STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. Building B. Wing	07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Falls Transitional Care of Cascadia	674 Eastland Drive Twin Falls, ID 83301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006 Based on record review, policy review and staff interview, it was determined the facility failed to ensure the MDS assessment accurately reflected a resident's status. This was true for 1 of 24 residents (Resident #16) whose MDS assessment was reviewed. This deficient practice had the potential for negative outcomes if the resident was not assessed and cared for or monitored due to inaccurate MDS assessments. Findings include: The facility's Resident Assessment policy, dated 10/15/22, stated A comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity and needs is conducted using the Resident Assessment Instrument (RAI), which directs the care of the resident based on his or her individual needs . The results of the assessment are used to develop, review, and revise the resident's comprehensive plan of care on admission, quarterly, and with change of condition. Resident #16 was admitted to the facility on [DATE], with multiple diagnoses including brain cancer and right hemiplegia and hemiparesis (paralysis and weakness on one side of the body) following stroke and chronic respiratory failure with hypoxia (low levels of oxygen in the body tissue). A quarterly MDS assessment, dated 5/23/24, documented Resident #16 was severely cognitively impaired and rarely/never able to make herself understood. The assessment documented Resident #16 received application of topical ointments. The assessment did not include documentation Resident #16 had current open lesions or wounds. Resident #16's physician orders, included the following: - gentamicin (antibiotic) topical cream to be applied to her scalp wounds two times a day every day and cover the wounds, ordered 2/8/24, - Monitor scabbing to ensure no s/s [signs or symptoms] of infection, no pain, no adverse effects of head injury hit, every shift for impaired skin integrity., ordered 11/21/23. Resident #16's care plan, revised 4/3/23, documented she had impaired skin on top of her head and the staff were directed to apply treatments as indicated, notify provider with any complications, observe skin during ADL cares, report alterations to the licensed nurse, and licensed nurse to perform weekly skin assessment to include review/check footwear and report alterations as indicated. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/05/2024
NAME OF PROVIDER OR SUPPLIER Twin Falls Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 674 Eastland Drive Twin Falls, ID 83301	

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #16's May 2024 and June 2024 MAR, documented gentamicin topical cream was applied to her scalp two times a day and the wounds were covered every day during day shift. A provider progress note, dated 2/1/24, documented, Patient is seen today for focused visit related to her scalp wound. Patient was seen by dermatology 2 [sic] days ago, and wound provider yesterday. She has a large scabbed over wound on the top of her head. This was partially debrided by dermatology and no evidence of skin malignancy was suspected. No biopsies taken. She was started on a steroid cream and minocycline, with recommendations that the patient be seen in the wound clinic for further debridement. Dermatology assessment was gross of pustular dermatosis. The remainder of the scabbed over area was debrided by the wound clinic. Hardware was noted. A physician progress note, dated 5/3/24, documented Resident #16 continues to be followed by wound care for her scalp lesion. The plan at this time is to have a joint surgery with neurosurgery and plastic surgery to do a removal of the hardware in her scalp and coverage of her calvarium. She is scheduled to see plastic surgery in Boise on 5/30/2024. On 7/4/24 at 11:22 AM, LPN #2 stated Resident #16 had two round scabbed wounds on her scalp. LPN #2 stated Resident #16's wounds were present since she began working with her in May 2024 and she was unsure whether her wounds were open with hardware visible, or if it was just scabbed over. On 7/4/24 at 11:27AM, the NP stated Resident #16's wounds to her scalp were open, as they could not heal due to the presence of hardware on the skull. The NP stated Resident #16 had the wounds for over a year and was planning on having a reconstructive surgery soon to address the wounds. On 7/4/24 at 12:14 PM, the CRRN stated the MDS Coordinator started in the position last week and worked remotely. The CRRN stated she was unsure whether MDS coding instructions required Resident #16's skin wounds to be reflected in her MDS assessment.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a new Level 1 Preadmission Screening and Resident Review (PASARR) was completed after a resident had a newly identified mental illness. This was true for 1 of 1 resident (Resident #30) whose PASARR record was reviewed. This deficient practice had the potential to cause harm if residents' specialized services for mental health needs were not provided due to a lack of updated screening. Findings include: The facility's Pre-Admission Screening and Resident Review (PASARR) policy, dated 11/28/17, stated Pre-admission Screening and Resident Review is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term. Any resident with newly evident or possible serious mental disorder is to be referred by the facility to the appropriate state designated mental health authority for review . Resident #30 was admitted to the facility on [DATE], with multiple diagnoses including depression and anxiety. A quarterly MDS assessment, dated 5/28/24, documented Resident #30 was moderately cognitively impaired. The assessment documented he had a diagnosis of Post Traumatic Disorder (PTSD). A PASARR Level 1 assessment, dated 9/14/23, documented Resident #30 had diagnoses of depression and anxiety. Resident #30's record, documented PTSD was added as a diagnosis on 12/13/23. Resident #30's record did not include documentation a new level 1 PASARR was completed. On 7/4/24 at 8:31 AM, the SSM stated when a resident had a new mental illness diagnosis, they were supposed to complete a new PASARR Level 1. The SSM stated Resident #30 should have a new PASARR level 1 completed after she was newly diagnosed to have PTSD. On 7/5/24 at 10:05 AM, the CNO and CEO both stated a new level 1 PASARR should have been completed after Resident #30 had a new mental illness diagnosis.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006 Based on record review, policy review, and staff and Resident interview, it was determined the facility failed to implement a restorative nursing program for 2 of 4 Residents (#47 and #308) reviewed for restorative nursing services. This deficient practice created the potential for Residents to experience a decline in strength, range of motion (ROM), and increased pain. Findings include: The facility's policy, Restorative Nursing, dated 1/20/20, stated Restorative nursing program is a set of nursing interventions that are implemented to promote Resident abilities to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning . Designated Restorative Program - Specific programs that are associated with rehabilitative programs that the Resident has just completed . [and]: Include the development of specific restorative care programs such as range of motion and prosthesis care . The Resident is generally in the restorative care program until a specific goal is reached or maintained for a period of time. 1. Resident #308 was admitted to the facility on [DATE], with multiple diagnoses including multiple sclerosis (a disorder in which the body's immune system attacks the protective covering of the nerve cells in the brain, optic nerve and spinal cord), pain in her right knee, difficulty walking, and right tibia and fibula osteomyelitis (inflammation or swelling that occurs in the bone). An admission MDS assessment, dated 6/12/24, documented Resident #308 was cognitively intact. She did not exhibit any behavioral symptoms, including rejection of care. Resident #308 had impaired range of motion in her lower extremity on one side. She required supervision with touching assistance for bed mobility and transfers and required partial to moderate assistance with walking. The assessment documented Resident #308 needs assistance with self-care and mobility due decreased mobility, weakness, and knee pain . Problems Resident is at risk for because of functional decline: Complications of immobility, such as contractures, depression. The assessment documented the facility would include functional abilities in Resident #308's care plan related to being at risk for loss of dignity and independence, falls, contractures, increased/unrelieved pain, decreased ROM, and risk for depression. The assessment documented goals for Resident #308 were to maintain and improve her current level of function, maintain her dignity and independence and involvement in making decisions regarding care and try to establish Resident #308's previous patterns of ADLs. During an interview on 7/2 24 at 11:48 AM, Resident #308 stated she was in the facility for short-term rehabilitation and care. She stated she was working with therapy but was recently told she was moved to a lower level of care (restorative nursing). Resident #308 stated since the day she was told she would be receiving restorative services; she had not received the services including exercising her right knee which was sore and stiff. Resident #308 stated it was important to her to continue receiving instruction for proper exercises to work toward strengthening and returning home. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physical Therapy Discharge Summary, dated 6/17/24, documented Resident #308 Will be transitioned to RNA [restorative nurse aide] to assist with set up as needed. Therapy will be available is [sic] anything changes such as improvements with WB [weight bearing] on RLE [right lower extremity] . Discharge Recommendations: d/c [discharge] from skilled services to RNA program . Restorative Program Established/Trained = Restorative Range of Motion program. Range of Motion Program Established/Trained: ROM of R [right] knee . Prognosis to maintain CLOF [current level of function] = excellent with participation in RNP [restorative nursing program]. Resident #308's care plan, dated, 6/22/23, documented Resident #308 required an active ROM restorative nursing program related to ability to participate in ADLs, hygiene care, and strengthening due to physical weakness. The care plan documented the goal was for Resident #308 to be able to perform active ROM in her left lower extremities with RNA assistance through the next review date. The care plan documented if Resident #308 refused the RNA assistance, staff were to see her refusal care plan and follow directives as indicated. The care plan documented staff were to monitor and report pain and to see Resident #308's pain management care plan and follow directives as indicated. The care plan further documented for staff to monitor Resident #308 for decline in function and to notify the physician. The care plan also documented staff were to refer to therapy as indicated. The following was also included in the care plan: - Restorative nursing: ROM - cross trainer (recumbent stationary bike) for 5-10 minutes as able. - Bilateral extremity therapeutic exercises: Lower left extremity - 5 pounds, 2 sets for 20 repetitions and right lower extremity 2 sets for 20 repetitions 3-6 times per week as tolerated. - Restorative nursing: Splint or brace assistance - right knee brace when out of bed 3 to 6 times per week. Resident #308's Kardex (a communication system used as a quick reference for health care personnel), dated 7/3/24, documented: - Restorative nursing: ROM - Active. cross trainer for 5-10 minutes as able. - Bilateral extremity therapeutic exercises: Lower left extremity - 5 pounds, 2 sets for 20 repetitions and right lower extremity 2 sets for 20 repetitions 3-6 times per week as tolerated. - Restorative nursing: Splint or brace assistance - right knee brace when out of bed 3 to 6 times per week. Resident #308s record did not include documentation restorative nursing activities were provided to Resident #308 and no refusals were documented. A restorative progress note, dated 6/21/24, documented Resident #308's RNA program changes were discussed with the DOR, RN, CNO, ACNO, Administrator and RNAs. The note documented the plan was to start Resident #308 working on the program on upcoming Monday [6/24/24]. The note further documented Therapy notified Resident #308 of plan and she stated she was ready. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/3/24 at 10:57 AM, the RNA stated she worked in the facility from Wednesday to Saturday and there was a part-time aide that would cover the days she was not in. The RNA stated Residents were placed on restorative nursing programs upon recommendation from therapy, and the recommendations were entered into the Tasks section of the residents' record for charting completion of the activities or whether the resident refused. The RA stated, I have not been working with [Resident #308]. I spoke with her last week and told her it was pending. I said I would check back with her. I can see her programs listed [her record] but there was some confusion, but they were listed that they were ready to begin . I hadn't [sic] spoken to the Director [of Rehabilitation Services] to see what to actually do . I am unsure about the how and when of the cross-trainer. The RNA again verified neither she nor the part-time restorative aide had implemented the recommended restorative nursing program for Resident #308. During an interview on 7/3/24 at 11:49 AM, the DOR stated he had recommended a restorative nursing program for Resident #308 on 6/17/24 to include use of the cross-trainer and therapeutic exercises for her legs. The DOR stated he educated the RNA and RN #1, who was overseeing restorative nursing services, on the program for Resident #308. The DOR stated the recommended restorative nursing program for Resident #308 should have been implemented as soon as possible, as a delay could cause increased stiffness in her knee which could be uncomfortable or painful. The DOR stated Resident #308 mentioned a concern to regarding not receiving restorative services, and the DOR stated he discussed this with RN #1 who said she would follow up. During an interview on 7/3/24 at 1:15 PM, RN #1 stated she wrote a progress note regarding restorative services beginning on 6/24/24; however, she was out sick that week and was not able to follow up on starting the program. She stated she discussed starting the program on 6/24/24 with Resident #308 but it had not been started. RN #1 stated she did not have a plan for coverage if she was out of the facility and needed to work on a plan to ensure coverage. RN #1 stated the restorative program for Resident #308 should have started when planned on 6/24/24, but no one was able to follow up and the facility dropped the ball. During an interview on 7/5/24 at 10:22 AM, the CEO stated a restorative program should be initiated immediately upon recommendation from therapy. He stated the restorative program had not been implemented immediately for Resident #308 due to the restorative nurse being out sick for a week and the ball may have been dropped. 2. Resident #47 was admitted to the facility on [DATE] with multiple diagnoses including contracture of muscles to multiple sites. A quarterly MDS assessment, dated 4/4/24, documented Resident #47 was severely cognitively impaired. Resident #47's care plan, dated 10/5/23, documented Resident #47 had an ADL self-care performance deficit related to his limited ROM and he required full staff assistance with all cares due to immobility of his entire body and contractures. A physician order, dated 1/12/24, documented Resident #47 was to have a small abductor wedge inside a pillowcase above his knee at all times, a ball to the left side of his neck for support to the left side as tolerated, a right hand splint for 2 fingers during the day, and a left-hand palm protector 24/7 (24 hours a week for 7 days) except when cleaning. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #47's Kardex, dated 12/28/23, documented Resident #47 was to have a small abductor wedge inside a pillowcase above knee at all times, ball to neck to support left side as tolerated, right hand splint to 2 fingers during the day and a left-hand palm protector 24/7 except when cleaning. On 7/2/24 at 3:00 PM, and 7/3/24 at 10:40 AM, Resident #47 was observed lying in bed with no fingers splinted on Resident #47's right hand, no ball to his neck or wedge under his legs for positioning. On 7/3/24 at 10:40 AM, Resident #47 was not wearing his left hand palm protector. During an interview on 7/3/24 at 11:17 AM, RNA acknowledged Resident #47 was not wearing his left hand palm protector. She stated the CNA staff were waiting on the restorative aide to put on the palm protector. She stated she did not know about a right hand finger splint, wedge, or ball. She stated she had not seen those used for Resident #47. During an interview on 7/3/24 at 11:54 AM, the DOR stated there were times due to the Resident #47's contractors that he would refuse to wear the splint or have the ball placed behind his neck. He stated the recommendations for the ball were to help with neck position, the abductor for positioning with his legs to prevent skin breakdown when knees were together, the palm protector to help protect the palm from skin breakdown and help prevent worsening of the contractures. He was unsure why these were not being provided. During a follow up interview on 7/3/24 at 1:30 PM, the DOR stated Resident #47 experienced no decline and there should have been documentation prior to today about why the restorative interventions were not being provided daily per the physician orders and therapy recommendations. During an interview on 7/5/24 at 10:05 AM, the CNO stated staff should be following physician orders and they should be documenting refusals and notifying the physician.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, record review, policy review, and resident and staff interview, the facility failed to ensure a fall intervention was implemented. This was true for 1 of 6 residents (Resident #19) reviewed for falls. This deficiency had the potential to cause injury to Resident #19 if he should fall. Findings include: The facility's policy, Fall Response & Management, revised 5/17/21 documented, staff were to review information gathered from the resident and witness, if applicable and implement immediate interventions to prevent a repeat fall. Resident #19 was admitted to the facility on [DATE], with multiple diagnoses including traumatic brain injury, dementia, and contractures of the left and right hip. A quarterly MDS assessment, dated 4/12/24, documented Resident #19 was severely cognitively impaired. A physician order, dated 10/5/22, documented Resident #19 was to have his bead in a low position with mats [on the floor] for safety. Resident #19's care plan, revised 3/11/24, documented Resident #19 had impaired mobility with risk for falls, a history of traumatic brain injury, poor safety awareness, pain, neuropathy, impulsiveness related to the traumatic brain injury, weakness, history of being resistive to cares and re-direction. Interventions included, Low bed with mat on left side for safety and use bedside impact absorbing floor mat when in bed. Place on left side of bed. Resident 19's Kardex (a communication system used as a quick reference for health care personnel), undated, documented Use bedside impact absorbing floor mat when in bed. Place on left side of bed. A Fall Risk assessment, dated 4/8/24, documented Resident #19 was at high risk for falls. A Health Status progress note, dated 4/22/24, documented during shift change staff found Resident #19 on his knees on the floor mat next to his bed. The LN evaluated Resident #19 and noted he had no signs/symptoms of injury at that time. The note documented Resident #19 denied pain or discomfort and appeared to have rolled off the bed attempting to get up on his own. The note documented Resident #19 was mechanically lifted to his bed from the floor without incident. A Health Status progress note, dated 5/20/24, documented the CNA was walking into Resident #19's room, and Resident #19 was sliding out of the bed onto the floor, in a sitting position. The bed was in the lowest position and Resident #19 landed in a sitting position, upright against the bed. The note did not include documentation the fall mat was in place on the floor next to Resident #19's bed. On 7/3/24 at 1:49 PM, Resident #19 was observed awake in bed with the bed in the lowest position and the bed against the wall. There was no fall mat next to his bed. The mat was observed folded up laying against the far wall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/3/24 at 5:19 PM, Resident #19 was observed awake in bed with the bed in the lowest position and the bed against the wall. There was no fall mat next to the bed. The mat was observed folded up laying against the far wall. During an interview on 7/3/24 at 5:19 PM, CNA #2 was asked if he provided cares for Resident #19 and CNA #2 stated, Yes. CNA#2 was then asked if Resident #19 was supposed to have a fall mat next to his bed and CNA #2 stated, No. CNA #2 was asked if Resident #19 fell out of the bed and he said, Yes. During an interview on 7/3/24 at 5:21 PM, RN #1 was asked if Resident #19 was supposed to have a fall mat next to his bed. RN #1 stated she was currently asking about that and would check to see if it was discontinued. RN #1 was asked if Resident #19 fell out of his bed and RN #1 stated, Yes. During an interview on 7/4/24 at 11:11 AM, LPN #1 was asked if Resident #19 had a history of falls. LPN #1 stated he had worked at the facility for five months and Resident #19 had not fallen on his shift. LPN #1 was asked if Resident #19 was supposed to have a fall mat next to his bed. LPN #1 stated he was not sure and he would have to check the orders. During an interview on 7/4/24 at 12:58 PM, the NP was asked if the facility notified her when Resident #19 experienced a fall and the NP stated, Yes. The NP was asked what her expectation was if Resident #19 had an order for a fall mat next to his low bed. The NP stated she would be happy if the staff used the mat. During an interview on 7/5/24 at 10:10 AM, the CNO was asked about Resident #19's fall history and why Resident #19's fall mat was not in place the afternoon of 7/3/24. The CNO confirmed the fall mat was listed on the Kardex, and the CNA should have been aware. The CNO stated it should have been in place when Resident #19 was in bed. The CNO stated RN #1 confirmed the mat was care planned and there was a physician order. The CEO was present and stated his expectation was the CNAs were to review the Kardex. The CNO stated if there was a physician order, it should be followed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure catheter care was provided as ordered. This was true for 2 of 2 residents (#39 and #158) reviewed for urinary catheters. This failed practice created the potential for residents to experience urinary tract infections (UTIs) due to lack of proper care. Findings include: The facility's policy titled Indwelling Catheters, dated 4/12/22, stated an indwelling catheter was used only when a resident's clinical condition demonstrated that catheterization was necessary. Physician orders were followed and resident refusals were documented, and the physician was contacted for directives. 1. Resident #158 was admitted to the facility on [DATE], with multiple diagnoses including sepsis (a serious condition in which the body responds improperly to an infection) related to urinary tract infection. A quarterly MDS assessment, dated 6/23/24, documented Resident #158 was cognitively intact and had a diagnosis of obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow), septicemia and an indwelling catheter (device that drains urine from the urinary bladder into a collection bag outside of the body). A physician order, dated 6/17/24, documented Resident #158 was to have his indwelling catheter to straight drain (allows urine to flow freely from the body to the drainage bag using gravity). Resident #158's care plan, dated 6/17/24, documented he had a foley (indwelling) catheter related to obstructive uropathy. Staff were to position his catheter bag and tubing below the level of the bladder. Resident #158's progress notes, dated 6/17/24 to 7/5/24, did not include documentation Resident #158 refused to position the catheter bag below his bladder. On 7/2/24 at 10:10 AM, Resident #158's catheter bag was observed hanging to the left side of his wheelchair at waist level. Resident #158 stated he was on an antibiotics recently for a urinary tract infection. On 7/2/24 at 2:00 PM, Resident #158's catheter bag was observed hanging to the left side of his wheelchair at waist level. On 7/3/24 at 1:48 PM, Resident #158's catheter bag was observed hanging to the left side of his wheelchair at waist level. The tubing contained sediment and cloudy urine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/05/2024
NAME OF PROVIDER OR SUPPLIER Twin Falls Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 674 Eastland Drive Twin Falls, ID 83301	

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/3/24 at 3:54 PM, CNA #2 was asked if he was Resident 158's care giver. CNA #2 stated, Yes. CNA #2 was asked why Resident #158's catheter bag was positioned at waist level on his wheelchair. CNA #2 stated, It's his preference to have it on the wheelchair so [Resident #158] can have access to it. CNA #2 was asked if he was aware the catheter bag was to be positioned below the bladder. CNA #2 stated, Yes. CNA #2 entered Resident #158's room and confirmed the catheter bag was positioned on the wheelchair above the bladder. CNA #2 again stated, It's [Resident #158's] preference since he used to care for his catheter at home. CNA #2 stated he was not sure if Resident #158's preference was documented. On 7/4/24 at 9:05 AM, Resident #158's catheter bag was observed at waist level hanging on his wheelchair with cloudy urine and sediment in the tubing. Resident #158 was asked if staff told him or offered to lower the catheter bag below his waist and Resident #158 stated, No. During an interview on 7/4/24 at 9:07 AM, RN #2 was asked about Resident #158's catheter bag positioned at waist level and having a history of urinary tract infection and sepsis. RN #2 confirmed the history and stated the staff had offered to lower the catheter bag but Resident #158 said it was his preference to have it at waist level. RN #2 was asked if his refusals were documented, or care planned. RN #2 stated she did not know. During an interview on 7/4/24 at 11:11 AM, LPN #1 was asked about the position of Resident #158's catheter bag. LPN #1 stated Resident #158 liked his catheter bag to hang on his wheelchair at waist level next to him so it was in his sight. LPN #1 stated having the bag hang on the side of the wheelchair presented issues with infection control and drainage. LPN #1 further stated he had not had a problem with Resident #158 insisting on hanging the catheter bag on the side of the wheelchair as he always placed it under his wheelchair. LPN #1 stated he hoped the CNAs would do the same or at least report his refusal to the nurse. LPN #1 stated, It doesn't matter if the resident prefers it in sight, it needs to drain, especially with his history. During an interview on 7/4/24 at 12:45 PM, the NP was asked her expectation for positioning of Resident #158's catheter bag. The NP stated, gravity drainage below the bladder. The NP was asked if staff let her know it was Resident #158's preference to hang his catheter bag on the side of his wheelchair at waist level. The NP stated, No, but I'm okay with that level because Resident #158 will do what he does at home. The NP stated her expectation would be to educate Resident #158 on the consequences of poor drainage and care plan his preference. During an interview on 7/5/24 at 10:06 AM, the CNO and the CEO were asked who developed the care plans. The CEO stated the Interdisciplinary Team and the MDS Coordinator were responsible for the oversite. The CEO stated the MDS Coordinator worked remotely and had started his position two weeks ago. The CNO was asked who would be responsible to care plan Resident #158's refusal or not following the plan of care in regard to his preference to hang his catheter bag above his bladder and not below the bladder. The CNO stated she was made aware two days ago of Resident #158's preference to position the catheter bag on the side of his wheelchair. The CNO stated there should be documentation about Resident #158 not allowing staff to position the bag below the bladder. 40902 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #39 was admitted to the facility on [DATE], with multiple diagnoses including obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional). A quarterly MDS assessment, dated 3/18/24, documented Resident #39 was cognitively intact. Resident #39's care plan, dated 3/20/24, documented Resident #39 had an indwelling foley catheter (device that drains urine from the urinary bladder into a collection bag outside of the body). Interventions included staff were to secure the catheter with a leg strap (a fabric band or pouch that goes around the leg to comfortably secure a urinary drainage bag in place). A physician order, dated 11/14/23, documented staff were to secure Resident #39's indwelling catheter using an anchoring device to prevent movement and urethral traction (can cause irritation and trauma to the urethra which can result in pain and spasm). Resident #39's TAR, dated July 2024, documented on 7/2/24, 7/3/24 and 7/4/24 catheter care included an anchoring device with leg strap was completed. On 7/2/24 at 2:28 PM, 7/3/24 at 3:47 PM, and 7/4/24 at 10:30 AM, Resident #39 was observed without a leg strap securing his indwelling urinary catheter tubing to his leg. Resident #39 stated staff were not securing his catheter tubing to his leg. During an interview on 7/4/24 at 10:56 AM, LPN #1 stated he did mark on the TAR dated 7/4/24 that Resident #39's catheter care was provided, but he was unsure if the tubing was secured to his leg. He stated he should not have documented that the treatment was completed before he was certain that it was. LPN #1 stated if a resident refused care that the refusal should be documented in the resident's progress notes and the physician should be notified. During an interview on 7/5/24 at 10:05 AM, the CNO stated staff should be following physician orders, and they should be documenting refusals and notifying the physician.

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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** 40902 Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure a resident received oxygen therapy per physician's orders. This was true for 1 of 1 resident (Resident #14) reviewed for oxygen therapy. This failure created the potential for Resident #14 to experience hyperoxia (cells, tissues, an organs are exposed to an excess supply of oxygen. Findings include: The facility's policy titled, Oxygen Therapy, dated 8/4/23 stated staff were to verify the physician's order prior to administering oxygen therapy. Resident #14 was admitted to the facility on [DATE] with multiple diagnoses including acute respiratory failure with hypercapnia (a buildup of carbon dioxide in the bloodstream that can cause shortness of breath and fatigue). Resident #14's annual MDS assessment, dated 3/15/24, documented he was receiving oxygen therapy. A physician order, dated 7/21/23, documented Resident #14 was to receive oxygen at 2 liters per minute (LPM) via nasal cannula continuously. Resident #19's TAR, dated July 2024, documented on 7/4/24, LPN #1 documented Resident #14 was receiving oxygen at 2 LPM continuously. On 7/2/24 at 10:30 AM, 7/3/24 at 10:42 AM, and 7/4/24 at 10:20 AM, Resident #19 was observed lying in bed using a nasal cannula and the oxygen cannister was set at 3 LPM. During an interview on 7/4/24 at 10:55 AM, the ACON observed Resident #14's oxygen cannister and stated it was set at 3 LPM. The ACON said she was unsure what the physician order for oxygen was for Resident #14 without reviewing the orders. During an interview on 7/4/24 at 10:56 AM, LPN #1 stated the MAR indicated the correct level of oxygen the cannister should be set. He stated he gave Resident #14 his medication and looked at the oxygen setting but he could not remember what it was set at or what it was supposed to be set at. LPN #1 stated he must not have looked closely, since he marked on the TAR that the oxygen was at 2 LPM per the physician order. During an interview on 7/5/24 at 10:05 AM, the CNO stated staff should be following physician orders and not signing off on the MAR/TAR incorrectly.

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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. 36190 Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure proper procedures for cooling leftovers were followed; maintain proper holding food temperatures; and equipment, floors, and dishware were cleaned and/or maintained. This placed all 52 residents residing in the facility who received meals from the kitchen at risk for potential contamination of food and adverse health outcomes, including food-borne illnesses. Findings include: The facility's policy titled, Use of Leftovers, dated 2021, documented leftovers must be cooled to 70 degrees F (Fahrenheit) within 2 hours and then to 41 degrees F within another 4 hours. The facility's policy titled, Food Storage, dated 2021, documented all refrigerator units should be kept clean and in good working condition at all times. Time/temperature control for safety foods must be maintained at or below 41 degrees F unless otherwise specified by law. The facility's policy titled, Food Temperatures, dated 2021, documented temperatures should be taken periodically to assure hot foods stay above 135 degrees F and cold foods stay below 41 degrees F during the holding and plating process and until food leaves the service area. The facility's policy titled, General Sanitation of Kitchen, dated 2021, documented, Food and nutrition services staff will maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. During the kitchen tour on 7/2/24 at 9:27 AM with [NAME] #2 and on 7/3/24 at 1:56 PM with the RD the following observations were made: On 7/2/24 at 9:27 AM, the temperature of the walk-in refrigerator measured 48 degrees F. [NAME] #1 was asked if 48 degrees F was correct. [NAME] #1 stated, No, but the gaskets around the door were torn and a work order was placed for repair. The gaskets were observed torn on the lower door. [NAME] #1 demonstrated how the door should be pushed shut since the door did not seal on its own. The floor in the walk-in refrigerator was observed with food, trash debris, rusted areas, and a build-up of dirt-like debris under the shelving. The floor also contained a large yellow spill. On 7/3/24 at 1:56 PM, the RD stated the walk-in refrigerator was deep cleaned but she was not sure how often. The two range ovens contained dried cream-like spillage on the outside doors. Inside the right oven contained a foiled baking sheet with a collection of dried food debris. On 7/3/24 at 2:05 PM, the RD confirmed the soiled condition and stated it should be cleaned. The walls in and around the steam table and coffee station contained dried splatters. On 7/3/24 at 2:06 PM, the RD stated the walls should be cleaned frequently. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The floor throughout the kitchen contained scuff marks, worn areas, cracked tiles, and gaps with a dark gummy substance between tiles. An accumulation of dried food debris was observed on the floor between the oven and steamer. On 7/3/24 at 2:07 PM, the RD acknowledged the floor needed cleaning and repair. The RD stated the facility had discussions about it. On 7/3/24 at 2:08 PM, [NAME] #2 was asked if there were leftovers. [NAME] #2 stated, Yes, the breakfast gravy placed in the walk-in refrigerator at 9:00 AM. A half size six-inch-deep stainless-steel pan was observed covered with tin foil containing gravy in the walk-in refrigerator. [NAME] #2 was asked to check the temperature of the gravy. The gravy measured at 65 degrees F. [NAME] #2 was asked how she cooled hot foods down quickly. [NAME] #2 stated she poured the gravy from a larger deep steamtable pan and into the current pan. The RD was present and acknowledged the gravy was still too hot after five hours, stating the staff should be using shallow pans, leave the lid off for a few hours, etc. to get the temperature down quickly. According to calculations using Newton's Law of Cooling, the temperature of the gravy after five hours should be at 43.7 degrees F. On 7/4/24 at 7:33 AM, [NAME] #1 was observed taking the holding temperatures of the cold foods and beverages on the breakfast tray line. The pears were measured at 45 degrees F, cut strawberries measured at 43 degrees F, cottage cheese was measured at 46 degrees F, milk was measured at 43 degrees F, chocolate milk was measured at 44 degrees F, and the health shake was measured at 42 degrees F. [NAME] #1 was asked what the holding temperatures should be for cold foods and [NAME] #1 stated below 50 degrees F. On 7/4/24 at 7:38 AM, eight beverage pitchers on the breakfast cart, trays, plate bases and lids on the tray line were noted to be coated with a white residue. [NAME] #2 stated the white coating was due to hard water, stating she was waiting for the product to arrive as they were out of the product for three to four months. During an interview 7/4/24 at 11:42 AM, the CEO was asked about the kitchen's dishes and pitchers that contained hard water stains. The CEO stated he was aware and was considering a water softener for the facility. During a follow-up interview on 7/5/24 at 12:23 PM, [NAME] #1 was asked if she was aware the cold food and beverage items on the breakfast tray line on 7/4/24, should be held at 41 degrees F but some measured above 41 degrees F. [NAME] #2 stated, No, not until 7/4/24.