| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135090 | A. Building<br>B. Wing | 03/07/2025 |

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| Shaw Mountain of Cascadia | 909 Reserve Street<br>Boise, ID 83712 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>50983<br><br>Based on observation, review of the State Operations Manual, policy review, and staff interviews, the facility failed to treat residents with respect and dignity during dining operations. This failed practice had the potential to negatively affect resident's self-esteem, decreased enjoyment of meals and mealtime, and may negatively impact resident's food and fluid intake. Findings include:<br><br>State Operations Manual, Appendix PP, updated 8/8/24, documented to promote independence and dignity while dining, avoid standing over residents while assisting them to eat.<br><br>The facility policy, Dining Standards, updated 9/10/20, documented staff are to sit down next to the resident while feeding and/or assisting with feeding.<br><br>On 3/3/25 at 8:37 AM, CNA #5 was observed standing next to the dining room table, spoon feeding 2 of 5 residents seated at the table eating their breakfast.<br><br>On 3/3/25 at 8:45 AM, LPN #2 stated staff should not be standing over the residents when assisting with feeding.<br><br>03/06/25 at 10:00 AM, the DON stated staff should not be standing while feeding residents. |

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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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121<br><br>Based on 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 Advance Directive. This was true for 2 of 24 Residents (#18 and #30) whose records were reviewed for Advance Directives. This deficient practice created the potential for harm or adverse outcomes if the residents' wishes were not followed or documented regarding their advance care planning. Findings include:<br><br>1) Resident #18 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including Parkinson's disease with dyskinesia (a condition where someone with Parkinson's disease experiences involuntary, uncontrolled movements) and dementia.<br><br>Resident #18's medical record had not contained a copy of his Advance Directives.<br><br>Resident #18's admission agreement document which contains the following wording By signing below, I acknowledge that I am legally bound by this Agreement and I indicate that I have: been offered information regarding Advance Directives was not signed by the resident or resident representatives.<br><br>Resident #18's Social Services Progress note dated 2/19/25, documented social services will request DPOA, Power of Attorney, and Living Will from the family.<br><br>Resident #18's Multidisciplinary Care Conference dated 2/20/25, documented under Key Reviews 4b. Does the resident have an advance directive: YES, 4c. Does the facility have a copy of the resident's advanced directives on file? YES.<br><br>On 3/7/25 at 9:45 AM, the Administrator stated the Social Services Director incorrectly checked the YES 4b. box and facility had not obtained a copy of the Resident #18's Advance Directives.<br><br>2) Resident #30 was admitted to the facility on [DATE], with multiple diagnoses including pulmonary embolism (a condition where a blood clot (embolus) travels from another part of the body, usually the legs (deep vein thrombosis), and blocks an artery in the lungs) and acute respiratory failure with hypoxia (occurs when the lungs are unable to exchange oxygen and carbon dioxide properly, resulting in low oxygen levels in the blood).<br><br>Resident #30's medical record had not contained a copy of his Advance Directives.<br><br>Resident #30's admission agreement document which contains the following wording By signing below, I acknowledge that I am legally bound by this Agreement and I indicate that I have: been offered information regarding Advance Directives was not signed by resident or resident representatives.<br><br>Resident #30's Multidisciplinary Care Conference dated 1/6/25, documented under Key Reviews 4b. Does the resident have an advance directive: YES, 4c. Does the facility have a copy of the resident's advanced directives on file? YES.<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #30's Social Services Progress note dated 2/18/25, documented Social Services Director will request DPOA, Power of Attorney, and Living Will from the family.<br><br>On 3/7/25 at 9:45 AM, the Administrator stated the Social Services Director incorrectly checked the YES 4b. box and facility had not obtained a copy of the Resident #30's Advance Directives. |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121<br><br>Based on record review and staff interview, it was determined the facility failed to provide the Notice of Medicare Non-Coverage (NOMNC) form CMS-10123 at least 2 days prior to discharge for 1 of 3 residents (Resident #302) reviewed for beneficiary protection notification. This deficient practice had the potential to cause financial harm or distress for residents when they were not informed of their potential liability for payment when their Medicare Part A benefits ended. Findings include:<br><br>Resident #302 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including post-traumatic stress disorder (a mental health condition that can develop after experiencing or witnessing a traumatic event) and cirrhosis (a condition in which your liver is scarred and permanently damaged).<br><br>Resident #302 was discharged from Medicare Part A 12/16/24, and the NOMNC was signed on 12/16/24.<br><br>On 3/7/25 at 9:45 AM, the Administrator stated Resident #302's NOMNC had not been completed at least 2 days prior to Medicare Part A ending as required. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552<br><br>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure resident's care plans were revised to reflect current needs and interventions. This was true for 1 of 24 residents (Resident #52) whose care plans were reviewed. This placed residents at risk for adverse outcomes if care and services were not provided due to care plans not being revised as resident's needs changed. Findings include:<br><br>The facility's Comprehensive Care Plans policy, revision date 10/15/22, documented the team of qualified persons monitors the resident's condition and effectiveness of the care plan interventions and revises the care plan annually, with a significant change assessment, or more frequently as needed.<br><br>Resident #52 was admitted to the facility on [DATE], with multiple diagnoses which include dementia and weakness.<br><br>Resident #52's medical recorded documented that she fell out of bed on 12/7/24.<br><br>Resident 52's care plan was not updated with new fall interventions.<br><br>On 3/5/25 at 3:45 PM, the DON stated the Fall Investigation report documented the new fall intervention was for Resident #52's bed to be in the lowest position. The DON stated her care plan was not updated with this new fall prevention intervention, and it should have been. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552<br><br>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure adequate care and treatment was provided to 1 of 1 resident (Resident #21) reviewed for feeding tube use. This created the potential for harm if complications developed from improper tube feeding practice. Finding include:<br><br>The facility's Enteral Nutrition policy, revised 10/30/18, directed staff to verify tube placement by gently tugging on the tube and taking note of the marking on the tube. The policy also directed staff to properly label and date the enteral formula bottle.<br><br>Resident #21 was admitted to the facility on [DATE], with multiple diagnoses including Spastic Diplegic Cerebral Palsy (a neurological disorder that affects movement and causes overly toned muscles) and anxiety.<br><br>Resident #21's Physician's order dated 11/15/24, documented enteral feed every shift. For enteral nutrition precautions check feeding tube placement by observing change in the external length 4cm's marked at entry point before administering formula, medication administration, or flushing of tube.<br><br>On 3/5/25 at 7:08 AM, observed LPN #1 check Resident #21's feeding tube placement by using a 60cc syringe, a stethoscope, and pushing 10cc of air into Resident #21's feeding tube while auscultating her abdomen.<br><br>Resident #21's Physician's order dated 1/1/25, documented she was to receive Jevity 1.2 at 85 ML/HOUR for 12 hours.<br><br>On 3/5/25 at 7:08 AM, observed in Resident #21's room a bottle of Jevity 1.2 (a type of feeding formula that provides complete, balanced nutrition). The bottle of Jevity 1.2 was not labeled with resident's name, start date, time, and rate of feeding to be delivered per hour.<br><br>On 3/5/25 at 7:27 AM, LPN #1 stated Resident #21 received the feeding on the night shift, the bottle of Jevity 1.2 should have been labeled and the feeding pole should have been cleaned daily or when there was a spill.<br><br>On 3/5/25 at 2:04 PM, the DON stated Resident #21's Jevity 1.2 bottle should have been labeled when it was started and the feeding pole should have been cleaned. |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552<br><br>Based on personnel record review, resident record review, and staff interview it was determined the facility failed to ensure employees had completed the required annual trainings and competencies necessary to care for resident's needs. This was true for 1 of 5 employees whose training information was reviewed and 1 of 1 resident (Resident #32) medical records reviewed. This failure had the potential to affect all residents in the facility and increased the risk of harm to residents if staff were not trained on how to provide care and services to residents. Findings include:<br><br>1) RN #2's hire date was 5/29/21. Review of his personnel file did not document he had completed his dementia and communication training.<br><br>RN #2's personnel file documented a Statement of Discussion dated 1/2/25, regarding the need to complete assigned training.<br><br>On 3/7/25 at 10:00 AM, the DON stated RN #2 had not completed his training.<br><br>2) Resident #32 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (a group of lung diseases that cause ongoing inflammation and damage to the airways and air sacs in the lungs, leading to breathing difficulties) and depression.<br><br>On 3/4/25 at 8:22 AM, Resident #32 was not wearing her oxygen cannula during this visit and stated she wears the oxygen when she needs it.<br><br>Resident #32's physician oxygen order dated 10/1/24, documented oxygen at 2 to 3 liters per minute to keep oxygen saturations (SpO2) greater than 90% continuously via nasal cannula with humidification. Check Q4 hours.<br><br>Resident #32's oxygen SpO2 was checked on the following dates and times;<br><br>- 10/6/24 20:20 SpO2 86% room air (R/A) by CNA #1<br><br>- 11/10/24 10:16 SpO2 90% R/A by CNA #3<br><br>- 11/18/24 03:22 SpO2 82% R/A by LPN #4<br><br>- 11/25/24 09:06 SpO2 87% with oxygen by LPN #5<br><br>- 12/3/24 05:35 SpO2 87% with oxygen by CNA #4<br><br>- 1/24/25 08:05 SpO2 3% with oxygen by LPN #6<br><br>- 2/26/25 05:00 SpO2 85% R/A by LPN #7<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - 2/27/25 01:42 SpO2 88% R/A by LPN #4<br><br>- 2/27/25 05:29 SpO2 291% with oxygen by LPN #4<br><br>- 3/4/25 19:32 SpO2 89% R/A by RN #3<br><br>Resident #32 medical record had not contained nursing progress notes documenting nursing staff addressed the low O2 levels or that Resident #32 was not on her oxygen per physician's orders.<br><br>On 3/7/25 at 8:47 AM, the DON stated the oxygen SpO2 desaturations should have been addressed by nursing staff and was not.<br><br>51121 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>49552<br><br>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure controlled medications were tracked and kept secure from potential theft and/or diversion. This was true for 1 of 3 medication carts reviewed. This failure created the potential for undetected misuse and/or diversion of controlled medications and had the potential to affect all residents who received controlled medication in the facility. Findings include:<br><br>The facility's Controlled Substance Administration & Accountability policy dated 12/16/24, documented it is the policy of the facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place to prevent loss, diversion, or accidental exposure.<br><br>On 3/5/25 at 12:41 PM, during hall 300's medication cart audit, observed the narcotic accountability record, dated 11/22/24 to 12/3/24, with 16 licensed nurse signatures for each shift not documented. Review of the narcotic accountability record, dated 2/9/25 to 3/5/25, with 2 licensed nurse signatures for each shift not documented.<br><br>On 3/5/25 at 12:33 PM, RN #1 stated the nurses should have signed the narcotic accountability sheet when they accepted the medication cart or released the medication cart. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552<br><br>Based on observation, policy review, and staff interview, it was determined the facility failed to ensure the medication error rate was less than 5%. This was true for 3 medications (8.82%) which affected 1 of 6 residents (Resident #58) whose medication administration were observed. This failed practice placed residents at risk of not receiving their prescribed medication or dosage of their medication. Findings include:<br><br>The facility's Oral Medication Administration policy dated 1/1/18, documented oral medications are to be administered per physician orders.<br><br>The facility's Eye Drop Administration policy dated 2/28/18, documented wait a sufficient contact time of approximately 3-5 minutes before applying additional medication to the eye.<br><br>The facility's Insulin Pen Use policy undated, documented before administering insulin, a 2-unit air shot must be performed to remove air bubbles and ensure accurate dosing.<br><br>The following was observed during the medication pass:<br><br>1. Resident #58 was admitted [DATE], with multiple diagnoses including kidney disease and right leg, below the knee, amputation.<br><br>Resident #58's physician order documented Glargine insulin, administer 10 Units subcutaneously.<br><br>On 3/5/25 at 7:35 AM, observed RN #1 remove Glargine insulin pen from the medication cart and dial the insulin pen to 10 Units. RN #1 did not prime the insulin pen before dialing the ordered dose. RN #1 then administered the Glargine insulin to Resident #58.<br><br>On 3/5/25 at 7:39 AM, RN #1 stated she did not realize she needed to prime the insulin pen before dialing the insulin pen to the ordered dose.<br><br>Resident #58's physician order documented Dorzolamide (eye drops used to treat increased pressure in the eye) 22.3-6.8mg/ml 1 drop to her left eye and Rednisol acetate (steroidal eye drop used to treat redness and swelling) 1 %, give 1 drop left eye.<br><br>On 3/5/25 at 7:40 AM, observed RN #1 administer both of Resident 58's ordered eye drops. RN #1 did not wait the required 3-5 minutes in between eye drop administration.<br><br>On 3/5/25 at 7:46 AM, RN #1 stated she should have waited 3-5 minutes before she gave the second ordered eye drops. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>49552<br><br>Based on observation, CDC guidelines review, and staff interview, it was determined the facility failed to ensure medications available for residents were labeled, dated, and stored appropriately. This was true for 1 of 1 medication storage rooms inspected and 3 of 5 medication carts audited for labeling and storage of medication. This failure created the potential for residents to have missed doses of medication and to receive expired medications with decreased efficacy. Findings include:<br><br>The CDC guidelines for Preventing Unsafe Injection Practices dated 3/26/24, documented once a multi-dose vial is opened (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer states another date for that opened vial. The beyond-use-date should never exceed the manufacturer's original expiration date.<br><br>On 3/5/25 at 10:45 AM, the Hall 100 medication cart was audited with RN #4 present. In the top drawer of the medication cart a dairy digestive tablet was observed with an expiration date of July 2024.<br><br>On 3/5/25 at 10:47 AM, RN #4 stated the dairy digestive tablet should not have been in the medication cart.<br><br>On 3/5/25 at 12:33 PM, the medication storage room audit was done with LPN #8 present. Observed in the medication storage room a bottle with 12 Calcium tablets with an expiration date of October 2023.<br><br>On 3/5/25 at 12:36 PM, LPN #8 stated the expired medication should have been in the medication destruction tote.<br><br>On 3/5/25 at 12:41 PM, the Hall 300 medication cart was audited with RN #1 present. Observed in the second drawer, under blister packs, one loose Losartan tablet.<br><br>On 3/5/25 at 12:45 PM, RN #1 stated that the loose pills should have been placed in the drug buster (drug disposal system).<br><br>On 3/5/25 at 12:48 PM, the Friendship house medication cart was audited with LPN #3 present. The following was observed:<br><br>- In the bottom of the second drawer on the left, one Remeron (antidepressant) tablet.<br><br>- In the bottom of the third drawer, three yellow pills and three white pills.<br><br>- Also in the third drawer one multi-dose vial of Lidocaine with no open date.<br><br>On 3/5/25 at 12:54 PM, LPN #3 stated the loose pills should have been destroyed and the bottle of Lidocaine should have been dated when it was opened. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983<br><br>Based on observation, review of the State Operations Manual, policy review, and staff interview, it was determined the facility failed to ensure infection control and prevention practices were maintained when 1) staff was assisting residents with meals and 2) medication administration, and 3) unsanitary conditions in the laundry room. This failure had the potential to impact all residents in the facility by placing them at risk for cross contamination and infection. Findings include:<br><br>The State Operations Manual, Appendix PP, updated 8/8/24, documented failure to change gloves and wash hands between tasks, such as medical treatments or contact with residents .can contribute to cross-contamination.<br><br>The facility policy, Dining Standards, updated 9/10/20, documented staff was to complete hand hygiene using soap and water at the beginning of meal service and are to sanitize hands when changing tasks or assisting different residents.<br><br>The following issue were observed in the dining room;<br><br>On 3/3/25 at 8:37 AM, CNA #5 was observed alternating between 2 of 5 residents sitting at the same table, offering spoon feeding assistance using the same gloved hand. CNA #5 did not change gloves, wash hands, or hand sanitize in between feeding each resident.<br><br>On 3/3/25 at 8:45 AM, CNA #5 grabbed a folding chair located behind her to sit in. CNA #5 did not change her gloves, wash hands, or hand sanitize before continuing to feed the 2 residents.<br><br>On 3/6/25 at 10:00 AM, the DON stated when staff is feeding more than one resident, they should have a designated hand for each resident or hand sanitize in between each resident assist.<br><br>The following was observed for medication administration;<br><br>Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including heart failure and anxiety.<br><br>Resident #3's physician order dated 1/17/24, documented Buprenorphine HCl Sublingual Tablet Sublingual 2 MG (Buprenorphine HCl). Give 1 tablet sublingually one time a day for pain.<br><br>On 3/5/25 at 7:50 AM, observed RN #1 place a Buprenorphine HCl tablet in her bare hand then place it in Resident #3's medication cup. RN #1 then administered the pill to Resident #3.<br><br>On 3/5/25 at 7:54 AM, RN #1 stated she should not have touched Resident #3's pill with her bare hand.<br><br>Resident #21 was admitted to the facility on [DATE], with multiple diagnoses including Spastic Diplegic Cerebral Palsy (a neurological disorder that affects movement and causes overly toned muscles) and anxiety.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135090 | A. Building<br>B. Wing | 03/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Shaw Mountain of Cascadia | 909 Reserve Street<br>Boise, ID 83712 |

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

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Resident #21's Physicians order dated 11/15/24, documented enteral feed every shift. For enteral nutrition precautions check feeding tube placement by observing change in the external length 4cm's marked at entry point before administering formula, medication administration, or flushing of tube.<br><br>On 3/5/25 at 7:08 AM, observed in Resident #21's room a feeding pole and pump with a dried light brown substance on the pump and on the base of the pole.<br><br>On 3/5/25 at 7:08 AM, the following was observed when LPN #1 was flushing Resident #21's feeding tube;<br><br>- LPN #1 placed the 60cc syringe on Resident #21's bed while she put her stethoscope on.<br><br>- LPN #1 connected the 60cc syringe to the feeding tube.<br><br>- LPN #1 removed the plunger from the 60cc syringe and placed it on Resident #21's bed.<br><br>- LPN #1 poured the crushed medication with liquid into the 60cc syringe barrel.<br><br>- LPN #1 picked the syringe plunger up off the bed and inserted it back into the 60cc syringe which was still connected to Resident #21's feeding tube.<br><br>On 3/5/25 at 7:27 AM, LPN #1 stated Resident #21's feeding pole and pump should have been cleaned daily or when there was a spill.<br><br>On 3/5/25 at 11:07 AM, the DON stated LPN #1 should have placed her tube feeding supplies on a protective cover on top of Resident #21's bedside table, not on her bed.<br><br>On 3/5/25 at 7:35 AM, observed Hall 300 medication cart with RN #1's personal drink on top of the cart.<br><br>On 3/5/25 at 7:41 AM, RN #1 stated she should not have had her personal food or drinks on the medication cart.<br><br>The following was observed in the laundry room;<br><br>On 3/6/25 at 3:41 PM, observed the following in the laundry room:<br><br>- a large amount of water, with a dark green substance on it, in front of the washing machine.<br><br>- a thick layer of fuzzy gray substance under hand washing sink.<br><br>- no goggles available in laundry room, in case of splashing.<br><br>- the pipes between washers observed with a thick layer of gray, fuzzy substance.<br><br>- the pipes behind dryer observed with thick layer of gray, fuzzy substance.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | - the ceiling piping cover above the clean linen folding table was observed with a thick layer of fuzzy gray substance.<br><br>- two outside wall vents were observed with a thick fuzzy substance.<br><br>On 3/6/25 at 3:47 PM, the Laundry Manager stated the laundry room is cleaned daily but there was no check off sheet to direct the staff on what needed to be cleaned.<br><br>On 3/7/25 at 9:38 AM, the Administrator stated the laundry room should have been kept clean.<br><br>49552 |