STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135089	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Desert View	820 Sprague Avenue Buhl, ID 83316

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on policy review, record review, and staff interview, it was determined the facility failed to ensure residents and their representatives received assistance to exercise their right to formulate an advanced directive. This was true for 3 of 12 residents (Resident #6, #36, and #38) whose records were reviewed for advanced directives. This deficient practice created the potential for harm or adverse outcomes if residents' wishes were not followed or documented regarding their advance care planning. Findings include: The facility's Residents' Rights Regarding Treatment and Advanced Directives policy, revised September 2022, documented on admission the facility will determine if the resident has executed an advanced directive, and if not, determine whether the resident would like to formulate an advanced directive. Should the resident have an advanced directive, copies will be made and placed on the chart as well as communicated to the staff. Any decision-making regarding resident's choices will be documented in the resident's medical record. The following residents' records did not include documentation an advance directive was offered: a. Resident #6 was admitted to the facility on [DATE], with multiple diagnoses including metabolic encephalopathy (a chemical imbalance in the blood that damages the brain) and hypertension. Resident #6's record did not include an advanced directive or documentation an advanced directive was discussed with her or her representative. b. Resident #36 was admitted to the facility on [DATE], with multiple diagnoses including osteoarthritis of the left hip and late onset Alzheimer's disease. Resident #36's record did not include an advanced directive or documentation an advanced directive was discussed with him or his representative. c. Resident #38 was admitted to the facility on [DATE], with multiple diagnoses including multiple sclerosis (a chronic disease of the central nervous system) and adult failure to thrive (general decline in older adults). Resident #38's care plan date 3/15/24, documented staff would maintain all advanced directives in her chart. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #38's record did not include an advanced directive or documentation information about an advanced directive was provided and discussed with her or resident representative. On 5/30/24 at 1:55 PM, the DON stated there was no documentation stating Resident #6, #36, or #38 was offered assistance to formulate an advanced directive, and there should have been.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on policy review, record review, and staff interview, it was determined the facility failed to ensure residents' rights were protected to be free from neglect. This was true for 2 of 2 residents (#191 and #192) reviewed for neglect. This failure caused physical harm to Resident #191 when she suffered a cut to her lower left leg and to Resident #192 when her thighbone was fractured. Findings include: The facility's Abuse policy, undated, documented Residents are to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility's Abuse policy also documented neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. 1. Resident #191 was admitted to the facility on [DATE], with multiple diagnoses including spinal stenosis (narrowing of the spinal canal in the lower back that may cause pain or numbness in the legs). A progress note, dated 6/4/21, documented Resident #191 was out on a van ride. The van stopped suddenly and Resident #191's seat belt failed causing her to fall forward out of her chair landing in the center aisle causing a significant cut to her lower left leg. Inspection of the seat belt showed no damage to the mechanism where it buckled around the resident. Inspections of the restraints that secured the wheelchair found no issues. Additional inspections found no concerns with the van itself. All facility drivers were in-serviced on 6/7/21, on the proper procedure for securing and un-securing passengers in wheelchairs. On 6/7/21, new seat belts were purchased, and maintenance added a monthly check of all seatbelts to routine van maintenance. On 5/31/24 at 11:00 AM, the Administrator stated she was not aware of Resident #191's incident because she did not work at the facility at that time. 2. Resident #192 was admitted to the facility on [DATE], with multiple diagnoses including kidney disease and stroke. A progress note, dated 6/2/23 at 5:15 PM, documented Resident #192 tipped backwards in his wheelchair while in the van. Resident #192 received an open contusion to his right elbow, measuring 1 cm x 1.2 cm. A progress note, dated 6/2/23 at 10:05 PM, documented Resident #192 could not move his right lower extremity and was sent to the emergency room for evaluation. A progress note, dated 6/2/23 at 11:57 PM, documented Resident #192 returned from the hospital with a new diagnosis of non-displaced fracture of right femur (thighbone). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/30/24 at 4:48 PM, the Maintenance Supervisor stated he was asked to inspect the van when each of the incidents occurred and nothing was wrong with the van's equipment. He stated it was the staff not strapping the wheelchair in properly. All facility drivers were educated on 6/5/23, on ensuring all van straps were in place and tightened on the wheelchair before transport and the lap seatbelt was in place before the van moved. The van was inspected on 6/5/23, to ensure the seat belts were properly functioning. On 5/31/24 at 11:00 AM, the Administrator stated the metal hooks that fastened Resident #192's wheelchair to the van slipped off because the connection was not tight and her wheelchair flipped backwards. She also stated there were no issues with the van because the hook used to secure the wheelchair to the van was not tight enough. She further stated training with return demonstration was provided to the van drivers. On 2/14/24 a 2-person wheelchair securement check before each resident transport was put into place. The 2-person wheelchair securement checks before van transport from 2/14/24 - 5/29/24 were reviewed. There were no missing van checks during this time period. These findings represent past noncompliance with this regulatory requirement. There was sufficient evidence the facility corrected the noncompliance as of 2/14/24 and there were no other occurrences of alleged neglect. At the time of this survey the facility was in substantial compliance and therefore does not require a plan of correction.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on policy review, record review, and staff interview, it was determined the facility failed to ensure pertinent health information was provided to the receiving hospital. This was true for 2 of 6 residents (#6 and #30) reviewed for transfers. This deficient practice had the potential to result in adverse outcomes if residents were not treated in a timely manner due to a lack of information provided upon transfer. Findings include: The facility's Transfer or Discharge policy, dated October 2022, documented should a resident be transferred or discharged for any reason: A. The following information is communicated to the receiving facility or provider: -The basis for the transfer or discharge -Contact information of the practitioner responsible for the care of the resident -Resident representative information including contact information -Advanced directive information -All special instructions or precautions for ongoing care, as appropriate -Comprehensive care plan goals -All other information necessary to meet the resident's needs B. When a resident is transferred or discharged from the facility the following information is documented in the medical records: -The basis for the transfer -That an appropriate notice was provided to the resident and/or legal representative -The date and time of the transfer or discharge -The new location of the resident -The mode of transfer -A summary of the resident's overall medical, physical, and mental condition -Disposition of personal effects -Disposition of medications (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Others as appropriate or as necessary: and -The signature of the person recording the data in the medical record The following resident records did not include documentation pertinent information was sent to the hospital upon their transfer: a. Resident # 6 was admitted to the facility on [DATE], with multiple diagnoses including metabolic encephalopathy (a chemical imbalance in the blood that damages the brain) and hypertension. A nurses note, dated 2/2/24 at 6:35 PM, documented Resident #6 was having seizure-like activity with low blood oxygen saturation. His family and physician were both in agreement for his transfer to the hospital. Resident #6's record did not include documentation pertinent medical information was provided to the receiving hospital. b. Resident #30 was admitted to the facility on [DATE], with multiple diagnoses including heart failure and diabetes. A physician's order, dated 8/20/23, documented ok to send to hospital for assessment. Resident #30's record did not include documentation pertinent medical information was provided to the receiving hospital. On 5/30/24 at 12:10 PM, the DON stated discharge/transfer forms that should be sent to the hospital with the resident are the medication list, face sheet, POST (a form containing crucial information about caring for a person nearing the end of life) and what documentation was sent with the resident to the hospital should be documented in the resident's chart. She also stated this information was not documented in Resident #6's and #30's chart and should have been.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on policy review, record review, and staff interview, it was determined the facility failed to ensure a bed hold notice was provided to residents or their representatives upon transfer to the hospital. This was true for 2 of 6 residents (#6 and #30) reviewed for transfer. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time. Findings include: The facility's Transfer or Discharge policy, dated October 2022, documented the Notice of Facility Bed-Hold and Return policies are provided to the resident and representative within 24 hours of emergency transfer. The following resident records did not include documentation the resident or their representative was provided a Notice of Facility Bed-Hold: a. Resident #6 was admitted to the facility on [DATE], with multiple diagnoses including metabolic encephalopathy (a chemical imbalance in the blood that damages the brain) and hypertension. A nurse's note, dated 2/2/24 at 6:35 PM, documented Resident #6 was having seizure-like activity with low blood oxygen saturation. His family and physician agreed to transfer him to the hospital. Resident #6's record did not include documentation a bed-hold notice was provided to him or his representative when he was transferred to the hospital. b. Resident #30 was admitted to the facility on [DATE], with multiple diagnoses including heart failure and type 2 diabetes. A physician's order, dated 8/20/23, documented, ok to send to hospital for assessment. Resident #30's record did not include documentation a bed-hold notice was provided to him or his representative when he was transferred to the hospital. On 5/30/24 at 1:50 PM, the DON confirmed there were no notifications of bed-hold for Resident #6 or Resident #30 in their medical record and the bed-holds should have been completed and scanned into the medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 48401 Based on record review and staff interview, it was determined the facility failed to ensure appropriate assessments for assistive devices were completed for 2 of 2 residents (#1 and #38). This deficiency created the potential for injury if the residents were not assessed and monitored appropriately. Findings include: The HALO Safety Ring Instructions, undated, included a warning, ENTRAPMENT MAY OCCUR. Proper patient assessment and monitoring, and proper maintenance and use of equipment is required to reduce the risk of entrapment. (A HALO Safety Ring is a bed mobility device that increases environmental independence, prevents mattress movement, and is considered a type of bed rail.) 1. Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including a traumatic brain injury, spastic hemiplegia of his nondominant side (a condition that causes muscle tightness and involuntary contractions in the limbs and extremities on one side of the body), muscle weakness, and a history of falls. On 5/28/24 at 1:00 PM, a HALO Safety Ring was observed on Resident #1's bed. Resident #1's care plan, revised 9/27/23, documented, Assess entrapment risk quarterly and PRN to ensure proper usage of assistive devices. On 5/30/24 at 4:48 PM, the Maintenance Supervisor stated the facility could not provide documentation Resident #1 was assessed to safely use the assistive HALO Safety Ring device. 49552 2. Resident #38 was admitted to the facility on [DATE], with multiple diagnoses including multiple sclerosis (a chronic disease of the central nervous system) and adult failure to thrive (general decline in older adults). On 5/28/24 at 12:03 PM, Resident #38 was observed lying in his bed with a HALO Safety Ring on the left side of his bed. Resident #38's care plan, initiated 3/15/24, directed staff to assess entrapment risks to ensure proper usage of assistive devices. On 5/29/24 at 9:11 AM, Resident #38's record did not include documentation of an assessment for his HALO Safety Ring. On 5/30/24 at 4:00 PM, the DON stated Resident #38 did not have his HALO Safety Ring assessment completed.

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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** 49552 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a residents', PASARR Level I (Preadmission Screening and Resident Review) had correct information and if residents' PASARR Level I indicated the resident had been identified with possible indicators of mental illness and required further screening, a PASARR Level II was to be completed. This was true for 2 of 2 residents (#6 and #30) whose PASARR records were reviewed. This deficient practice had the potential to cause harm if residents' specialized services for mental health needs were not provided due to lack of screening. Findings include: The facility's Behavioral Assessment, Intervention and Monitoring policy, revised February 2024, documented if the PASARR Level I screen indicates that the individual may meet the criteria for a mental disorder, intellectual disability, or related condition, he or she will be referred to the state PASARR representative for the Level II (evaluation and determination) screening process. 1. Resident #6 was admitted to the facility on [DATE], with multiple diagnoses including metabolic encephalopathy (a chemical imbalance in the blood that damages the brain) and bipolar disorder. An MDS assessment, dated 2/8/24, documented Resident #6 was severely cognitively impaired. The assessment also documented Resident #6 had a diagnosis of bipolar disorder. Resident #6's Level I PASARR Screen, dated 2/5/24, did not include documentation of his bipolar disorder. The Level I PASARR was signed by the physician. There was no documentation a Level II PASARR was completed. On 5/30/24 at 8:29 AM, the Social Services Supervisor stated she did not know why Resident #6's PASARR Level I did not include his bipolar disorder diagnosis. She also stated the hospital conducted the assessment and then the DON reviewed them. On 5/30/24 at 9:10 AM, the DON stated Resident #6's PASARR Level I should have had his bipolar disorder included and the error should have been recognized and corrected prior to admission. 2. Resident #30 was admitted to the facility on [DATE], with multiple diagnoses including heart failure and psychosis (a mental disorder characterized by a disconnection from reality). A quarterly MDS assessment, dated 4/23/24, documented Resident #30 was moderately cognitively impaired. The assessment documented Resident #30 had a diagnosis of a psychotic disorder other than schizophrenia. Resident #30's Level I PASARR Screen, dated 4/6/21, documented he had a major mental illness and required further screening. Resident #30's record did not include documentation a Level II PASARR was completed. On 5/30/24 at 8:57 AM, the Social Services Supervisor stated she did not know where Resident #30's PASARR Level II was. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/24 at 9:10 AM, the DON stated Resident #30 should have had a PASARR Level II completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 49552 Based on policy review, observation, and staff interview, it was determined the facility failed to ensure respiratory equipment was changed as indicated. This was true for 1 of 4 residents (Resident #7) reviewed for respirator care. This created the potential for respiratory infections due to growth of pathogens (organisms that cause illness) in respiratory treatment equipment. Findings include: Resident #7 was admitted to the facility on [DATE], with multiple diagnoses including congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should) and kidney disease. A quarterly MDS assessment, dated 5/9/24, documented Resident #7 had severe cognitive impairment and received oxygen therapy. A physician's order, dated 4/1/24, directed staff to change Resident #7's oxygen tubing and humidifier and clean concentrator filter, twice a month, on the 1st and the 15th, during the night shift. On 5/28/24 at 12:42 PM, Resident #7 's concentrator humidifier (container of water attached to the oxygen concentrator) was observed dated 5/1/24. The oxygen tubing was undated. On 5/29/24 at 11:34 AM, the DON stated the oxygen tubing and water bottle were to be changed every week and should have been dated when it was changed.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48401 Based on observation, record review, and staff interview, it was determined the facility failed to ensure informed consent was given by the resident or their representative for the use of bed rails. This was true for 2 of 2 residents (#1 and #38) reviewed for having bed rails. This failure created the potential for harm when the resident did not understand the risks associated with the use of bed rails. Findings include: The facility was unable to provide the policy and procedure for the use of assistive devices and the requirement of obtaining informed consent prior to the use of assisted devices. The facility stated they followed the manufacturer's HALO Safety Ring Instructions for installation. 1. Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including a traumatic brain injury and spastic hemiplegia of his nondominant side (a condition that causes muscle tightness and involuntary contractions in the limbs and extremities on one side of the body), muscle weakness, and a history of falls. On 5/28/24 at 1:00 PM, a HALO safety ring was observed on Resident #1's bed. Resident #1's record did not include documentation he signed an informed consent for the use of the HALO safety ring. On 5/30/24 at 4:00 PM, the DON stated Resident #1 did not have an informed consent for the use of the HALO safety ring. 49552 2. Resident #38 was admitted to the facility on [DATE], with multiple diagnoses including multiple sclerosis (a chronic disease of the central nervous system) and adult failure to thrive (a general decline in health in older adults). On 5/28/24 at 12:03 PM, Resident #38 was observed lying in his bed with a HALO safety ring installed on the left side of his bed. Resident #38's medical record did not include documentation he signed an informed consent for the use of the HALO safety ring. On 5/30/24 at 4:21 PM, the DON stated Resident #38 did not have an informed consent for the use of the HALO safety ring.

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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. 50603 Based on observation and staff interview, it was determined the facility failed to ensure the kitchen equipment and environment was maintained, and food was stored in a safe and sanitary manner. These deficiencies had the potential to affect the 39 residents residing in the facility 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: 1. The FDA Food Code Section 3-305.11(A) documented food should be protected from contamination and stored in a clean, dry location where it was not exposed to splash, dust, or other contamination; and at least 6 inches above the floor. On 5/30/24 at 3:45 PM, during an inspection of the dry food pantry, the following was observed: - The bottom shelves were measured at 4.25 inches. Individual bags of potato chips, tortilla chips, paper goods, single use cups, and plastic silverware were stored on the bottom shelves. - A layer of dust was observed on one of the upper shelves where a television was placed above an active cooling unit on a shelf below. On 5/30/23 at 3:45 PM, the Kitchen Manager confirmed the pantry shelves were built-in and could not be changed. She stated she did not notice the dust on the pantry shelf as it was storing a television monitor and not food items. 2. The FDA Food Code Section 3-501.12 Time/Temperature Control for Safety Food, Slacking documented frozen time/temperature control for safety food that is slacked to moderate the temperature shall be held: (A) Under refrigeration that maintains the food temperature at 5 C (41 F) or less; or (B) At any temperature if the food remains frozen. On 5/28/30, refrigeration and freezer temperature logs were reviewed on the nursing unit and behavioral unit residents' food refrigerators. A review of the temperature log for May 2024, documented the behavioral unit residents' food refrigerator' temperature was above 41 degrees for 14 of 30 days during the morning shift, and for 14 of 30 days during the evening shift. On 05/30/24 at 4:28 PM, the Kitchen Manager verified temperatures of the resident refrigerators and freezers on the [nursing] unit, and on the [behavioral] unit, were monitored by the kitchen workers. She also stated whenever the larger resident refrigerators were out of temperature range, the maintenance supervisor was notified. On 05/30/24 at 05:12 PM, the Maintenance Supervisor stated, If I am notified that the temperatures are not in compliance, I will adjust the thermostat to see if that works first. If it doesn't, we will buy a replacement fridge as that is easier to do than to repair the fridge. I do not recall being notified this month [May] that there was an issue with the larger resident fridges. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Desert View	820 Sprague Avenue Buhl, ID 83316

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. The FDA Food Code Section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking, documented (A) (1) The day the original container is opened in the food establishment shall be counted as Day 1, and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. (D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (3) 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 as specified under (B) of this section. During a kitchen tour on 5/30/24 at 3:15 PM, the following observation was made: - In the chest freezer, an open bag of peas and carrots were observed without a use by or receipt date. - Multiple opened ice cream containers did not have use by or receipt dates on them. On 5/30/24 at 3:59 PM, the Kitchen Manager stated, When the food vendor delivers packaged foods, the packages can get wet and will not hold a written sharpie date . [a kitchen aide] worked last Tuesday and forgot to put the dates on the food in the chest freezer. 4. The FDA Food Code Section 4-301.14 Ventilation Hood Systems, Adequacy, documented if a ventilation system is inadequate, grease and condensate may build up on the floors, walls and ceilings of the food establishment, causing an unsanitary condition and possible deterioration of the surfaces of walls and ceilings. The accumulation of grease and condensate may contaminate food and food-contact surfaces as well as present a possible fire hazard. During a kitchen tour on 5/28/24 at 11:45 AM, the following observations were made: - Dust-covered residue was seen on the hood above the stove and the oven. - An accumulation of dust was observed hanging from the supporting chains of the ventilation hood. On 5/30/24, the cleaning schedules were provided by the facility. The schedules documented the hood was to be cleaned once per week. The schedules reviewed for May 2024, documented the hood was not cleaned from 5/1/24 through 5/29/24. On 5/30/24 at 3:15 PM, the Kitchen Manager confirmed that of the two full-time kitchen workers, herself included, had physical limitations and were not able to clean the kitchen surfaces well due to their limitations. 5. The FDA Food Code Section 4-602.13 documented nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. During a kitchen tour on 5/28/24 at 11:45 AM, the following observations were made: - Food debris was observed on the top left corner of the dishwashing machine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- The gas stovetop was observed to have food debris around the burners. - A dark-colored buildup of food residue was observed on the metal burner grates. - Dust-covered residue was seen on the hood above the stove and the oven. - An accumulation of dust was observed hanging from the supporting chains of the ventilation hood. - Dust-covered food particles and a sticky residue, was observed on the shelf below the steam table which stored the clean steam table pans. - Dark-colored residue was seen along the edge of the floor and wall coving near the kitchen stove. - A discolored, dried substance was observed running down the wall of the kitchen near the hand washing sink. - A dark-colored residue was seen running down two walls inside of the walk-in refrigerator, near the seams where the wall and ceiling met. - The ridge above the food preparation sink was observed with a thick dust-covered residue where two uncovered kitchen knives and a knife sharpener tool were stored. On 5/30/24, the cleaning schedules were provided by the facility. The schedules documented: - The grill and the walls behind the preparation areas were to be cleaned daily. - The walk-in was to be cleaned daily on both shifts. - The hood, dish machine, pantry, and refrigerators were to be cleaned once per week. The schedules reviewed for May 2024, documented: - The grill was cleaned daily except on 5/10/24. - The hood was not cleaned from 5/1/24 through 5/29/24. - The walls behind the food preparation area were cleaned daily except on 5/10/24. - The pantry was not cleaned the week of 5/19/24 through 5/25/24. - The refrigerators were not cleaned between 5/1/24 and 5/29/24. On 5/30/24 at 3:15 PM, the Kitchen Manager confirmed that of the two full-time kitchen workers, herself included, had physical limitations and were not able to clean the kitchen surfaces well, like the walls and floors, due to their limitations. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. The FDA Food Code Section 6-202.15 Outer Openings, Protected, documented (A) Except as specified in (B), (C), and (E) and under (D) of this section, outer openings of a food establishment shall be protected against the entry of insects and rodents by: (1) Filling or closing holes and other gaps along floors, walls, and ceilings; (2) Closed, tight-fitting windows; and (3) Solid, self-closing, tight-fitting doors. On 5/30/24 at 3:15 PM, it was observed that the back delivery door was open, and the automatic-closing outerdoor, with a screened portion, was closed. The screen was observed to be ripped and loose. The bottom left door guard was broken, leaving a gap approximately 4 inches wide, and 1 inch high. On 5/30/24 at 3:50 PM, the Kitchen Manager stated, The [screen] door was messed up during Tuesday's delivery. The automatic closure was just fixed this week from the damage received last month, but the screen and bottom [door guard] were not replaced.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. These failures had the potential to impact 1 of 1 resident (Resident #38) reviewed for catheter care, by placing him at risk for cross-contamination and infection. Findings include: The facility Catheter Care, Urinary policy, revised February 2024, directed staff to be sure the catheter tubing and drainage bag are kept off the floor. Resident #38 was admitted to the facility on [DATE], with multiple diagnoses including multiple sclerosis (a chronic disease of the central nervous system) and adult failure to thrive (general decline in health in older adults). On 5/28/24 at 11:38 AM, Resident #38 was observed lying in his bed and his foley catheter (a semi-flexible plastic tube inserted into the bladder and the other end is attached to a bag that collects urine--used when a person cannot urinate normally) drainage bag was lying on the floor next to his bed. On 5/30/24 at 2:35 PM, the DON stated Resident #38's foley catheter drainage bag should not be placed on the floor and it should be in a bag attached to the side of the bed.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40733 Based on record review and staff interview, it was determined the facility failed to ensure residents were offered the pneumococcal vaccine. This was true for 1 of 5 residents (Resident #20) whose records were reviewed for pneumococcal vaccinations. This failure created the potential for residents to have an increased risk of pneumococcal (bacterial) pneumonia and the potential for severe illness or death. Findings include: The Centers for Disease Control and Prevention (CDC) website, dated 9/22/23, and accessed on 6/4/24, included recommendations for pneumococcal vaccinations for all adults [AGE] years or older as follows: - If you never received any pneumococcal vaccine, the CDC recommends receiving one dose of PCV20 or PCV15. - If you have previously received PCV13 at any age and PPSV23 at less than [AGE] years of age, the CDC recommends receiving PCV20 at least five years after administration of PCV13 or PPSV23. Resident #20 was admitted to the facility on [DATE], with multiple diagnoses including paranoid schizophrenia, chronic kidney disease (when the kidneys have become damaged over time and have a hard time doing all their important jobs), and dementia. Resident #20's record documented he received the PPSV23 on 6/8/2007 (at age 61), and the PCV13 on 12/20/18. The record noted the vaccinations were given by another medical provider, prior to his admission to the facility. There was no documentation Resident #20 was offered PCV20 after he was admitted . On 5/31/24, at 12:30 PM, the IP was interviewed and Resident #20's record was reviewed in her presence. When asked if Resident #20 was offered the PCV20 or PCV15 vaccine after he was admitted , she replied she was not sure and would have to look into the matter. No further information or documentation was provided to surveyors.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48401 Based on observation, record review, and staff interview, it was determined the facility failed to regularly inspect bed rails to identify areas of possible entrapment. This was true for 2 of 2 residents (#1 and #38) who were reviewed for the use of bed rails. This failure created the potential for injury or harm if a resident was to become trapped by unmonitored equipment. Findings include: The HALO Safety Ring Instructions, undated, included, Regularly check the HALO device to identify areas of possible entrapment, immediately cease using the bed until entrapment risk is fixed. 1. Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including a traumatic brain injury and spastic hemiplegia of his nondominant side (a condition that causes muscle tightness and involuntary contractions in the limbs and extremities on one side of the body), muscle weakness, and a history of falls. On 5/28/24 at 1:00 PM, Resident #1 was observed with an assistive device called a HALO safety ring attached to his bed. On 5/30/24 at 4:48 PM, the Maintenance Supervisor stated he conducted visual inspection of the device, but he was unable to provide documentation of the inspections. 49552 2. Resident #38 was admitted to the facility on [DATE], with multiple diagnoses including multiple sclerosis (a chronic disease of the central nervous system) and adult failure to thrive (general decline in health in older adults). On 5/28/24 at 12:03 PM, Resident #38 was observed lying in his bed with a HALO safety ring installed to the left side of his bed. Resident #38's care plan, initiated 3/15/24, directed staff to assess entrapment risks to ensure proper usage of assistive devices. Resident #38's medical record did not include documentation of an assessment for his HALO safety ring. On 5/30/24 at 4:21 PM, the DON stated the Maintenance Supervisor measured the space between the bed and the HALO safety ring when he installed the HALO safety ring on the bed. There was no documentation in Resident 38's record the HALO safety ring was inspected for entrapment risks. On 5/30/24 at 4:48 PM, the Maintenance Supervisor stated there was no documentation the HALO safety ring was assessed, and he assumed whoever asked for the HALO safety ring to be placed on the bed, did the assessment.

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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** 49552 Based on observation, review of grievance logs, and resident and staff interviews, it was determined the facility failed to ensure all call lights were functioning. This was true for 2 of 2 residents (#7 and #30) reviewed for call lights. This had the potential for harm if residents were unable to summon staff assistance by activating the call light. Findings include: The facility's Call System, Resident policy, dated September 2022, documented residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. 1. Resident #7 was originally admitted to the facility on [DATE], with multiple diagnoses including congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should) and kidney disease. Resident #7's care plan, revised 2/3/24, directed staff to provide a safe environment: call light in reach and answer call light promptly. A quarterly MDS assessment, dated 5/9/24, documented Resident #7 had severe cognitive impairment and required maximum assistance for activities of daily living. On 5/28/24 at 12:46 AM, Resident #7 was observed in his room, sitting in his wheelchair. His call light was observed clipped to itself on the wall, out of Resident #7's reach. A cow bell was observed on a shelf at the foot of Resident #7's bed behind his personal items. On 5/29/24 at 9:22 AM, Resident #7 was observed in his room, sitting in his wheelchair at the foot of his bed. Resident #7 did not have his call light or the cow bell within reach. On 5/29/24 at 9:24 AM, Resident #7 stated if he needed help, he would ask his roommate (Resident #38) to use his own cell phone to call the facility to help him. Resident #38's cell phone was observed on top of a dresser, out of his reach. On 5/29/24 at 9:53 AM, LPN #1 stated the staff makes rounds to Resident #7's room every 15 minutes and Resident #38 had a cell phone to call the facility for help. 2. Resident #38 was admitted to the facility on [DATE], with multiple diagnoses including multiple sclerosis (a chronic disease of the central nervous system) and adult failure to thrive (general decline in health in older adults). Resident #38's care plan, revised 3/15/24, documented he required extensive assistance with repositioning, transfers, and dressing. His care plan also documented Resident #38 was at low/moderate risks for falls and directed staff to answer call lights promptly. Resident #38 filed a Grievance/Complaint Report, dated 5/7/24, stating his call light in his room was not working. The Grievance/Complaint Report follow-up, dated 5/8/24, documented a bell was given to both residents to use to call for help if needed. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly MDS assessment, dated 5/16/24, documented Resident #38 was cognitively intact. On 5/28/24 at 12:03 PM, Resident #38 was observed lying in his bed with his call light attached to itself on the wall, out of Resident #38's reach. On 5/28/24 at 12:11 PM, Resident #38 stated it did not matter that he could not reach his call light, it did not work, and it had not worked for several weeks. Resident #38 also stated he was given a cow bell to use to call for help but due to his MS (multiple sclerosis) he was having difficulty shaking it hard enough to make a loud sound that could be heard outside his room for staff to hear. On 5/29/24 at 8:29 AM, the Maintenance Supervisor stated one company had come out to check out the call light system on 5/13/24, but could not fix it and tried selling him a new system. On 5/31/24 at 10:54 AM, the Administrator stated, on 5/7/24, a grievance was filled out and that is when she found out Resident #7's and Resident #38's call lights were not working and they were offered to move to another room and safety checks were put in place. The Administrator stated the Social Services Supervisor made Resident #7's family aware of the malfunctioning call light and the family told the Social Service Supervisor they did not want Resident #7 moved. The Administrator was unable to provide documentation that Resident #7's family was aware of the call light not working or their refusal for a room change. The Administrator stated the conversation with Resident #7's family should have been documented in his record.