STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135105	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple View Transitional Care Center	660 South Second Street West Rexburg, ID 83440

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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** 51121 Based on observation and interview, the facility failed to ensure dignity of residents when staff enter their rooms without knocking and waiting for acknowledgement to enter. This was true for 2 out of 2 resident rooms observed during the morning meal tray delivery. This deficient practice placed residents at risk of embarrassment and diminished sense of self-worth. Findings include: On 10/21/24 at 8:04 AM, observed CNA #2 had not knocked or waited for resident acknowledgement prior to entering room [ROOM NUMBER] when delivering the breakfast meal. On 10/21/24 at 8:05 AM, CNA #2 stated she normally does knock but the door was open, so I did not knock on the resident's door. On 10/21/24 at 8:06 AM, observed NA #2 had not knocked or waited for resident acknowledgement prior to entering room [ROOM NUMBER] when delivering the breakfast meal. On 10/21/24 at 8:07 AM, NA #2 stated she should have knocked before entering the resident's room. On 10/25/24 at 11:20 AM, the ADON stated staff need to knock prior to entering a resident's room, even if you see the resident in their bed.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on policy review, observation, record review, and staff interview, it was determined the facility failed to ensure residents were assessed to determine if they were safe to self-administer medications for 2 of 6 residents (#3 and #36) reviewed for self-administration of medications. This failure created the potential for adverse effects if residents self-administered medications inappropriately. Findings include: The facility's Self Administration of Medications policy dated June 2023, documented: - If a resident desires to participate in self-administration of medications, the interdisciplinary team will assess and periodically re-assess the resident based on change in the resident's status. - If the resident is a candidate for self-administration of medications, a physician's order for self-administration of medications or for specific medications to be administered (example inhalers) will be obtained. Self-administration of medications will be care planned. - Resident will be instructed regarding proper administration of medication by the nurse. - Nursing will be responsible for monitoring self-administered doses in the resident's medication administration record. - Storage and location of drug administration (e.g., resident's room, nurses' station, or activities room) will comply with state and federal requirements for medication storage. 1. Resident #3 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves resulting in nerve damage) and nicotine dependence. On 10/21/24 at 10:24 AM, observed in Resident #3's room, a bottle of Equate Fiber Powder. A quarterly MDS, dated [DATE], documented Resident #3 had moderate cognitive impairment. A care plan, dated 11/19/21, documented Resident #3: - chooses to self-administer medications -Resident will self-administer Preparation H in accordance with the dosage and frequency prescribed by the physician x 90 days - Complete the self-medication assessment per protocol - Establish means of resident/nurse documentation of self-administered meds - If the resident requests, obtain a physician's order to store the medication at the bedside (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- May safely administer Preperation H and may keep at bedside - Obtain a complete physician's order for the resident to self-administer the specific medication - Re-assess resident's ability to safely self-administer with any significant changes in condition On 10/23/24 at 11:54 AM, a review of Resident #3's medication order list had not documented an order for the Fiber Powder. On 10/23/24 at 1:34 PM, LPN #1 stated she did not know the Fiber Powder was in Resident #3's room. On 10/23/24 at 2:13 PM, the DON stated she was told about the Fiber Powder being in Resident #3's room and she stated she had a hard time getting the case worker to not let Resident #3 buy items she does not need. The DON stated if a resident chooses to self-administer medication, an assessment is done, an order is received to allow them to self-administer the medication, and it is care planned. The DON stated the medication should not have been in Resident #3's room. 2. Resident #36 was admitted on [DATE], with multiple diagnoses including acute respiratory failure and COPD (a group of lung diseases that block airflow and make it difficult to breathe). On 10/21/24 1:46 PM, a bottle of TUMS (antacid medication) was observed in room Resident #36's room. Resident #36's physician order list did not document an order for the Tums. Resident #36's care plan dated 1/6/24, directed staff to assess resident quarterly and with COC for continued safety with self-administration of medications. A Self-Administration of Medications - IDT Determination assessment dated [DATE], documented Resident #36 was found safe to partially administer nebulizer. Nurses to open and place solution in nebulizer machine. No other self-administration assessments were documented in his medical records. A quarterly MDS, dated [DATE], documented Resident #36 was cognitively intact. On 10/23/24 at 1:35 PM, LPN #1 stated she was not sure if Resident #36 was care planned to have TUMS at the bedside, but he does have an order for the Tums. On 10/23/24 at 1:38 PM, LPN #1 reviewed Resident #36's physician's orders and stated he did not have an order for the TUMS. On 10/23/24 at 1:42 PM, LPN #1 stated, PRN medications are only good for 14 days then they come off the physician's order list. Resident #36 had a PRN order for TUMS but it must have fallen off his physician order list. LPN #1 also stated Resident #36 had no self-administration assessment for the TUMS but he should have had one completed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with a clean, safe, homelike environment. This was true for all 65 residents who resided in the facility whose equipment and environment were observed. This deficient practice created the potential for harm if: a) cross contamination due to equipment not being cleaned between use b) residents were embarrassed by and/or felt the disrepair in the facility was unacceptable, disrespectful, undignified, or c) residents were injured due to unsafe areas in the facility. Findings include: The facility's Housekeeping policy, revision date May 2007, documented the facility would provide a clean, comfortable, homelike, and sanitary living area. The following areas were observed: a) On 10/22/24 at 8:35 AM, observed the sit-to-stand (a device used to rise from a seated position to a standing position without using hands for assistance) base sides had a white dried substance, while the center of the base and in the crevasses had visible dirt and other debris on it . On 10/22/24 at 11:49 AM, Resident #49s feeding pump stand was observed with a dry, cream colored substance on the base. On 10/22/24 at 12:33 PM, the Housekeeping Supervisor stated the equipment in the rooms are cleaned 2-3 times a week. She also stated, when the housekeepers clean a resident's room they clean the bathroom, the oxygen concentrators top to bottom, and the feeding pump stands are cleaned top to bottom, including the base. On 10/22/24 at 12:39 PM, observed Resident #49's feeding pump pole with the Housekeeping Supervisor and she stated that pole got missed, it should have been cleaned. On 10/23/24 at 12:18 PM, the DON stated the Hoyer lifts, sit-to-stands, and vital sign machines should be cleaned after each use. The equipment in the room is cleaned by housekeeping and she was not aware of how often the housekeepers clean the equipment in the room. On 10/24/24 at 8:37 AM, the Maintenance Manager stated the sit-to-stand device should have been cleaned before being put in the storage room. b) On 10/21/24 at 9:35 AM, observed in room [ROOM NUMBER], food particles and large stains in the carpet. On 10/22/24 at 10:31 AM, room [ROOM NUMBER]-A's floor was observed with chunks of food substance and black, dry, smearing on the floor. On 10/22/24 at 2:11 PM, observed in room [ROOM NUMBER], the wall and wallpaper had large scrapes and scratches. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/24 at 3:23 PM, the privacy curtain in room [ROOM NUMBER] was observed with a dry, brown substance. On 10/24/24 at 10:00 AM, observed food particles smashed into the carpet in room [ROOM NUMBER] similar to what was observed on 10/21/24. On 10/24/24 at 10:09 AM, the housekeeping supervisor stated room [ROOM NUMBER] should have been vacuumed. c) On 10/21/24 at 8:00 AM, observed in room [ROOM NUMBER]'s bathroom, a piece of flooring was missing and there was a quarter inch gap between the flooring and the toilet base. On 10/21/24 at 10:10 AM, observed the window in room [ROOM NUMBER] with an approximate 8 inch crack. On 10/21/24 at 3:59 PM, observed loose plastic door protectors on the following rooms: room [ROOM NUMBER], 114, 208, 221, and the janitor closet on hall 100. On 10/23/24 at 8:04 AM, the Administrator stated the loose plastic door covering could cause a skin tear and it should have been repaired. On 10/24/24 at 10:18 AM, the Maintenance Supervisor stated the plastic door covering being loose could cause hazards and it does not look very good. On 10/24/24/ at 2:01 PM, the Maintenance Supervisor stated he did see where the missing door cover could be an issue and they should be fixed. 50983 51121

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on record review and staff interview, the facility failed to ensure residents' Minimum Data Set (MDS) had correct assessment information. This was true for 4 of 4 residents (#3, #4, #15, and #38) reviewed for accuracy of MDS assessments. This deficient practice created the potential for residents to have their mental health needs not met due to inaccurate assessments. Findings include: The Resident Assessment Instrument (RAI), revised 10/1/2024, documents if a PASRR (Preadmission Screening and Resident Review) Level II determines a resident has a serious mental illness then section A1500 of the MDS should be marked yes. 1. Resident #3 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including schizophrenia and bipolar disorder. Resident #3's PASRR Level II dated 4/18/24, documented she had schizophrenia. Resident #3's admission MDS dated [DATE], documented she was not currently considered by the state level II PASRR to have serious mental illness and/or intellectual disability or a related condition. On 10/24/24 at 9:24 AM, the MDS clinical resource nurse stated Resident #3's diagnosis of schizophrenia should have been on her MDS. 2. Resident #4 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of bipolar disease. Resident #4's PASRR Level II dated 5/31/12, documented she had a past diagnosis of bipolar disorder and meets the criteria of major mental illness. Resident #4's annual MDS dated , 8/13/20, 6/29/21, 6/25/22, 6/21/23, and 5/22/24 documented section A1500 was marked no. 3. Resident #15 was admitted to the facility on [DATE], with a diagnosis of schizophrenia. Resident #15's PASRR Level II dated 7/10/23, documented he had a diagnosis of schizophrenia. Resident #15's admission MDS dated [DATE], and annual MDS dated [DATE], documented section A1500 was marked no. 4. Resident #38 was admitted to the facility on [DATE], with a diagnosis of schizophrenia. Resident #38's PASRR Level II dated 5/11/23, documented he had a diagnosis of schizophrenia. Resident #38's admission MDS dated [DATE], and annual MDS dated [DATE], documented section A1500 was marked no. On 10/24/24 at 9:00 AM, the MDS Resource Nurse stated if the there was a mental illness diagnosis the MDS section A1500 should have been marked yes . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/25/24 at 10:53 AM, the Regional Nurse, with the ADON and Administrator present, stated resident's #3, #4, #15, and #38, all had Level II PASRR's with a diagnosis of mental illness and section A1500 of their MDS's should have been marked yes. 49552

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on record review, policy review, and interview, it was determined the facility failed to ensure a baseline care plan was developed within 48 hours of resident's admission. This was true for 1 of 5 residents (Resident #52) reviewed for baseline care plan. This failure created the potential for harm when the care plan failed to provide direction for care. Findings include: The facility's Comprehensive Person-Centered Care Planning policy, revised December 2023, documented under Procedure #1, Within 48 hours of the resident's admission, the facility will develop and implement a baseline care plan that includes instructions needed to provide effective and person-center care. The State Operation Manual, Appendix PP revised on 8/8/24, documents S483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. Resident #52 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic right heart failure (occurs when the right side of the heart can't pump blood properly to the lungs) and COPD (a lung disease that causes breathing problems and restricted airflow). On 10/23/24, observed in Resident #52's record, the initial baseline care plan had not been completed for his admission on 9/26/24. On 10/24/24 at 9:39 AM, the MDS clinical resource nurse and ADON stated Resident #52's baseline assessment for his admission on 9/26/24 had not been completed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure resident's care plans were revised to reflect current needs and interventions. This was true for 2 of 17 resident's (#3 and #21) whose care plans were reviewed. This placed resident at risk of adverse outcomes if care and services were not provided due to care plans not being revised as resident's needs changed. Findings include: The facility's Comprehensive Person-Centered Care Planning Policy, revision date December 2023, documented the resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments. 1. Resident #3 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves resulting in nerve damage) and nicotine dependence. Resident #3's Smoking Evaluation dated 7/19/24, documented she was able to light her own cigarette, holds smoking materials safely, and disposes of smoking materials appropriately. A quarterly MDS, dated [DATE], documented Resident #3 had moderate cognitive impairment. Resident #3's Smoking Evaluation dated 9/9/24, documented she had cognitive loss, a dexterity problem, falls/leans sideways, able to light her own cigarette, holds smoking materials safely, disposes of smoking materials appropriately, and had a need for adaptive clothing/device/assistance (smoking apron). Resident #3's care plan documented patient may smoke with supervision per facility policy. Maintain patients smoking materials at nurse's station. Resident #3's care plan also documented resident was able to smoke safely and independently, resident is able to keep smoking materials in her room in a locked box. On 10/23/24 at 3:42 PM, the DON stated Resident #3's care plan should have been updated. She is independent with smoking now. 2. Resident #21 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including cirrhosis of the liver (chronic liver damage from a variety of causes leading to scarring and liver failure) and nicotine dependence. Resident #21's care plan dated 3/25/24, documented staff to assess resident quarterly and with change in condition for continued safety with self-administration of medications. A Self-Administration of Medication -IDT Determination assessment dated [DATE], was documented in Resident #21's medical record. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Self-Administration of Medications - Initial Evaluation dated 7/10/23, was documented in Resident #21's medical record. Resident 21's medical record did not document quarterly self-administration of medication assessments. A quarterly MDS assessment, dated 10/10/24, documented Resident #21 was cognitively intact. On 10/23/24 at 11:24 AM, the DON stated the self-administration assessment should be done periodically per regulations. She also stated Resident #21's care plan was incorrect and should have been updated.

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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** 50983 Based on policy review, record review, observation, and interviews, the facility failed to ensure residents were free from accidents. This was true for 1 of 1 resident (Resident #9) reviewed for accidents. This failure had the potential to cause residents significant injuries. Findings include: The facility's Smoking Policy, undated, documented: - An independent smoker is a smoker who has been evaluated by the IDT team using the smoking assessment form and determined to be safe to smoke independently. - An assisted smoker is a smoker who has been evaluated by the IDT team using the smoking assessment form and determined to require assistance with smoking privileges. Current residents who have been assessed as assisted smokers will be supervised during designated times and smoking material will be kept in the designated area. Resident #9 was admitted on [DATE], with multiple diagnoses including anxiety disorder, depression, and malnutrition. Resident #9's care plan dated 7/22/24, documented he required supervised smoking. A nursing note dated 8/6/24, documented Resident #9 was outside smoking unsupervised when another resident gave him a cigarette. Resident #9 fell out of his wheelchair when attempting to put the cigarette butt in the ashtray. Resident #9 and other residents who were outside smoking stated he hit his head when he fell out of his wheelchair. Nursing assessed Resident #9 and found no injuries. A Fall Incident report dated 8/6/24, documented under Description, Resident #9 was outside smoking when he leaned forward to put his cigarette butt in the ashtray and fell out of his wheelchair hitting his head on the wall and received a skin tear to the left forearm. On 10/23/24 at 2:05 PM, the DON stated Resident #9 was put on supervised smoking after he was involved in a resident-to-resident incident in the smoking area on 7/21/24. When asked about the incident on 8/6/24, with the resident falling out of his wheelchair while smoking independently, she stated they had taken him off the supervision and he was able to smoke independently again. On 10/24/24 at 11:25 AM, the DON stated Resident #9 was a supervised smoker from 7/21/24 until 10/2/24. The DON was unable to provide documentation showing Resident #9 had been supervised during the incident.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on policy review, observation, record review, and interviews, it was determined the facility failed to provide respiratory services as ordered by the physician. This was true for 3 of 15 residents (#14, #28, and #52) whose records were reviewed for respiratory services. This failure created the potential for residents to experience increased fatigue and low oxygen levels. Findings include: 1. Resident #14 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic respiratory failure with hypercapnia (occurs when there is too much carbon dioxide (CO2) in the blood) and acute respiratory failure with hypoxia (occurs when the body doesn't have enough oxygen in the tissues). On 10/21/24 at 10:16 AM, observed Resident #14 outside her room without her oxygen cannula on, with staff present and talking to her. Resident #14's physician's order dated 7/2/24, documented oxygen at 3 liters per minute via nasal cannula continuously and check liter flow four times a day. On 10/25/24 at 11:18 AM, the DON stated staff should be reminding residents about oxygen usage when they see them without their oxygen cannula on. 2. Resident #28 was admitted to the facility on [DATE], with multiple diagnoses including emphysema (a chronic lung disease that damages the upper lobes of the lungs) and COPD (a lung disease that causes breathing problems and restricted airflow). On 10/22/24 at 10:50 AM, observed COTA #1 apply the nebulizer medication mask to Resident #28 and then started the nebulizer device. On 10/22/24 at 11:10 AM, RN #1 stated that she had filled Resident #28's nebulizer cup with the ipratropium-albuterol solution and left the nebulizer with the resident. Resident #28's medical record, IDT self administration of medication determination dated 1/8/24, documented resident can administer own nebulizer medications. The facility provided the COTA job description which had no documentation authorizing the COTA to apply the nebulizer mask or start the respiratory medication treatment. On 10/23/24 at 2:08 PM, the DON stated the COTA should not have administered the nebulizer medication mask treatment to Resident #28. 3. Resident #52 was initially admitted to the on facility 5/2/24, and readmitted on [DATE], with multiple diagnoses including chronic right heart failure (occurs when the right side of the heart can't pump blood properly to the lungs) and COPD (a lung disease that causes breathing problems and restricted airflow). (continued on next page)

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Temple View Transitional Care Center	660 South Second Street West Rexburg, ID 83440

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 8:41 AM, observed resident #52 in his room without his oxygen cannula on and his oxygen concentrator turned off. On 10/22/24 at 8:46 AM, Resident #52 stated he only uses the oxygen at night during sleep. On 10/22/24 Resident #52's physician's order dated 9/26/24, documented oxygen at 2 liters per minute via nasal cannula continuously and check liter flow four times a day. On 10/23/24 at 4:10 PM, the DON stated Resident #52 should have been wearing the oxygen cannula continuously as ordered, not just at night.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 51121 Based on observation and staff interview, it was determined the facility failed to ensure nurse staffing information was accurate and posted daily for each shift. This failed practice had the potential to affect all residents residing in the facility and their representatives, visitors, and others who wanted to review the facility's staffing levels. Findings include: The State Operation Manual, Appendix PP revised on 8/8/24, documented S483.35(g) Nurse Staffing Information. S483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. On 10/24/24 at 1:30 PM, observed the Daily Staffing sheets for April 2024 through October 2024, noting 46 days were not completed accurately with the scheduled total hours and the actual hours worked by RNs, LPNs, and CNAs. The following dates were missing the required data: - April 10 and 11, 2024 - May 15, 16, 18. 19, 21 through 30, 2024 - June 1 through 30, 2024 On 10/24/24 at 2:30 PM, the DON stated those dates listed were not completed and probably had been posted incomplete or were not posted at all. On 10/24/24 at 4:30 PM, the Administrator and ADON stated the Daily Staffing sheets had not been completed on those dates list above.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on record review and staff interview, it was determined the facility failed to ensure residents were monitored appropriately for medication, therapeutic range, and toxicity levels. This was true for 1 of 17 residents (Resident #49) reviewed for unnecessary medications. This failure created the potential for residents to experience adverse reactions due to the lack of appropriate monitoring. Findings include: Resident #49 was admitted to the facility on [DATE], with multiple diagnoses including acute osteomyelitis (a bone infection that occurs when an infection spreads to the bones, usually within two weeks of the onset of disease) and cerebral palsy (a group of neurological disorders that affect a person's ability to move, balance, and maintain posture). Resident #49's physician's order dated 3/7/24, documented Levetiracetam Oral Tablet 1000 MG, give 1000 MG three times a day for Seizure Disorder. On 10/25/24 at 8:46 AM, the ADON and Clinical Resource nurse stated they were going to call the Physician and Pharmacist for clarification on the drug dosage and blood monitoring. On 10/25/24 at 9:00 AM, the ADON stated the Physician and Pharmacist agreed Resident #49 should have gotten a Levetricetam baseline level and then monitored for therapeutic levels every 6 months.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure medications available for residents were labeled, dated, and stored appropriately. This was true for 1 of 1 medication storage rooms inspected, 2 of 46 residents (#3 and #36) resident rooms inspected, and 1 of 2 treatment carts observed. This failure created the potential for residents to receive expired medications with decreased efficacy, the potential for adverse effects if residents self-administered medications inappropriately, and the potential for residents to obtain prescribed wound care supplies used for other residents and presented the risk for cross-contamination of wound care products stored in the treatment cart. Findings include: The CDC guidelines for Preventing Unsafe Injection Practices, dated 3/26/24, documented once a multi-dose vial is opened (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer states another date for that opened vial. The beyond-use-date should never exceed the manufacturer's original expiration date. The facility's Medication Administration: Controlled Medication policy, undated, documented it is the policy of this facility to provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. The facility's Self Administration of Medications policy, revision date June 2023, documented: - If a resident desire to participate in self-administration, the interdisciplinary team will assess and periodically re-assess the resident based on change in the resident's status. - Storage and location of drug administration (e.g., resident's room, nurse's station, or activities room) will comply with state and federal requirements for medication storage. The facility provided Policy/Procedure - Nursing Clinical for Med/Tx cart security, non-dated, documented Carts must be locked when 1. They are not in use (such as the station), 2. They are not in line of sight, 3. They are not in conscious control. 1. On 10/22/24 at 10:03 AM, the medication storage room was inspected with RN #1 present. Observed Tubersol solution vial with no opened date in the medication storage refrigerator. On 10/22/24 at 10:09 AM, RN #1 stated, should the Tubersol bottle be dated after opening? On 10/22/24 at 10:15 AM, the DON stated the bottle of Tubersol solution should have been dated. 2. The following observations were made for medications stored in resident's rooms: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a) Resident #3 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves resulting in nerve damage) and nicotine dependence. On 10/21/24 at 10:24 AM, a bottle of Equate Fiber Powder was observed in Resident #3's room. A quarterly MDS dated [DATE], documented Resident #3 had moderate cognitive impairment. Resident #3's medication order list did not document an order for the Fiber Powder. On 10/23/24 at 1:34 PM, LPN #1 stated she did not know the Fiber Powder was in Resident #3's room. On 10/23/24 at 2:13 PM, the DON stated she was told about the Fiber Powder being in Resident #3's room and she had a hard time getting the case worker to stop Resident #3 from buying items she does not need. The DON stated the medication should not have been in Resident #3's room. b) Resident #36 was admitted on [DATE], with multiple diagnoses including acute respiratory failure and COPD (a group of lung diseases that block airflow and make it difficult to breathe). On 10/21/24 1:46 PM, a bottle of TUMS (antacid medication) was observed in room Resident #36's room. Resident #36's physician order list did not document an order for the Tums. A Self-Administration of Medications - IDT Determination assessment dated [DATE], documented Resident #36 was found safe to partially administer nebulizer medication. Nurses to open and place solution in nebulizer machine. No other self-administration assessments were documented in his records. A quarterly MDS dated [DATE], documented Resident #36 was cognitively intact. On 10/23/24 at 1:35 PM, LPN #1 stated Resident #36 does have an order for the Tums but, she was not sure if he is care planned to have TUMS at the bedside. On 10/23/24 at 1:38 PM, LPN #1 reviewed Resident #36's physician's orders and did not see that he had an order for the TUMS and his care plan did not document that he was able to keep them on his bedside table. On 10/23/24 at 1:42 PM, LPN #1 stated PRN medications are only good for 14 days then they come off the physician's order list. Resident #36 had a PRN order for TUMS and it must have fallen off his physician's order list. LPN #1 also stated Resident #36 had no self-administration assessment completed for the TUMS. On 10/23/24 at 2:16 PM, the DON stated Resident #36 did not have an order for him to self-administer TUMs and he should not have had them in his room. 3. On 10/21/24 at 9:48 AM, observed an unlocked wound care treatment cart parked outside of rooms [ROOM NUMBERS]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/21/24 at 10:00 AM, RN #2 came out of room [ROOM NUMBER], locked the cart and stated the treatment cart should have been locked. On 10/21/24 at 10:08 AM, RN #2 stated there were several prescription wound care supplies for various residents in the cart. On 10/25/24 at 11:15 AM, the ADON stated the treatment cart should not have been left unlocked. 51121

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 51121 Based on observation and staff interviews, it was determined that the facility failed to employ sufficient staff with the appropriate competencies and skill sets to carry out the functions of food and nutrition services, including resident assessments, individual plans of care, and the number, acuity, and diagnoses of the facility's resident population. These deficiencies had the potential to affect all residents requiring medical nutrition therapy, nutritional assessments, and appropriate supplementation and dietary interventions. Findings include: The State Operations Manual, Appendix PP, revised 8/8/24, documented, if a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. The director of food and nutrition services must at a minimum meet one of the following qualifications: - A certified dietary manager. - A certified food service manager, or - Has similar national certification for food service management and safety from a national certifying body; or - Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or - Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, forborne illness, sanitation procedures, and food purchasing/receiving. On 10/21/24 at 9:10 AM, the Food Service Manager stated the Dietician is part time, only coming in once or twice per month to do chart audits, but is available by the phone when needed. On 10/21/24 at 9:15 AM, observed the Food Service Manager's Idaho Nutrition and Food Service Professional online training program completion document. On 10/24/24 at 12:15 PM, the Food Service Manager stated she had attended a 26-hour course in Boise but did not complete the Certified Dietary Manager exam and had not obtained the Certified Dietary Manager certification. On 10/24/24 at 2:18 PM, the Administrator stated he thought the Food Service Manager was considered a CDM when she completed her training and was not aware she had to take a test to be certified.

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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. 51121 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure the food was stored in a safe and sanitary manner. These deficiencies had the potential to affect all residents 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: The FDA (Food Drug Administration) Food Code Section 3-501.17 Ready-to-Eat, TCS (time/temperature control for safety) food, date marking, states 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. The facility's Kitchen Resource: Food Safety for Your Loved One policy/procedure, non-dated, documented Food or beverages that have past the manufacturer's expiration dated should be thrown away. Food and beverages items without a manufacturer's expiration date should be dated upon arrival in the facility and thrown away three days after the date marked. Food in unmarked or unlabeled containers should be marked with the current date the food item was stored. The facility's Handling Cold foods for Trayline policy, non-dated, documented under At the time of service: Cold food items will be taken from the refrigerator one tray at a time to be used at the meal service (unless a reach-in refrigerator is available). Milk will be iced to chill it for use at meal service. During the initial kitchen inspection conducted on 10/21/24 at 7:53 AM, the following was observed: Single serve milk and yogurt containers were placed on the counter without any ice tray to keep them cold. In the reach-in refrigerator: - one bag of shredded cheese, opened to the air, had not been sealed correctly - one tray of poured juice cups had not been dated - 5-pound sour cream container had not been labeled with opened date In the walk-in refrigerator: - one whipped cream container with use by date of 10/9/24 - two containers of Pesto with use by date of 10/17/2023 On 10/21/24 at 8:42 AM, the Food Service Manager stated the Dietary Aide should not have left the milk and yogurt on the counter without an ice tray to keep it cold. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/21/24 at 8:45 AM, the Food Service Manager stated the unlabeled and outdated food items in the refrigerators and freezer should have been removed and disposed of. On 10/22/24 at 10:22 AM, observed in the snack refrigerator/freezers, the following items: Hall two refrigerator: - 4 containers of non-dated cottage cheese - small milkshake bottles not dated - small bag of non-dated, opened, shredded cheese labeled with resident's name - opened cheese spread dated 9/30 - non-dated wrapped sandwich labeled with resident's name - non-dated plate of pizza - non-dated plate with brownies - non-dated opened food item wrapped in foil Hall one refrigerator: - non-dated open rice bowl with meat labeled with resident's name - opened non-dated potato salad container - opened non-dated macaroni salad container 10/22/24 at 11:05 AM, the Food Service Manager stated all the food in the refrigerators should have been labeled with a resident name and dated when opened.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49552 Based on observation and staff interview, it was determined the facility failed to ensure infection control and prevention practices were maintained to provide a safe and sanitary environment when staff did not offer or encourage residents hand hygiene prior to meals and follow proper handling of medications. These failures had the potential to impact all residents in the facility by placing them at risk for cross contamination and infection. Findings include: The following was observed: 1. On 10/21/24 at 8:00 AM, observed food tray delivery and set up on Resident #19's overbed table. CNA #1 did not encourage him to perform hand hygiene before eating. On 10/21/24 at 8:03 AM, observed food tray delivery and set up on Resident #42's overbed table. NA #1 did not encourage him to perform hand hygiene before eating. On 10/21/24 at 8:09 AM, CNA #1 stated she should have provided hand hygiene to the residents. On 10/21/24 at 8:12 AM, NA #1 stated she should have asked if the residents wanted their hands cleaned before eating their meals. On 10/24/24 at 10:21 AM, the IP stated the staff should have offered hand hygiene before meals. 2. On 10/22/24 at 12:09 PM, RN #1 was observed dispensing medication into the medication bottle cap and poured out three tablets when she only needed two tablets. RN #1 held the third tablet in the medication bottle cap touching it with her ungloved finger and dispensed the two tablets into a medication cup and put the tablet she touched with her ungloved hand, back into the medication bottle. On 10/22/24 at 12:11 PM, RN #1 stated, she should not have touched the tablet with her bare hand. On 10/23/24 at 7:49 AM, LPN #1 was observed dispensing medication for Resident #53. She popped an Oxycodone tablet out of the package into her bare hand and then placed it in Resident #53's medication cup. LPN #1 then administered the medication to Resident #53. On 10/23/24 at 8:00 AM, LPN #1 stated she did not realize she had popped the pill directly into her hand. She also stated should not have touched the pill.