with three other male residents. His head was observed to be tilted to his right side while he was eating. There was a neck cushion behind his neck. - On 10/23/24 at 10:33 AM, he was sitting in the [NAME] common area together with other residents listening to the Activity Director (AD) as she reads the Chronicle. Resident #11's head was observed to be tilted to his right side with a neck cushion behind his neck. - On 10/23/24 at 11:37 AM, he was observed listening to the surveyor during the Resident Council meeting. His head was tilted to his right side with a neck cushion behind his neck. - On 10/24/24 at 10:00 AM, Surveyor entered Resident #11's room. He was sitting in his wheelchair and looked up at the Surveyor without moving his head. When asked how he was doing, Resident #11 stated he was fine. When asked how his neck was, Resident #11 without moving his head pointed to his neck and stated bad. - On 10/24/24 at 10:04 AM, the AD together with the Surveyor, entered Resident #11's room. The AD asked Resident #11 how his neck was, Resident #11 brought both hands to his neck and stated rotten. with his face grimacing. - On 10/24/24 at 10:07 AM, during the group exercise, Resident #11 was seated together with the other residents. The AD who also was the RNA Coordinator instructed the resident to turn their head to their right, left, up and down. Six residents participated in the neck exercises. Resident #11 was not observed to participate in the neck exercises. <p>All throughout these observations, Resident #11 was not observed to bring his neck to neutral anatomical position. Resident #11 was not observed to have a device to support his head to prevent him from tilting his head to right side.</p> <p>(continued on next page)</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/23/24 at 4:23 PM, the Acting Director of Rehabilitation (DOR) stated he did not believe Resident #11 had a neck contractures. He stated Resident #11 was provided with a u-shaped pillow for his neck, but he refused to use it. When asked the last time he assessed Resident #11's head for positioning, the Acting DOR stated he will check Resident #11's record and come back to the Surveyor.</p> <p>On 10/23/24 at 1:57 PM, during a follow-up interview. The Acting DOR stated all residents in the facility are being assessed quarterly and as needed. The Acting DOR provided documentation Resident #11 was seen for PT (Physical Therapy) from 6/13/24 to 8/23/24. When asked if Resident #11's neck positioning was addressed, the Acting DOR stated he did not assess Resident #11's neck positioning since he was told Resident #11 was doing good with his neck exercises and he refused to use his neck pillow. When asked what other devices was recommended or tried to keep Resident #11's head in the neutral position. The Acting DOR stated no other devices were tried for Resident #11 to keep his head in the neutral position,</p> <p>The WebMD website, accessed on 10/30/24, documented abnormal head posture occurs when your head is at an angle with the body. The head moves away or tilts from its straight position. Abnormal head positions include: chin up, chin down, head tilting to the right or left and combinations of these abnormal head positions. The WebMD website also stated Abnormal head posture can lead to permanently tight neck muscles. It can cause long term neck pain or headache.</p>		