STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Nursing & Rehabilitation	1140 North Allumbaugh Street Boise, ID 83704

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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 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** 36193 Based on observation, and resident and staff interview, it was determined the facility failed to maintain or enhance residents' dignity during dining when residents seated at the same table were served their meals at different times. This was true for 1 of 2 residents (Resident #5) observed during dining in the facility. This failure had the potential to cause a decrease in resident's sense of self worth and psychosocial wellbeing. Findings include: Resident #5 was admitted to the facility on [DATE], with multiple diagnoses including anxiety, depression, and paraplegia (paralysis of the legs and lower body, typically caused by spinal cord injury). On 6/24/24 at 12:30 PM, Resident #5 and Resident #23 were seated across from each other at a table in the main dining room. Resident #23 was served her meal and started eating. Resident #5 did not receive his meal tray. He was quiet as he observed Resident #23 while she ate her meal. Resident #5 was also observed looking at the other residents seated at the table next to his table while they ate their meals. At times Resident #5 was observed looking around the dining room. On 6/24/24 at 12:46 PM, Resident #5's lunch tray was served, and he started eating. Resident #23 was almost done eating. Resident #5's lunch tray was delivered 16 minutes after Resident #23's tray was delivered to her. On 6/24/24 at 12:50 PM, the IP stated residents seated at the same table should be served their meals at the same time. The IP stated Resident #5 and Resident #23 were not served their meals at the same time. On 6/24/24 at 12:53 PM, the Dietary Aide stated the residents' meal cards should have been organized according to the residents seated at the same table. On 6/24/24 2:19 PM, Resident #5 stated his meal tray was sometimes delivered late but not often.

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 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 6 of 16 residents (#12, #24, #42, #50, #54, and #55) 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 State Operations Manual, Appendix PP, defined an advance directive as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. Physician Orders for Life-Sustaining Treatment (or POLST [POST]) paradigm form is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST [POST] paradigm form is not an advance directive. The facility's Residents' Rights Regarding Treatment and Advanced Directives policy, revised September 2022, documented upon admission, the facility will determine if the resident has executed a living will, a power of attorney for health care, or any other advance 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 residents' 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 #12 was admitted to the facility on [DATE], with multiple diagnoses including end-stage renal disease (the stage of renal impairment that appears irreversible and permanent, requiring a regular course of dialysis or kidney transplantation to maintain life), and type 2 diabetes. Resident #12's record did not include an advanced directive or documentation an advance directive was discussed with him or his representative. b. Resident #24 was admitted to the facility on [DATE], with multiple diagnoses including quadriplegia (an injury to the spinal cord of the neck that can cause paralysis affecting all a person's limbs and body from the neck down), calculus of kidney (also known as kidney stones that are hard deposits made of minerals and salts that form inside your kidneys), and history of traumatic brain injury. Resident #24's record did not include an advance directive or documentation an advance directive was discussed with her or her representative. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Resident #50 was admitted to the facility on [DATE], with multiple diagnoses including hypo-osmolality and hyponatremia (a condition produced by the retention of water, by loss of sodium or both), and decreased white blood cell count. Resident #50's record did not include an advance directive or documentation an advance directive was discussed with him or his representative. d. Resident #55 was admitted to the facility on [DATE], with multiple diagnoses including nondisplaced fracture of lateral end of left clavicle, acute respiratory failure with hypoxia (a condition where there is not enough oxygen in the tissues of the body), and type 2 diabetes mellitus with diabetic chronic kidney disease. Resident #55's record did not include an advance directive or documentation an advance directive was discussed with him or his representative. 49552 e. Resident #42 was admitted to the facility on [DATE], with multiple diagnoses including respiratory failure and liver disease. Resident #42's record did not include an advance directive or documentation information about an advance directive was provided and discussed with him or his representative. Resident #42's care plan, dated 6/13/22, documented staff would review his healthcare directives with him at least quarterly to verify his wishes had not changed. The care plan also documented the facility would place his Advance Directive in his medical record. f. Resident #54 was initially admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including fractured left femur (upper leg bone) and stroke. Resident #54's record did not include an advance directive or documentation information about an advance directive was provided and discussed with her or her representative. Resident #54's care plan, dated 11/21/23, documented staff would review her healthcare directives with her at least quarterly to verify her wishes had not changed. A Care Conference evaluation, dated 11/20/23, did not include documentation Resident #54's advance directive were discussed. A Care Conference evaluation, dated 2/29/24, documented Resident 54's advance directive was reviewed and there were no changes. On 6/26/24 at 3:11 PM, the SW stated the POST form, section C, was the resident's advance directive because it stated the residents wishes. On 6/26/24 at 3:36 PM, the SW stated the facilities advance directive policy was readdressed annually but she tried to review it with the resident or family quarterly. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/24 at 4:22 PM, the SW Resident #54 did not have an advance directive or documentation of offering to assist formulate an advance directive.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on record review and resident and staff interview, it was determined the facility failed to ensure the physician was notified of resident weight changes as ordered. This was true for 2 of 6 residents (#12 and #48) reviewed for timely physician notification. This placed Resident #12 and Resident #48 at risk of experiencing complications related to unexpected weight changes. Findings include: 1. Resident #12 was admitted to the facility on [DATE], with multiple diagnoses including end-stage renal disease (the stage of renal impairment that appears irreversible and permanent, requiring a regular course of dialysis or kidney transplantation to maintain life), and type 2 diabetes mellitus. A physician's order, dated 4/1/22, stated to obtain Resident #12's weight every dayshift for CHF, notify MD if weight gain greater than 2-3 pounds in 24 hours or 5 pounds in one week. Resident #12's treatment administration record (TAR) documented his weights were not taken or recorded for the following dates: 4/2/24, 4/4/24, 4/13/24, 4/20, 4/29 5/3/24, 5/4/24, 5/15/24, 5/30 6/24/24 Resident #12's TAR documented the following weight gains for Resident #12 which exceeded the parameters on his physician's order: 4.8 lbs between 4/11/24 and 4/12/24. 4.2 lbs between 4/18/24 and 4/13/24. 5.1 lbs between 4/25/24 and 4/26/24. 3 lbs between 4/26/24 and 4/27/24. 2.6 lbs between 5/9/24 and 5/10/24. 3.3 lbs between 5/12/24 and 5/13/24. 6.5 lbs between 5/17/24 and 5/18/24. 2.8 lbs between 5/19/24 and 5/20/24. 2.9 lbs between 5/22/24 and 5/23/24. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4.6 lbs between 5/25/24 and 5/26/24. 3.1 lbs between 5/27/24 and 5/28/24. 2.3 lbs between 5/28/24 and 5/29/24. 6.3 lbs between 5/22/24 and 5/28/24. 9.4 lbs between 6/1/24 and 6/2/24. 2.9 lbs between 6/3/24 and 6/4/24. 6.8 lbs between 6/1/24 and 6/7/24. 6.6 lbs between 6/8/24 and 6/14/24. 5.5 lbs between 6/20/24 and 6/27/24. 3.2 lbs between 6/26/24 and 6/27/24. Resident #12's record did not include documentation the physician was notified of his weight changes as ordered. On 6/28/24 at 1:40 PM, the DON confirmed all communication with physicians should be recorded in residents' progress notes. When asked if Resident #12's physician was notified of his weight gains, the DON stated they were not available. 2. Resident #48 was admitted to the facility on [DATE], with multiple diagnoses including viral encephalitis (an inflammation of the brain caused by a virus), encephalopathy (a group of conditions that cause brain dysfunction), acute and chronic respiratory failure with hypoxia (a condition where there is a lack of oxygen in the tissues of the body), type 2 diabetes mellitus. A physician's order, dated 5/16/24, stated to obtain Resident #48's weight every dayshift for CHF, notify MD if weight gain greater than 2-3 pounds in 24 hours or 5 pounds in one week. Resident #48's treatment administration record (TAR) documented weights were not taken or recorded for the following dates: 5/20/24, 5/25/24, 5/27/24, 5/28/24 6/10/24, 6/11/24 Of the weights that were taken, there was no notification to the physician on multiple dates when Resident #48's weight exceeded the parameters on the physician's order: 21.1 lbs between 5/16/24 and 5/22/24. 7.2 lbs between 5/23/24 and 5/24/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	13.9 lbs between 5/23/24 and 5/29/24. 3.9 lbs between 6/5/24 and 6/6/24. 5.6 lbs between 6/8/24 and 6/14/24. 3.5 lbs between 6/12/24 and 6/13/24. 4.4 lbs between 6/18/24 and 6/19/24. 2.8 lbs between 6/21/24 and 6/22/24. 3.7 lbs between 6/24/24 and 6/25/24. 3.7 lbs between 6/26/24 and 6/27/24. Resident #48's record did not include documentation the physician was notified of her weight changes as ordered. On 6/28/24 at 1:45 PM, the DON confirmed all communication with physicians should be recorded in residents' progress notes. When asked if Resident #48's physician was notified of his weight gains, the DON stated they were not available.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49552 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with a safe, clean, homelike environment. This was true for all 63 residents who resided in the facility whose environment was observed. This deficient practice created the potential for harm if: a) residents were embarrassed by dirty equipment and/or felt the lack of cleanliness in the facility was unacceptable, disrespectful, or undignified, and b) cross-contamination from spread of microorganisms. Findings include: The facility's Cleaning and Disinfection of Resident-Care Items and Equipment policy, revised September 2022, documented resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Centers for Disease Control and Prevention) recommendations for disinfection and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogens Standard. The following was observed: - On 6/24/24 at 2:33 PM, the stand aide (a lifting device used to assist residents who have difficulty rising from a seated position to standing) on the 200-hall had dried food crumbs on the base of the machine. The right seat base had a dry brown substance. - On 6/26/24 at 2:06 PM, the 100-hall ice chest stand had an empty straw wrapper and a layer of a light gray substance on it. - On 6/26/24 at 2:11 PM, the vital sign machine on the 100-hall had dried liquids and dust on the base. - On 6/26/24 at 2:15 PM, one Hoyer lift (an assistive device that allows resident to be transferred by the use of electrical power) on the 200-hall had a dried, brown substance on the base. Another Hoyer lift on the 200-hall also had a dried light brown substance on the base. On 6/28/24 at 9:55 AM, the DON stated the transfer equipment was cleaned by the night shift and the vital sign machines were cleaned after each resident use. She also stated there was no list of equipment to be cleaned or check off sheet to show the equipment was cleaned.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 36193 Based on policy review, record review, review of facility grievances, and resident and staff interview, it was determined the facility failed to ensure grievances were investigated and prompt corrective action was taken to resolve them. This was true for 1 of 1 resident (Resident #16) reviewed for grievances. This failure created the potential for psychological harm if residents' grievances were not acted upon. Findings include: The facility's Grievances/Complaints, Filing policy, revised April 2017, documented upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings to the administrator within (5) working days of receiving the grievance and/or complaint. Resident #16 was admitted to the facility 1/3/24, with multiple diagnoses including opioid dependence, anxiety, depression, and morbid obesity. Resident #16's quarterly MDS assessment, dated 4/10/24, documented she was cognitively intact. On 6/25/24 at 2:37 PM, Resident #16 stated that about two weeks ago, while she was watching the television, a nurse came in and placed the medication cup containing her medications on top of her bedside table. Resident #16 stated the bedside table was behind her and when she turned around to pick up the medication cup, she knocked off the medication cup and her medications spilled on the table. Resident #16 stated she picked up her medications one at a time and noticed her oxycodone (narcotic pain medication) was not there. Resident #16 stated she noticed a round purple colored tablet which she said was not an oxycodone. Resident #16 stated she asked her son the following day to look what the round purple medication was and found out it was a thyroid pill. Resident #16 stated she was not prescribed a thyroid pill. When asked if she knew who the nurse was, Resident #16 stated she could not remember who the nurse was. When asked if she reported the incident to the facility, Resident #16 stated I informed [name of nurse] about it. The facility's Grievances file, dated January 2024 through June 2024 were reviewed. There was no grievance report regarding Resident #16's report of her oxycodone not given to her. On 6/26/24 at 2:45 PM, the IP stated she was on duty on 6/12/24, and remembered Resident #16 reported to her that a nurse left her medication cup on her bedside table and when she turned around to pick up her pills, she dropped them on the floor and had to pick up the medication one at a time and noticed the oxycodone was not there. The IP stated Resident #16 asked her son the following day to look what the pill was and found out it was a thyroid medication. The IP stated she reported the incident to the DON the following day. On 6/27/24 at 11:20 AM, during a follow-up interview, the IP stated Resident #16 could not remember the exact date her oxycodone was not administered to her and who the nurse was on duty. The IP stated Resident #16 told her it happened over the weekend, but definitely not on Sunday. The IP stated she wrote a statement about the incident and submitted it to the DON. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24 at 5:07 PM, the DON stated when she and the LSW spoke to Resident #16, Resident #16 could not remember the day/date and who the nurse was on duty when she did not receive her oxycodone. The DON stated she reviewed the Narcotic book and EMR (Electronic Medical Record) and did not find any concern. When asked if other residents were interviewed the week prior to 6/12/24, the DON stated she did not interview other residents. The DON stated she was not exactly sure about the accuracy of what Resident #16 was telling them.

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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, review of the State Agency's Long Term Care Reporting Portal, and staff interview, it was determined the facility failed to ensure residents' rights were protected to be free from sexual abuse. This was true for 1 of 9 residents (Resident #63) reviewed for abuse. Application of the reasonable person concept caused harm to Resident #63 when she was inappropriately touched by Resident #42. Findings include: The Centers for Medicare and Medicaid Services (CMS) Psychosocial Outcome Severity Guide, dated October 2022, states: The following are examples of circumstances in which a resident's psychosocial outcome may not be readily determined through the investigative process and the reasonable person concept should be used: - When a resident may not be able to express their feelings, there is no discernable response, or when circumstances may not permit the direct evaluation of the resident's psychosocial outcome. Such circumstances may include, but are not limited to, the resident's death, cognitive impairments, physical impairments, or insufficient documentation by the facility; or - When a resident's reaction to a deficient practice is markedly incongruent (or different) with the level of reaction a reasonable person in the resident's position would have to the deficient practice. The Guide further states: In addition to the evidence gathered by the surveyor, the use of the reasonable person concept should be applied and may reveal that the resident is likely to, or may potentially, suffer a greater psychosocial outcome. For example, in the case of a sexual assault, the resident did not exhibit a change in behavior as a result of the incident. The facility's Abuse Prevention Policy, revised December 2016, documented residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. - Resident #63 was admitted to the facility on [DATE], with multiple diagnosis including heart failure and dementia. An annual MDS assessment, dated 10/20/23, documented Resident #63 was severely cognitively impaired. - Resident #42 was readmitted to the facility on [DATE], with multiple diagnoses including respiratory failure and liver disease. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A quarterly MDS assessment, dated 9/14/23, documented Resident #42 was moderately cognitively impaired. a. A Facility Reported Investigation, dated 10/1/23 at 9:50 AM, documented There were two staff members sitting at the nurses' station doing some charting. On the other side of the counter [Resident #63] was sitting as she does often. At that time [Resident #42] walked up next to [Resident #63]. The staff at the desk said they were just talking but when another staff member walked up on the same side these two residents were sitting it was noted [Resident #42] was massaging [Resident #63's] breasts on top of her clothes. She was not upset and appeared to be enjoying this. The staff member who saw this separated them and alerted the nurse. Both residents are severely cognitively impaired and unable to make their own choices. The nurse assessment found no injury and no pain reported. {Resident #42] was moved downstairs to separate the two. Families were notified and facility leadership also immediately called. Both residents placed on alert charting and frequent checks. The report conclusion documented after interviews, observation, and record reviews, that Resident #42 thought Resident #63 was his wife because he remembered that she passed away. The report documented Resident #63 was pleasant and seemed to enjoy interactions with Resident #42 and did not protest when his interactions turned inappropriate. The report further documented both residents' cognition was at a level they were not able to make these kinds of decisions. The facility moved Resident #42 to a downstairs room so the residents would have little or no contact. b. A second Facility Reported Investigation, dated 10/6/23 at 4:37 PM, documented [Resident #63 was sitting in the dining room. Staff had placed her there just 10 minutes prior. [Resident 42] somehow came upstairs via the elevator and came into the dining room. No staff member had seen him come into the dining room. At 4:30 AM a CNA came into the dining room right as [Resident #42] was walking away from [Resident #63] at a quick pace. [Resident #63] was saying to him to get out of here. Staff did not see what happened, but it appeared [Resident #63's blouse was disheveled. [Resident #42] was escorted downstairs. [Resident #63] was unable to say if or what had happened. The nurse's assessment showed no bruising, swelling or any injury. Staff were alerted to redirect [Resident #42] to stay downstairs where his room is now located. There have been some staff who have been off and did not realize [Resident #42] had moved downstairs and have directed him up the elevator. All staff working have now been informed and we will ensure all staff will be informed. The report conclusion documented after interviews, observation, and record reviews the facility concluded Resident #42 possibly touched Resident #63 inappropriately. The conclusion documented the incident was not witnessed, but Resident #63 answered Yes to the nurse's question about Resident #42 touching her breast. On 6/27/24 at 11:14 AM, the DON stated Resident #42 did touch Resident #63's breast. When he did it the first time the residents were separated. She stated Resident #63 was assessed and there was no change in her behavior. When she notified Resident #63's daughter what had happened the daughter stated she understood. The DON stated Resident #42's daughter stated the female resident did look like Resident #42's late wife and he forgot that she had passed and had been looking for her, and it was determined by the facility Resident #42 would be moved to the first floor to separate the residents. The DON stated Resident #42 had not touched other female residents. He had tried touching female staff members but was redirected without incident. She said there were no further incidents with Resident #42. (continued on next page)

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	135098	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Nursing & Rehabilitation	1140 North Allumbaugh Street Boise, ID 83704

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility took the following actions: - The nurse assessed both residents for harm and evidence of injury - none noted. - Administrator, Regional Director of Operations notified. - Families of both residents notified. - The State Agency Long Term Care Program was notified via the portal - Staff members were interviewed. - Care plans for both residents were reviewed and updated. - Social Services interviewed other residents and no further concerns were found. - Staff education was provided to remind and redirect Resident #42 to stay downstairs. - Frequent checks were initiated for both residents. - Resident #42 was fully moved downstairs to a new room with all of his belongings set up to his preferences. These findings represent past noncompliance with this regulatory requirement. There was sufficient evidence the facility corrected the noncompliance as of 10/6/23, and there were no other occurrences of alleged sexual abuse. 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 - Some	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** 36193 Based on policy review, record review, and staff interview, it was determined the facility failed to ensure information was provided to the receiving hospital for 3 of 4 residents (#8, #42 and #54) reviewed for transfers. This deficient practice had the potential to cause harm if residents were not treated in a timely manner due to lack of information. Findings include: The State Operations Manual, Appendix PP, revised 02/03/23, documented when the facility transfers or discharges a resident under any of the circumstances, the facility must ensure that the transfer or discharge was documented in the resident's medical record and appropriate information was communicated to the receiving health care institution or provider. Documentation in the resident's medical record mush include: - The basis for the transfer or discharge. - Contact information of the practitioner(s) responsible for the care of the resident, - Resident representative information and contact information. - Advance Directive information, - All special instructions/precautions for ongoing care, and as appropriate treatments - Comprehensive care plans and goals and - All other necessary information including a copy of the resident's discharge summary and any other documentation to ensure a safe and effective transition of care. 1. Resident #8 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including cellulitis (potentially serious bacterial skin infection) of the right lower leg, liver cirrhosis (a condition in which the liver is scarred and permanently damaged), and chronic obstructive pulmonary disease (progressive lung disease characterized by increasing breathlessness). Resident #8's record documented she was transferred to the hospital as follows: A progress note, dated 3/25/24 at 9:47 AM, documented Resident #8 complained of increased pain to her right lower extremity. The note documented her right lower leg had increased redness and warmth. The note further documented per Resident #8's preference, a new order was received for her to be transferred to the hospital. A progress note, dated 5/15/24 at 12:09 PM, documented Resident showed this Nurse redness and skin that was hot to touch on right leg. Redness begins 5 inches below knee and extends to heel. The provider was notified and new order was received for Doxycycline (antibiotic) 100 mg by mouth two times a day for ten days. Resident #8 was given a stat (immediately) dose by mouth. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note, dated 5/15/24 at 4:09 PM, documented Resident #8 went to the Infection Control Nurse to look at her leg. The Infection Control Nurse then asked the nurse on duty to get an order to send Resident #8 to the hospital per her request. The progress note documented the provider was called and order obtained. Resident #8's record did not include documentation information was provided to the hospital when she was sent to the hospital on 3/25/24 and 5/15/24 to ensure a safe and effective transition of care. On 6/27/24 at 12:37 PM, the DON stated when a resident transferred to the hospital, the facility sent the resident's face sheet, POST, physician's orders, E-interact 9 (an electronic form used to communicate a change in a resident's status), transfer form, SBAR (Situation, Background, Assessment, Recommendation), and any pertinent laboratory results. The DON reviewed Resident #8's record and stated she was unable to find documentation, the necessary documents were sent with Resident #8 when she went to the hospital. 49552 2. Resident #42 was admitted to the facility on [DATE], with multiple diagnoses including respiratory failure and liver disease. A progress note, dated 1/3/24 at 7:52 PM, documented Resident #42 had a change in condition: shortness of breath. A physician's order, dated 1/3/24, documented to send Resident #42 to the emergency room for evaluation and treatment. A Transfer form Document Checklist, dated 1/3/24 at 7:47 PM, was not completed. Resident #42's record did not include documentation pertinent medical information was provided to the receiving hospital. On 6/27/24 11:28 AM, the DON stated the resident's orders, resident profile, POST, DPOA (Durable Power of Attorney) forms, E-INTERACT form, progress note, any labs or x-rays are sent to the hospital with the resident. Two copies of these forms are made and sent with the resident. One copy is for the EMT (Emergency Medical Technician) and one for the hospital staff. A progress note is put in and it should include what was sent with the resident to the hospital. 3. Resident #54 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including fractured left femur (thighbone) and stroke. A physician's order, dated 6/5/24 at 4:04 PM, documented Resident #54 was to be sent to the hospital due to an acute left femoral fracture. A Transfer form Document Checklist, dated 6/5/24 at 4:25 PM, was not completed. A nurses note, dated 6/5/24 at 5:31 PM, documented Resident #54 was sent to the hospital. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #54's record did not include documentation pertinent medical information was provided to the receiving hospital. On 6/27/24 at 11:36 PM, LPN #1 stated she forgot to document a progress note of what was sent to the hospital with Resident #54 but she did complete the E-INTERACT Transfer/Discharge form. Resident #54's E-INTERACT Transfer/Discharge form did not document what information was sent to the hospital with her.

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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** 49552 Based on observation, record review, and staff interview, it was determined the facility failed to develop and implement comprehensive resident-centered care plans. This was true for 1 of 16 residents (Resident #27) whose care plans were reviewed. These failures placed residents at risk of negative outcomes if services were not provided or provided incorrectly due to lack of information in their care plan. Findings include: The facility's Care Plan policy, revised 2022, documented the facility was to develop ongoing assessments and revise care plans as resident's condition changed. Resident #27 was admitted to the facility on [DATE], with multiple diagnosis including heart failure and kidney disease. 1. On 6/24/24 11:12 AM, Resident #27 was observed with upper and lower dentures in her mouth. Resident #27's care plan initiated 4/19/24, did not document she had dentures. On 6/28/24 at 9:45 AM, the DON stated Resident #27's dentures were not documented in her care plan, and it should have been. 2. On 6/24/24 at 11:49 AM, Resident #27 was observed using oxygen via a nasal cannula at 2 liters per minute. Review of Resident #27's record did not include a physician order for oxygen. On 6/28/24 at 10:44 AM, the DON stated Resident #27 should have had an order for oxygen and the oxygen should have been in her care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review, and staff interview, it was determined the facility failed to ensure professional standards of practice were followed for 2 of 16 residents (#27 and #53) reviewed for quality of care. Resident #27's physician's order to install a siderail to her bed was not followed. Resident #53's bowel medications were not administered as ordered by the physician. These failed practices had the potential to adversely affect or harm residents whose care and services were not delivered according to their physician's order. Findings include: 1. Resident #53 was admitted to the facility on [DATE], with multiple diagnoses including hypertensive chronic kidney disease (high blood pressure caused by damage to the kidneys), pressure ulcer and morbid obesity. Resident #53's physician's order included the following: - Lactulose Solution (a laxative) 10 gm/ml, 30 ml by mouth every 3 hours as needed for constipation if no bowel movement x 72 hours while awake until bowel movement, ordered 7/21/23 -Colace Oral Capsule (a stool softener) 100 mg, give one capsule by mouth two times a day for bowel care, hold for loose stools, ordered 9/14/23. - Dulcolax Suppository (a laxative) 10 mg, one suppository rectally as needed for bowel care if no BM x 4 days and not relieved by Lactulose, ordered 1/26/24. Resident #53's Bowel Movement Records, dated 5/30/24 through 6/28/24, documented he did not have a bowel movement on: - 5/29/24 through 6/1/24 (4 days) - 6/13/24 through 6/16/24 (4 days) On 6/24/24 at 2:30 PM, Resident #53 stated Yes, I am constipated. Last time it was about a couple of days, it came partly out. There was no documentation Resident #53 was offered or received Lactulose or Dulcolax suppository as ordered by his physician. On 6/28/24 at 2:19 PM, the DON reviewed Resident #53's record and stated Resident #53 should have received his bowel medications as ordered by the physician when he did not have a bowel movement for three days. 49552 2. Resident #27 was admitted to the facility on [DATE], with multiple diagnosis including heart failure and kidney disease. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order, dated 4/25/24, documented Resident #27 was to have half side rails x 2 to the right and left side of his bed to enable bed mobility. On 6/28/24 at 9:10 AM, with the DON present, Resident #27's bed was observed with no half side rails. On 6/28/24 at 9:13 AM, the DON stated Resident #27 should have had half side rails on her bed and the bed half side rails should have been documented in her care plan. On 6/28/24 at 1:14 PM, LPN #2 stated Resident #27 did not have half side rails on her bed and she 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** 49552 Based on observation and staff interview, it was determined the facility failed to ensure respiratory equipment was stored in a sanitary manner. This was true for 1 of 1 resident (Resident #27), reviewed for respiratory services. This created the potential for respiratory infections due to growth of pathogens (organisms that cause illness) in respiratory treatment equipment. Findings include: Resident #27 was admitted [DATE], with multiple diagnosis including heart failure and kidney disease. On 6/28/24 at 9:10 AM, in Resident #27 's room with DON present, Resident #27 's oxygen tubing and nasal cannula were observed lying on the floor. On 6/28/24 at 9:15 AM, the DON stated Resident #27 's oxygen tubing and nasal cannula should have been placed in the bag attached to the oxygen concentrator when it was removed from Resident #27.

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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** 36193 Based on observation, interview, and record review, it was determined the facility failed to ensure that prior to the placement of bed rails, alternatives to bed rails were attempted, individual residents were thoroughly assessed for the risk of entrapment, and consent was in place. This was true for 2 of 3 residents (#47 and #56) reviewed for bed rails. This failure created the potential for harm due to the risk of entrapment and due to lack of opportunity for the resident and/or their representative to make an informed decision regarding the use of bed rails. Findings include: 1. Resident #47 was admitted to the facility on [DATE], with multiple diagnoses including metabolic encephalopathy (disorders where medical problems such as infections, organ dysfunction, or electrolyte imbalance impair brain function), end stage renal disease (the final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own), and diabetes. A significant change MDS, dated [DATE], documented Resident #47 was moderately cognitively intact. A physician order, dated 3/28/24, documented Resident #47 was to have 1/4 rails x 2 to enable bed mobility. On 6/25/24 at 2:56 PM, Resident #47 was observed in bed with 2 half bed rails in the upraised position. A Siderail Enabler Assessment, dated 3/28/24, documented Resident #47 and/or his POA/Guardian consented to the use of side rails. The assessment documented side rails would assist Resident #47 with bed mobility, transfer, provide him a sense of security and avoiding rolling out of bed. The assessment documented side rail precautions were discussed with Resident #47 and it was signed by the Director of Physical Therapy. The assessment did not include documentation of what the risk versus benefits were or what other alternatives were attempted. Resident #47's record did not include documentation that he and/or his POA/Guardian signed a consent for use of the side rails. On 6/27/24 at 4:43 PM, the Director of Physical Therapy together with the DON, stated he assessed Resident #47's mobility, and discussed the risk of entrapment, potential isolation, and obstructions with the use of siderails/enabler. When asked if alternatives to side rails were attempted prior to the installation or use of siderails, the DON stated trapeze was considered but their ceiling was high. When asked why the Siderail/Enabler Assessment did not include the signature of the resident and/or her POA, the Director of Physical Therapy stated his signature on Resident #47's assessment form indicated he was the one who evaluated Resident #47 and that Resident #47 consented to the use of siderails/enabler. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #56 was admitted to the facility on [DATE], with multiple diagnoses including metabolic encephalopathy (are disorders where medical problems such as infections, organ dysfunction, or electrolyte imbalance impair brain function), left thigh fracture, alcohol dependence, and depression. A quarterly MDS assessment, dated 4/24/24, documented Resident #56 was cognitively intact. A physician's order, documented 1/4 rails x 2 to enable bed mobility was ordered on 3/19/24. On 6/24/24 at 12:07 PM, Resident #56 was observed in bed with 2 half bed rails in the upraised position. A Siderail Enabler Assessment, dated 3/19/24 and 4/24/24, documented Resident #56 expressed a desire to have siderails/enabler bars raised while in bed. The assessment documented siderails precautions had been discussed with the resident and a consent for use of siderails was signed. The assessment documented, side rails would assist Resident #56 with bed mobility and transfer and was signed by the Director of Physical Therapy. The assessment did not include documentation of what the risk versus benefits were or what other alternatives were attempted. Resident #56's record did not include documentation that she signed a consent for use of the side rails. On 6/27/24 at 4:43 PM, the Director of Physical Therapy together with the DON, stated he assessed Resident #56's mobility, and discussed the risk of entrapment, potential isolation, and obstructions with the use of siderails/enabler. When asked if alternatives to side rails were attempted prior to the installation or use of siderails, the DON stated trapeze was considered but their ceiling was high. When asked why the Siderail/Enabler Assessment did not include the signature of Resident #56 and/or her POA, the Director of Physical Therapy stated his signature on Resident 56's assessment form indicated he was the one who evaluated Resident #56, and that Resident #56 consented to the use of siderails/enabler.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 50603 Based on observation and staff interview, it was determined the facility failed to ensure census information was accurate and posted daily for each shift. This failed practice had the potential to affect the 63 residents residing in the facility and their representatives, visitors, and others who wanted to review the facility's census levels. Findings include: On 6/28/24 at 11:53 AM the daily census and staffing posting was located on first floor, across from the nursing station. The form included a resident census area that was left blank for the day, evening, and night shifts. On 6/28/24 at 1:35 PM, the Administrator stated, the [SDC] is the one who fills these out daily and posts them. On 6/28/24 at 1:40 PM, the SDC verified she never filled out the census information on the forms. On 6/28/24 at 1:45 PM, the census and staffing form was reviewed with the DON, who stated the census should have been listed on the form.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 36193 Based on policy review, staff interview, and record review, it was determined the facility failed to ensure the pharmacist recognized and reported medication irregularities related to PRN psychotropic medication. This was true for 1 of 5 residents (Resident #16) whose medications were reviewed. This failure created the potential for harm should residents receive medications that were unnecessary, ineffective, or used for excessive duration. Findings include: The State Operations Manual, Appendix PP, revised 02/03/23, documented PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Resident #16 was admitted to the facility 1/3/24, with multiple diagnoses including opioid dependence, anxiety, depression, and morbid obesity. Resident #16's physician's orders included the following: - Quetiapine (Seroquel - antipsychotic) Fumarate tablet 400 mg, give one tablet by mouth at bedtime for anxiety, ordered 1/3/24. - Quetiapine Fumarate 150 mg, one tablet by mouth PRN for repeat episodes of anxiety at bedtime. May take with scheduled 400 mg dose. The physician's order did not include a stop date for the PRN quetiapine. Resident #16's May 2024 MAR documented she received the PRN quetiapine 150 mg between 6:00 PM and 9:00 PM on 15 of 31 days. Resident #16's June 1 - 25, 2024 MAR, documented she received the PRN quetiapine 150 mg between 6:00 PM and 9:00 PM on 7 of 25 days. The Pharmacist Medication Review for March 2024, April 2024 and May 2024, did not include comments or recommendations from the pharmacist regarding Resident #16's PRN quetiapine. On 6/27/24 at 2:39 PM, the DON was asked for documentation the Pharmacist reviewed Resident #16's PRN quetiapine. The DON reviewed Resident #16's record and stated she was unable to find documentation Resident #16's PRN quetiapine was addressed by the pharmacist. On 6/28/24, the DON provided a copy of an email from the pharmacist, which stated I did not send a request for the 14 day PRN review on [Resident #16's name] quetiapine. She did visit [clinic name] on 6/16 and that note states she should continue her meds. [NP name] signed that note on 6/17. [NP name] also documented in his notes 2/5, 4/1 & 5/31 that seroquel should be continued . (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #15's record did not include documentation from the pharmacy they reviewed her PRN seroquel. The e-mail from the pharmacist referencing Resident #15 should continue her seroquel as documented by the NP did not specifically address the use of the PRN seroquel. Resident #15's record did not include a new order for her to continue the PRN seroquel.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 36193 Based on record review and staff interview, it was determined the facility failed to ensure PRN anti-psychotic medications were limited to 14 days. This was true for 1 of 5 residents (Resident #16) reviewed for unnecessary medications. This deficient practice created the potential for harm if residents receive PRN anti-psychotics medications that were unwarranted, ineffective, or used for excessive duration. Findings include: The State Operations Manual, Appendix PP, revised 02/03/23, documented PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Resident #16 was admitted to the facility 1/3/24, with multiple diagnoses including opioid dependence, anxiety, depression, and morbid obesity. Resident #16's physician's orders included the following: - Quetiapine (Seroquel - antipsychotic) Fumarate tablet 400 mg, give one tablet by mouth at bedtime for anxiety, ordered 1/3/24. - Quetiapine Fumarate 150 mg, one tablet by mouth PRN for repeat episodes of anxiety at bedtime, ordered 1/3/24. May take with scheduled 400 mg dose. The physician's order did not include a stop date for the PRN quetiapine. An IDT Psychotropic Review, dated 5/30/24, documented Resident #16's continues to have anxiety at night and her PRN quetiapine was being used frequently. Resident #16's May 2024 MAR documented she received the PRN quetiapine 150 mg between 6:00 PM and 9:00 PM on 15 of 31 days. Resident #16's June 1 - 25, 2024 MAR, documented she received the PRN quetiapine 150 mg between 6:00 PM and 9:00 PM on 7 of 25 days. The Nurse Practitioner's progress notes, dated 2/5/24 and 4/1/24, documented Resident #16's mood was stable. Continue Seroquel as currently ordered. The Nurse Practitioner's progress notes, dated 5/31/24, documented Resident #16 was agitated. Continue Seroquel. The Nurse Practitioner's progress notes did not include documentation the as needed quetiapine was still needed on a PRN basis. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/28/24, when asked about facility's process of reviewing the PRN anti-psychotic medications, the DON stated it should be looked at during the facility's psychotropic review. The DON stated there will be either an end date or note why to continue the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 49552 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure medications available for residents were labeled and dated; this was true for 1 of 2 medication storage rooms and 1 of 2 medication carts inspected. This failure created the potential for residents to receive expired medications with decreased efficacy. Findings include: The facility's Medication Labeling and Storage policy, revised 2/2023, documented labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. 1. On 6/26/24 at 9:17 AM, the facility's first floor medication storage room was inspected with LPN #1 present. The following medications were expired: * One bottle of Aspirin, expired 3/2024. * Three bottles of Saw Palmetto supplement, expired 3/2024. * One box of acetaminophen suppositories, expired 12/2022. On 6/26/24 at 7:58 AM, LPN #1 stated she was not sure whose job it was to check the medication room for expired medication. She also stated the medications should have been destroyed when they expired. 2. On 6/16/24 at 9:13 AM, 3 insulin pens were observed inside the top drawer of the 200-hall medication cart undated. On 6/26/24 at 9:23 AM, LPN #2 stated the insulin pen was usually dated when it was opened but Resident #38's insulin was used so quickly they usually did not date when it was opened, but they should have.

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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 63 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 2-301.14 states food employees shall clean their hands and exposed portions of their arms as specified under paragraph 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco products, eating, or drinking; E) After handling soiled equipment or utensils; (F) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (H) Before donning gloves to initiate a task that involves working with food; and (I) After engaging in other activities that contaminate the hands. On 6/27/24 at 12:04 PM, during the 200 Hall Kitchen tray line service, two kitchen aides were observed frequently changing their gloves between tasks such as plating food for residents and tray assembly without washing their hands in between donning new gloves. On 6/27/24 at 12:35 PM, one of the kitchen aides was observed sneezing into her shoulder and continued to plate the residents' food. On 6/27/24 at 1:15 PM, both kitchen aides confirmed that hand washing should be completed in the appropriate hand washing sink, that hands should be washed between glove use changes, and after sneezing or touching their body. 2. The FDA Food Code Section 2-301.15 states food employees shall clean their hands in a handwashing sink or approved automatic handwashing facility and may not clean their hands in a sink used for food preparation or warewashing, or in a service sink or a curbed cleaning facility used for the disposal of mop water and similar liquid waste. On 6/27/24 at 12:04 PM, during the 200 Hall Kitchen tray line service, one of the diet aides was observed washing her hands in the food preparation sink before putting on gloves to begin plating residents' food. On 6/27/24 at 12:20 PM, during the 200 Hall Kitchen tray line service, one of the aides was observed placing dirty dishes in the previously identified food preparation sink. On 6/27/24 at 1:15 PM, both kitchen aides confirmed hand washing should be completed in the appropriate hand washing sink and hands should be washed between glove use changes. They were unable to explain the difference between the food preparation sink and a dirty dish sink as the kitchen had limited areas to place dish items. (continued on next page)

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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 3-305.11(A) states 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 6/27/24 at 9:40 AM, during the main kitchen walkthrough, it was observed that a pantry shelf measured 4-inches off the floor. On 6/27/24 at 9:40 AM, the Food Service Manager (FSM) verified that shelves should be off the ground by 6 inches; however, the main kitchen had a separate food service manager who was responsible for the main kitchen. On 6/27/24 at 5:03 PM, the Main Kitchen FSM stated she was unaware that this shelf was not at the 6-inch level. 4. The FDA Food Code Section 6-305.11 states street clothing and personal belongings can contaminate food, food equipment, and food-contact surfaces. Proper storage facilities are required for articles such as purses, coats, shoes, and personal medications. On 6/27/24 at 9:40 AM, before the Main kitchen, Hall 100 kitchen, and Hall 200 kitchen inspection, it was observed that the FSM requested the Dietary Supervisor (DS) not enter the kitchens during the kitchen inspection due to wearing incorrect footwear. During the kitchen inspection, it was observed that the DS wore open toed slider shoes with bare feet while walking around the kitchen, into all the dry food storage areas, the main walk-in refrigerator, and the main walk-in freezer. On 6/27/24 at 5:06 PM, clothing items were observed in the main food pantry area hanging from a shelf and on top of food items located on the top shelf. On 6/27/24 at 5:07 PM, the Main Kitchen FSM verified employees had a separate break room to store their personal items. 5. The FDA Food Code Section 1-402.11 Effectiveness. (Hair Restraints) states except as provided in paragraph (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-serve and single-use articles. On 6/24/24 at 12:00 PM, a kitchen aide was observed plating residents' meals. Her hairnet covered the top of her head, but her remaining longer hair was unrestrained. On 6/27/24 at 9:00 AM, the FSM verified that all employees were trained on food service safety, including the use of gloves and hairnets. 6. The FDA Food Code Section 3-501.12 Time/Temperature Control for Safety Food, Slacking states frozen time/temperature control for safety of 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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/24/24 at 10:34 AM, during the initial kitchen walkthrough, the 100-hall kitchen refrigerator temperature log was observed. The log documented multiple dates the temperature was out of the recommended range. On 6/27/24 at 9:40 AM, during the kitchen inspection, the FSM stated he had confirmed the refrigerator vendor was sending out the parts to fix the temperature of the refrigerator. He had not previously put in a work order for the irregular temperatures. 7. The FDA Food Code Section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking, states (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. On 6/24/24 at 10:34 AM, during the initial kitchen inspection, it was observed that foods stored in the refrigerator, freezer, and pantry areas were not stored appropriately. The following observations were made: In the main kitchen: - A box of fresh potatoes was located on the pantry floor of the main kitchen. - In the main kitchen, opened spices above the food preparatory area were not labeled. - In the main kitchen, an opened spice was dated 2017. - A cart of uncovered food was cooling on a rack across from the air conditioning unit in the main kitchen refrigerator. In the 100-hall kitchen: -Opened spices were observed on a shelf under the air conditioner unit were not dated when opened. - An open package of lunch meat (ham) did not have a date when opened and was stored in an open plastic bag. - A bag of undated chicken strips with ice buildup. - Two plastic bags of undated hamburger patties were observed in the freezer. - The veggie line griddle spray and lemon juice were stored in a plastic bin located on the floor. - Three boxes of plastic lids, used for the resident serving bowls, were stored on the floor. - Food storage bags were observed stored on the floor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In the 200-hall kitchen: - Dates were not observed on open containers of juices, both thin and nectar thick. - Frozen links and sausage patties were in undated bags. - An open package of bacon was undated, and not in storage container or bag. - The nourishment refrigerator had undated, opened containers of juice, tzatziki sauce, a yellow bottle containing liquid without a label or date. - The handwashing sink had a brown smear on the wall near the storage shelves. - An Oreo package and dishtowel was observed on the floor under the metal shelving rack. - The handwashing sink trash can did not have a lid. - Potato pearls were open, undated, and stored on the top shelf. On 6/24/24 and 6/27/24, the FSM stated when foods and juices are used so quickly, usually within a day or two, dates are not usually put on those items. He stated the facility used the delivery date to identify how old foods were. On 6/24/24 and 6/27/24, the DS verified that the dates were not needed on the food items since he knew when the items were opened as he usually opened them. When asked to clarify how other kitchen aides would know when the food items were opened or the use by date, the DS stated, They would not know. I need to start being more consistent with my dating. On 6/27/24 at 3:50 PM, the Main Kitchen FSM stated she had moved the box of potatoes to the floor to get to something underneath and forgot to move them back on the shelf. 8. The FDA Food Code Section 4-501.14 Warewashing Equipment, Cleaning Frequency. A warewashing machine; states the compartments of sinks, basins, or other receptacles used for washing and rinsing equipment, utensils, or raw foods, or laundering wiping cloths; and drainboards or other equipment used to substitute for drainboards as specified under S 4-301.13 shall be cleaned: (A) Before use; (B) Throughout the day at a frequency necessary to prevent recontamination of EQUIPMENT and UTENSILS and to ensure that the EQUIPMENT performs its intended function; and (C) If used, at least every 24 hours. A review of the Main Kitchen Dishwasher Cleanside Daily Cleaning Schedule was incomplete. On 6/27/24 at 5:06 PM, the Main Kitchen FSM stated that in the 2.5 years she had been at the facility, the cleaning schedules were not filled out. A review of the SNF 100-hall and 200-hall cleaning schedule did not include documentation the warewashing machine was an item to be cleaned daily. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/27/24 at 3:47 PM, the FSM stated the cleaning schedules for the 100-hall and 200-hall satellite kitchens had inconsistencies in the dates documented for cleaning, what was cleaned, nor how to identify which kitchen the cleaning schedule was for. 9. The FDA Food Code Section 6-501.12 Cleaning, Frequency and Restrictions, states cleaning of the physical facilities is an important measure in ensuring the protection and sanitary preparation of food. A regular cleaning schedule should be established and followed to maintain the facility in a clean and sanitary manner. Primary cleaning should be done at times when foods are in protected storage and when food is not being served or prepared. On 6/24/24 at 11:05 AM, the ceiling above the air conditioner in the main kitchen walk-in refrigerator was observed coated in a thick layer of dirt residue. On 6/27/24 at 3:45 PM, the FSM rubbed his finger across the residue, removing some of the build-up. He stated he would have someone come in and clean the area. On 6/24/24 at 11:07 AM, in the main kitchen walk-in freezer, there were black spots observed on the ceiling with residue hanging from them. On 6/27/24 at 3:47 PM, the FSM rubbed his finger across the black spots, removing them from the ceiling. He stated he would have someone come in and clean the area. A review of the Main Kitchen cleaning schedule showed blank pages not completed. An Idaho Department of Health certificate was provided with the annual expiration date of 6/30/2024. On 6/27/24 at 05:06 PM, the Main Kitchen FSM stated she had worked at the facility for 2.5 years, and that she did not use a cleaning schedule. The Main Kitchen FSM stated the kitchen staff cleaned daily, but do not record what is getting cleaned or how often. She stated the state public health department inspected her kitchens, and she was not familiar with the skilled nursing facility kitchen regulations. A review of the cleaning schedules for the 100-hall and 200-hall kitchens documented unspecified kitchen cleaning schedules, and dates of cleaning. The following cleaning schedules had documentation cleaning was not completed or was incomplete on the following dates: 100-hall: 5/5/24, 5/8/24, 5/16/24 - Four of 12 cleaning and sanitation tasks were not completed. 5/22/24 - Clean and sanitize all food/beverage/trash carts was not completed. 5/23/24 - Three of 12 cleaning and sanitation tasks were not completed. 5/25/24 - Five of 12 cleaning and sanitization tasks were not completed. 6/9/24 - Clean and wash all kitchen prep equipment and knives was not completed. 5/21/24, 5/26/24, 5/27/24, 5/28/24, 6/10/24 - Cleaning was completed in any area. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5/10/24, 5/20/24, 5/31/24, 6/2/24, 6/6/24, 6/7/24, 6/14/24; 6/19/24 - Clean and sanitize all food/beverage/trash carts, and hot food transport boxes was not completed. 6/24/24 - Cleaning of the range top shelf, backsplash, burners, oven handles, doors, and griddles were not completed. 200-Hall: 5/5/24 - Five of 12 cleaning and sanitizing tasks were not completed. 5/3/24, 5/4/24, 5/11/24, 5/12/24 - Clean range top shelf, backsplash, burners, oven handles, doors, and griddle as needed was not completed. 5/16/24, 5/19/24 - Cleaning was not completed in any area. 5/20/24 - Clean and sanitize all employee station/food prep tables and chairs was not completed. 5/24/24 - Three of 12 cleaning and sanitation tasks were not completed. 5/2/24, 5/5/24, 5/7/24, 6/11/24 - Clean and sanitize all food/beverage/trash carts, and hot food transport boxes was not completed. On 6/27/24 at 3:47 PM, the FSM stated the cleaning schedules for the 100-hall and 200-hall satellite kitchens had inconsistencies in the dates of cleaning, what was cleaned, and with no way to identify the kitchen for the schedules. The FSM stated the Main Kitchen FSM did not record who cleaned what at the end of the day, and no records were kept of the cleaning.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review and staff interview, it was determined the facility failed to ensure care was coordinated with a hospice provider and duties of the hospice provider and the facility were delineated. This was true for 1 of 3 residents (Resident #56) reviewed for hospice care. This failure created the potential for Resident #56 to receive inadequate care due to a lack of coordination between the facility and the hospice agency. Findings include: Resident #56 was admitted to the facility on [DATE], with multiple diagnoses including metabolic encephalopathy (disorders where medical problems such as infections, organ dysfunction, or electrolyte imbalance impair brain function), left thigh fracture, alcohol dependence, and depression. A significant change in status MDS assessment, dated 5/17/24, documented Resident #56 received hospice services. Resident #56's care plan did not include documentation of the responsibilities or care delineated between the facility and the hospice agency. On 6/27/24 at 5:05 PM, the DON reviewed Resident #16's record and stated she was unable to find documentation of delineation of duties between the facility and the hospice agency.