STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135079	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Valley of Cascadia	8211 Ustick Road Boise, ID 83704

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on observation, policy review, and interviews it was determined the facility failed to ensure residents were treated with dignity and respect. This was true for 1 of 10 residents (Resident #21) reviewed for respect and dignity. This deficient practice placed residents at risk of embarrassment and diminished sense of worth. Findings include: The facility's Quality of Life policy dated 10/15/22, documented staff were to refrain from practices demeaning to residents such as keeping urinary catheter bags uncovered. Resident #21 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including Myotonic Muscular Dystrophy (a genetic disorder that causes progressive muscle weakness, stiffness, and other symptoms) and functional quadriplegia (a complete inability to move all four limbs due to severe physical disability or frailty, but without actual physical injury or damage to the brain or spinal cord). On 5/12/25 at 2:20 PM, observed a Hoyer lift transfer from bed to bath chair so Resident #21 could be taken to the shower room. After the transfer, CNA #1 and CNA #2, covered Resident #21 with blankets. On 5/12/25 at 2:21 PM, CNA #2 placed Resident #21's visible uncovered urinary bag at his feet. On 5/12/25 at 2:21 PM, CNA #2 stated Resident #21's urinary catheter bag was normally covered when he was in his wheelchair, but they were transporting him from his room on hall 800 to the shower room on 500 hall so it did not need to be covered. On 5/15/25 at 11:07 AM, the CNO stated the facility catheter bags have covers so she is not sure why the catheter bag did not have a cover over it but it should have.

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

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on observation, record review, policy review, and interviews, it was determined the facility failed to ensure residents received prior written rationale regarding room changes. This was true for 2 of 27 residents (#38 and #97) whose records were reviewed. This deficient practice placed residents at risk of embarrassment and diminished sense of worth. Findings include: The facility's Room to Room Transfer policy dated 11/28/17, documented under procedures: - Facility discusses transfer with resident, family and/or responsible party in advance to explain rationale and rights. - Residents are offered an opportunity to tour the room prior to a room move. - Residents are introduced to the new roommate prior to a room move. a. Resident #38 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including diabetes and acquired absence of left leg below knee. On 5/12/25 at 3:30 PM, Resident #38 stated when he was outside in his wheelchair smoking on 3/7/25, the CEO came outside and told him they were packing up his property and moving him from room [ROOM NUMBER] to room [ROOM NUMBER]. Resident #38's medical record Room Transfer Notification document dated 3/7/25, had no reason or rationale documented for the room transfer. On 5/12/25 at 2:37 PM, during Resident Council meeting Resident #38 stated he was not told why he had to move to another room when the room transfer occurred on 3/7/25. On 5/12/25 at 3:10 PM, Resident #38 stated this room transfer upset him because he did not meet the new roommate prior to the move and he could not find his prosthetic leg after the move. Resident #38's prosthetic leg was later found on top of the closet shelf, which he could not see or retrieve without help. On 5/14/25 at 1:20 PM, the CRN stated the facility had used an older room transfer document that did not require a rationale for transfer, so they did not have any documentation explaining the rationale for Resident #38's transfer to a different room. b. Resident #97 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including cutaneous abscess of abdominal wall and bipolar disorder. On 5/12/25 at 1:31 PM, Resident #97 stated she had been transferred from room [ROOM NUMBER] to room [ROOM NUMBER] on 6/13/24, and had not been provided a rationale when it happened. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #97's medical record Room Transfer Notification document dated 6/13/24, had no rationale documented for the room transfer. On 5/14/25 at 1:20 PM, the CRN stated the facility had used an older room transfer document that did not require a rationale for transfer, so they did not have any documentation explaining the rationale for Resident #97's transfer to a different room.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on observation, policy review, record review, and interviews, it was determined the facility failed to assess residents for safe smoking practices. This was true for 1 of 3 residents (Resident #97) whose medical records were reviewed. This deficient practice placed residents at risk for harm when proper smoking assessment or supervision was not provided. Findings include: The facility's Smoking Campus policy dated 10/5/22, documented the interdisciplinary team evaluates residents desiring to smoke for their ability to smoke independently or dependently upon admission, quarterly, with a significant change or as deemed necessary. Resident #97 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including cutaneous abscess of abdominal wall and bipolar disorder. Resident #97's Quarterly MDS dated [DATE], documented a BIMS score of 15 (meaning she was cognitively intact). On 5/12/25 at 4:29 PM, Resident #97 stated she is an independent smoker. Resident #97's medical record had no smoking assessment documented. Resident #97's care plan had not documented she smoked. On 5/14/25 at 11:40 AM, the CNO stated they did not know Resident #97 was a smoker and her smoking assessment had not been completed and should have been.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on review of the State Operations Manual, Appendix PP, policy review, record review, and staff interview, it was determined the facility failed to ensure 1 of 5 residents (Resident #123), received recommended specialized services, identified by the state's Level II PASARR process. This deficient practice had the potential to cause significant harm if the resident's mental health needs were not adequately met. Findings include. The facility's Pre-Admission Screening and Resident Review (PASARR) policy, revised 11/19/24, documented the following: - The state-designated authority determines the appropriate setting for the individual and recommends what, if any, specialized services, and/or rehabilitative services the individual needs. - Individuals who have or are suspected to have MD, ID, or a related condition (as indicated by a positive Level I screen) may not be admitted to a Medicaid-certified nursing facility unless approved based on Level II PASARR evaluation and determination. Resident #123 was admitted to the facility on [DATE], with multiple diagnoses including traumatic subdural hemorrhage and major depressive disorder. Resident #123's PASARR Level I dated 3/6/25, documented the following: - A diagnosis of depressive disorder. - A history of attempted suicide. - Instruction to forward to Bureau of Long-Term Care (BLTC) for further screening. Resident #123's PASARR Level II, Part I and Part 2, dated 3/6/25, documented the following: - A diagnosis of depressive disorder. - A recent attempt of suicide. - Requires further individualized evaluation for specialized services by a Professional Independent Evaluator and the state's MHA. On 5/15/25, a review of Resident #123's medical record did not have documentation the evaluation for specialized services by the state's MHA was completed. On 5/15/25 at 10:00 AM, the CNO stated she did not know if the state's MHA evaluated Resident #123. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/25 at 2:10 PM, the CNO stated the Mental Illness Evaluation and Determination report was not in Resident #123's medical record and should have been.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on review of the State Operations Manual, Appendix PP, policy review, record review, and staff interview, it was determined the facility failed to ensure 1 of 5 resident's (Resident #123), plan of care included recommended specialized services, identified by the state's Level II PASARR process. This deficient practice had the potential to cause significant harm if the resident's mental health needs were not adequately met. Findings include: The facility's Pre-Admission Screening and Resident Review (PASARR) policy, revised 11/19/24, documented the following: - The state-designated authority determines the appropriate setting for the individual and recommends what, if any, specialized services, and/or rehabilitative services the individual needs. - The facility's interdisciplinary Team uses the PASARR when conducting their assessments of the resident developing the care plan, when transitions of care occur to promote a comprehensive assessment, and development of a plan of care for residents with mental disorders. The facility's Trauma Informed Care policy, revised 10/15/22, documented the following: - Understand who is a trauma survivor and may be at risk for re-traumatization. - Person centered care planning should address triggers for re-traumatizing and interventions to avoid such an experience. The facility's Care Plans policy, revised 10/15/22, documented the comprehensive care plan will describe any specialized services or specialized rehabilitative services the nursing facility provides as a result of PASARR recommendations. Resident #123 was admitted to the facility on [DATE], with multiple diagnoses including traumatic subdural hemorrhage and major depressive disorder. Resident #123's PASARR Level II, Part I and Part 2, dated 3/6/25, documented the following: - A diagnosis of depressive disorder - A recent attempt of suicide - Requires further individualized evaluation for specialized services by a Professional Independent Evaluator and MHA. On 5/15/25, a review of Resident #123's care plan did not document his mental health diagnosis or recommendations from the PASARR Level II. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/25 at 11:00 AM, the CNO stated Resident #123's care plan did not include recommendations from his PASARR Level II, and it should have.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on observation, record review, and interviews, it was determined the facility failed to provide respiratory services as ordered by the physician. This was true for 2 of 8 residents (#2 and #18) whose records were reviewed for respiratory services. This failure created the potential for residents to experience increased fatigue and low oxygen levels. Findings include: a. Resident #2 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including cerebral palsy (a group of neurological disorders that affect movement, balance, and posture, and can also affect learning, speech, and other functions) and acute respiratory failure (a life-threatening condition where the lungs are unable to adequately exchange oxygen and carbon dioxide). On 5/13/25 at 9:02 AM, observed Resident #2 in bed sleeping with a nasal cannula in her nose with the oxygen concentrator liter flow set at 0 liters per minute. Resident #2's physician's order dated 3/12/25, ordered oxygen at 2 liters per minute via nasal cannula. Resident #2's care plan documented oxygen therapy at 2 liters per minute via nasal cannula QHS or while in bed. On 5/13/25 at 9:10 AM, RN #2 stated Resident #2's oxygen concentrator should have been set at 2 liters per minute but was not. On 5/14/25 at 11:59 AM, the CNO stated Resident #2's oxygen concentrator should have been set at 2 liters per minute but was not. b. Resident #18 was initially admitted to the facility on [DATE], and readmitted [DATE], with multiple diagnoses including chronic heart failure and chronic respiratory failure with hypercapnia (a long-term condition where the lungs struggle to remove carbon dioxide from the blood, leading to elevated levels of carbon dioxide). On 5/16/25 at 12:35 PM, observed Resident #18 sleeping in his bed with his oxygen cannula in his nose however the oxygen tubing was not connected to his oxygen concentrator. Resident #18's physician's order dated 8/29/24, ordered oxygen at 4 liters per minute via nasal cannula. Resident #18's care plan documented oxygen therapy as ordered via nasal cannula. On 5/16/25 at 12:38 PM, RN #4 stated the CNAs put Resident #18 to bed and must have forgotten to connect the tubing to the concentrator. On 5/16/25 at 12:42 PM, the CRN stated the CNAs should have confirmed Resident #18's oxygen cannula was connected to the concentrator after moving him in bed.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on policy review, observation, record review, and interviews, it was determined the facility failed to provide adequate pain management. This was true for 1 of 27 residents (Resident #61) whose medical records were reviewed. This failure created the potential for residents to experience continual pain and distress. Findings include: The facility's Quality of Life policy dated 10/15/22, documented the facility provides the appropriate treatment and services to maintain or improve his/her ability to carry out the activities of daily living and their abilities do not diminish unless circumstances of the individual's clinical condition demonstrate such diminution was unavoidable. Resident #61 was admitted to the facility on [DATE], with multiple diagnoses including end stage renal disease (a serious medical condition where the kidneys are no longer able to filter waste and excess fluid from the blood, requiring dialysis or a kidney transplant to survive) and cerebral palsy (a group of neurological disorders that affect movement, balance, and posture, and can also affect learning, speech, and other functions). Resident #61's annual MDS dated [DATE], documented a BIMS score of 15 (cognitively intact). On 5/12/25 at 2:05 PM, Resident #61 stated she was in pain on 5/11/25 late in the evening and had pushed her call light between 11:30 pm and 12 midnight to request a pain pill. Resident #61 stated she had to refuse dialysis on 5/12/25 due to her pain and no pain relief from the night before. A nurse documented in Resident #61 medical record pain level summary for 5/11/25 at 11:48 PM, 0 out of 10 for pain. A call light audit provided by the facility documented Resident #61 had pushed her call light button at 11:51 PM on 5/11/25 and it was answered at 11:56 PM. Resident #61 stated this was when she asked for her pain medication which was not given. A nurse documented in Resident #61 medical record pain level summary for 5/12/25 at 2:47 PM, 10 out of 10 for pain. On 5/15/25 at 2:50 PM, the Resident Care Manager LPN #3 stated Resident #61 told her she was in pain the night of 5/11/25 waiting for her pain pill, which never came, and she fell asleep.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49552 Based on policy review, facility grievances, review of call light logs, and resident interviews, it was determined the facility failed to ensure enough staff were available to answer call lights in a timely manner. This was true for 7 of 27 residents (#12, #24, #50, #64, #76, #97, and #116) reviewed for staffing concerns. This deficient practice created the potential for physical and psychosocial harm if residents did not receive appropriate care or received a delay in care. Findings include: The facility's Quality of Life policy revision date 10/15/22, documented the call light response is provided by nursing and non-nursing staff within their skill set. Resident needs are addressed in a timely and courteous manner. 1. Facility grievance/concerns for 6 months were requested. Two of the grievances dated 3/4/25 and 4/8/25, documented complaints with call light response time. A concern form dated 3/4/25, documented Resident #97 reported when she turned on her call light she had to wait an hour. It had only happened when one nurse was on duty, LPN #3. When Resident #97 told LPN #3 she had her call light on for a long period of time, LPN #3 told Resident #97 they must have had problems with the light because her call light just came on. Attached to the concern form was a Past Calls report dated 3/1/25 - 3/4/25, for all shifts. This form documented the To Room Elapsed Time for 3/2/25 at 3:51 PM, was 16:32 minutes. In the section for Action Taken, it documented the CNO was to educate night shift to increase monitoring of call lights. Attached to the concern form was follow-up documentation that the CNO spoke with LPN #3 regarding complaints about nighttime call lights, and LPN #3 stated she could not always see that the call lights had come on and now she goes down to check the computer regularly. Resident #97 was notified of the plan of correction and was satisfied with action to be taken. A concern form dated 4/8/25, documented Resident #50 reported on 4/5/25 and 4/7/25, her call light had been ignored and she had to wait too long to use the bathroom. Attached to the concern form was a Past Calls report dated 4/5/25, for all shifts. This form documented multiple call light response times with the longest To Room Elapsed Time was 23:36 minutes at 10:11 PM. In the section for Action Taken documented the call light report showed appropriate response times, very minimal wait. Resident #50's response to action taken documented she appreciated the help looking into this issue. 2. Call light logs for all shifts dated 2/13/25 to 5/11/25, were requested. During those 3 months, there were 1, 770 call lights with elapsed times greater than 30 minutes and 167 call light elapse time longer than an hour. 3. Residents were interviewed regarding call light response time. Examples include: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 5/12/25 at 11:42 AM, Resident #64 stated the call light response time has been 15 minutes up to 1 hour and sometimes the staff come in and turn off the call light and say they will be right back and do not return. - On 5/12/25 at 1:34 PM, Resident #97 stated the call light sometimes had been left on for hours. One time she turned her call light on at midnight and no one came in to answer it until 5 am. - On 5/12/25 at 1:36 PM, Resident #50 stated she has had to wait longer than 30 minutes for her call light to be answered. - On 5/12/25 at 1:57 PM, Resident #116 stated her roommate had to waited up to 2 hours to have her light answered on the day shift. - On 5/13/25 at 8:46 AM, Resident #76 stated there is not enough staff. It had taken up to an hour to get someone to answer her call light and sometimes you must call the phone at the front desk to get help. - On 5/13/25 at 11:48 AM, Resident #12 stated it takes a long time for staff to answer the call light in her bathroom to assist her with getting off the commode. She reported that she had to wait so long that her legs go numb, making it hard for her to stand up. - On 5/13/25 at 1:27 PM, Resident #24 reported she had waited over 45 minutes to 2 hours for her light to be answered. On 5/16/25 at 12:03 PM, the CEO stated resident call lights should be answered within 10 minutes. On 5/16/25 at 12:09 PM, the Staff Development Coordinator stated resident call lights should have been answered within 15 minutes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 52524 Based on observation, interview, policy review, and review of the Idaho Food Code, the facility failed to ensure food items were dated and labeled, sanitary, and hygiene practices followed. These deficient practices had the potential to impact all residents who received meals prepared in the facility's kitchen. This placed residents at risk for potential contamination, use of spoiled foods, and adverse health outcomes including food-borne illnesses. Findings include: The FDA Food Code Section 3-501.17 stated, Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking, states refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded . Review of the facility's Resident Personal Food policy revised 4/10/24, documented food items should be labeled with a 3-day use-by date. On 5/12/25 at 11:18 AM, observed in the kitchen with the Culinary Manager (CM) present, stacked clean dry plastic containers inverted on rack with water present on the insides of the top container. On 5/12/25 at 11:19 AM, the CM stated the containers should be completely dry before stacking them on the rack. On 5/12/25 at 12:00 PM, observed in the dining room during the lunch meal, grape juice being served to residents had a prepared date of 5/4 and use by date of 5/5. On 5/12/25 at 12: 15 PM, RN #3 stated the grape juice was outdated and should not have been served to residents. On 5/14/25 at 8:29 AM, the following were observed in the resident unit refrigerators, with the Activity Director (AD) present: - An opened container of potato salad with a resident's room number on it and an expiration date of 4/25/25. - A bag of salad greens with best used-by dates of 4/25/25. - An opened container of frozen strawberries which was past the 3-day use-by date. - An open box of ice cream bars did not have use-by date. On 5/14/25 at 9:40 AM, the AD stated the food items should have been discarded. On 5/14/25 at 9:55 AM, the Assistant Culinary Manager (ACM) stated the single serve ice cream bars' box should have been dated with the 6-month used-by date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135079	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Valley of Cascadia	8211 Ustick Road Boise, ID 83704

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 10:05 AM, the following was observed in the dry food storage area with the ACM present, six cartons of Thick and Easy food and beverage thickener with best used-by date of 12/26/24. On 5/14/25 at 10:07 AM, the ACM stated the cartons of thickener should have been discarded. On 5/15/25 at 10:09 AM, [NAME] #2 was observed in the kitchen preparing condiment trays. [NAME] #2 was noted to have no hairnet or hair restraint. On 5/15/25 at 10:12 AM, the ACM stated [NAME] #2 should have had a hairnet or hair restraint on but did not. 51121

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure infection control and prevention practices were maintained to provide a safe and sanitary environment when staff did not perform proper hand hygiene during wound care, did not follow proper wound care protocol, and did not clean equipment between resident use. This was true for 1 of 1 resident (Resident #2) reviewed for wound care and resident transfers using the Hoyer lift. These failures had the potential to impact all residents in the facility by placing them at risk for cross contamination and infection. Findings include: The facility's Hand Hygiene policy, revised 2/11/22, documented alcohol-based hand rub or soap and water was to be used before moving to a clean body site after caring for a soiled body site, after contact with any objects in the immediate vicinity of the resident, and after removing gloves. The facility's Clean Dressing Change policy, dated 11/28/17, documented: - Perform hand hygiene before providing wound care. - Put on first pair of gloves. - Remove soiled dressing and discard. - Remove gloves and dispose. - Perform hand hygiene and put on second pair of gloves. - Cleanse wound with prescribed solution. - Remove gloves and perform hand hygiene. - Open dressing pack. - Put on gloves. -Apply prescribed medication and apply dressing and secure. - Remove gloves and discard with all soiled supplies in plastic bag. - Perform hand hygiene. The facility's Work Practices - Cleaning policy dated 1/1/18, documented multiple use resident care items (resident lifts) are properly cleaned/disinfected between each resident use. Resident #6 was admitted [DATE], with multiple diagnoses including quadriplegia (the complete or partial paralysis of all four limbs) and pressure ulcer of unspecified site. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6 had an order dated 5/7/25, to cleanse his left posterior thigh pressure ulcer with wound cleanser or normal saline, pat dry, apply lightly dampened gauze with Vashe wound solution (wound cleanser) to wound bed, cover with dry dressing. Resident #6 had an order dated 5/7/25, to cleanse his right trochanter pressure ulcer with wound cleanser, pat dry, apply lightly dampened Vashe wound solution (wound cleanser) gauze to wound bed, cover with dry dressing. On 5/13/25 at 11:20 AM, LPN #1 was observed providing wound care to Resident #6. LPN #1 used alcohol rub for hand hygiene prior to donning gloves. LPN #1 than removed the soiled dressing with gloves on. LPN #1 removed her gloves after removing the old dressing and donned clean gloves. LPN #1 did not perform hand hygiene before donning clean gloves. LPN #1 then cleaned the wound and then applied new dressing. LPN #1 did not change her gloves after cleansing the wounds, before applying the new dressing. On 5/13/25 at 11:44 AM, LPN #1 stated she was not sure what the facility's policy for hand hygiene was when going from dirty area to a clean area. On 5/13/25 at 2:37 PM, LPN #1 stated her gloves should have been changed after cleaning the wound, before applying the new dressing and she should have used hand sanitizer between glove changes. On 5/12/25 at 2:47 PM, observed in room [ROOM NUMBER] a Hoyer lift transfer of resident to a bath chair. The Hoyer lift was positioned outside of room [ROOM NUMBER] in the hallway for over 20 minutes without being cleaned. On 5/12/25 at 3:07 PM, RN #3 stated the Hoyer lift should have been cleaned right after use and not left in the hallway dirty. 51121

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on observation, policy review and interviews, it was determined the facility failed to ensure all call light buttons or pads were easily accessible to residents. This was true for 1 of 27 residents (Resident #2) whose rooms were observed for call light device locations. This failure had the potential for harm if residents were not able to summon staff for assistance. Findings include: The facility's Quality of Life policy dated 10/15/22, documented the resident is treated with respect by validating call light is available and staff are responsive to resident needs. Resident #2 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including cerebral palsy (a group of neurological disorders that affect movement, balance, and posture, and can also affect learning, speech, and other functions) and acute respiratory failure (a life-threatening condition where the lungs are unable to adequately exchange oxygen and carbon dioxide). Resident #2's care plan documented she uses a touch pad call light. Validate placement upon leaving resident. On 5/13/25 at 9:00 AM, Resident #2's call light pad was on the bedside table, not accessible to her. On 5/13/25 at 9:08 AM, RN #2 stated Resident #2 really does not need the call light pad because they check on her often. On 5/14/25 at 11:59 AM, the CNO stated staff should have been making sure the call light pad is accessible to Resident #2 on her bed but had not.