STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135113	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeview Estates	1828 Bridgeview Blvd Suite 2 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 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** Based on observation, record review, and interviews, it was determined the facility failed to ensure residents were initially assessed to determine if they were safe to self-administer medications for 1 of 1 resident (Resident #10). This failure created the potential for adverse effects if residents self-administered medications inappropriately. Findings include:Resident #10 was admitted to the facility on [DATE], with multiple diagnoses including emphysema and anxiety. On 7/6/25 at 1:51 PM, observed in Resident #10's room [ROOM NUMBER] tubes of Cortisone-10 cream on her overbed table. Resident #10 stated she self-administers the medication when she needs it. Resident #10's medical record had not contained a self-administration assessment for the Cortisone-10 cream.On 7/8/25 at 2:15 PM, the DON stated Resident #10 should have been assessed for the Cortizone-10 cream to allow her to have it in her room to self-administer and was not.

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 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** Based on observation, interview, and record review, it was determined the facility failed to ensure the MDS assessment accurately reflected the resident's status. This was true for 1 of 1 resident (Resident #10) whose MDS, care plan, and nursing assessments were reviewed. This deficient practice had the potential for negative outcomes if residents were not assessed and cared for or monitored due to inaccurate assessments. Findings include:Resident #10 was admitted to the facility on [DATE], with multiple diagnoses including emphysema and anxiety. Review of Resident #10's Level I PASRR dated 10/6/23, and Level II PASRR dated 10/10/23, and noted PTSD was listed as a diagnosis. Review of Resident #10's MDS dated [DATE], 1/18/25, 10/18/24, 7/20/24, 4/19/24, 1/18/24, and 10/18/23 which documented under I6100 Post Traumatic Stress Disorder (PTSD) was marked NO.On 7/7/25 at 1:20 PM, the DON stated once PTSD is listed on the PASSR's it should have been documented in each MDS and was not.

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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 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** Based on observation, interview, and record review, the facility failed to develop and implement resident's comprehensive person-centered care plan. This was true for 1 of 1 resident (Resident #10) whose care plan was reviewed. This deficient practice of not developing and implementing care plans placed residents at risk to their health and wellbeing with negative outcomes if services were not provided or provided incorrectly. Findings include: Resident #10 was admitted to the facility on [DATE], with multiple diagnoses including emphysema and anxiety. Resident #10's comprehensive person-centered care plan had not documented PTSD diagnosis with goals and interventions.On 7/8/25 at 2:19 PM, the DON stated Resident #10's PTSD diagnosis should have been care planned and was not.

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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** Based on policy review, record review, and staff interview, it was determined the facility failed to update care plans when changes occur to resident's care. This was true for 2 of 14 residents (#12 and #34) whose care plans were reviewed. This placed residents at risk of adverse outcomes if care and services were not provided as resident's needs changed. Findings include:The facility's policy, Comprehensive Care Plans and Conferences dated 9/5/24, documented resident’s care plans must be reviewed after each assessment and revised based on changing goals, preferences, and needs of the resident and in response to current interventions. Resident #12 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including COPD (a type of lung disease marked by permanent damage to tissues in the lungs, making it hard to breathe), congestive heart failure, and repeated falls. On 3/3/25, Resident #12 had a fall when his quad-cane bent during a transfer, resulting in a laceration and skin tear. The incident report documented an intervention to replace the quad-cane. On 4/19/25, a PT (Physical Therapy) Evaluation and Plan of Treatment documented Resident #12’s prior level of functioning required minimum to maximum assist for self-cares using a hemi-walker, power wheelchair, and manual wheelchair. The evaluation did not document the use of a quad-cane. On 4/23/25, a PT treatment encounter note documented Resident #12 was to ambulate short distances with staff using a hemi-walker. The treatment encounter note did not document the use of a quad-cane. Resident #12’s care plan, with a last review completed date of 7/2/25, documented he requires 1 person transfer assistance with a quad-cane. The care plan did not document the use of a hemi-walker. On 7/8/25 at 4:30 PM, the DON stated the quad-cane was replaced with a hemi-walker after Resident #12’s fall on 3/3/25. The care plan should have been updated to change the quad-cane to hemi-walker but was not. Resident #34 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including acute respiratory failure with hypoxia (a condition where the lungs cannot adequately oxygenate the blood, leading to dangerously low levels of oxygen in the body) and cellulitis of right lower limb (a bacterial infection affecting the skin and underlying tissues of the right leg, causing redness, swelling, pain, and warmth). On 7/6/25 at 2:53 PM, observed Resident #34’s left leg was very red and swollen and was not wearing Tubi grips. Resident #34’s physician order dated 3/12/25, documented Apply edema wear (Tubi grips size F) to bilateral lower extremity. Apply from base of toes to 1 below the knee. To prevent rolling, turn over the top of edema wear making a 3 cuff. Edema wear is washable but must hang to dry. It may be removed for skin care and assessment, then replaced. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #34’s Weekly Skin Assessment 6/25/25 and 7/3/25, documented SEVERE edema to bilateral lower extremities. Resident noncompliant with Tubi grips and foot elevation. Resident #34’s comprehensive person-centered care plan had not documented the use of Tubi grips daily. On 7/8/25 at 2:17 PM, the DON stated Resident #34’s Tubi grips should have been care planned and were not.

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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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility standing orders, record review and staff interview, it was determined the facility failed to follow facility bowel care standing order of delivering specific medications when residents do not have BM within 72 hours for 3 of 4 Residents (#34, #41, and #43) who records were reviewed for bowel and bladder care. This failed practice created the potential for residents to experience discomfort when medications were not administered according to the physician's order. Findings include: The facility standing orders and protocols documented BM (Bowel Movement) Step 1: Lactulose 10GM/15ML: 30 ml PO daily PRN for no bowel movement X 72 hrs +. If no results within 8 hrs proceed to step 2: BM Step 2: Dulcolax Suppository 10mg: give one Suppos rectally PRN daily for NO BM X 72 Hrs +. If no results within 8hrs proceed to step 3. BM Step 3: Fleet Enema 7-19 GM/118 ml: Give one Enema rectally PRN daily for NO BM X 72 Hrs+. If no results within 8 hours Notify MD for further instructions. a. Resident #34 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including acute respiratory failure with hypoxia (a condition where the lungs cannot adequately oxygenate the blood, leading to dangerously low levels of oxygen in the body) and cellulitis of right lower limb (a bacterial infection affecting the skin and underlying tissues of the right leg, causing redness, swelling, pain, and warmth). Resident #34 had a BIMS of 15. Review of Resident #34's medical record contained a signed facility standing order for bowel care.On 7/7/25 at 9:47 AM, Resident #34's medical record had documented bowel movement (according to B&B CNA task) on 6/12/25 at 8:20 PM, and not again until 6/16/25 at 12:20 PM, 87 hours later. Resident #34's physician's orders dated 8/19/24, related to bowel care were as follows:- Lactulose Solution 10 GM/15ML Give 30 ml by mouth as needed for No BM x72 hours Step ONE. If no results within 8 hours, proceed to step TWO, - Step TWO, Dulcolax Suppository 10 MG (Bisacodyl) Insert 10 mg rectally as needed for constipation - if no results from Lactulose Step TWO. If no results within 8 hours, proceed to Fleet enema, step THREE, - Step THREE Fleet Enema 7-19 GM/118ML (Sodium Phosphates) Insert 1 application rectally as needed for constipation - no results from suppository Step THREE. If no results, notify MD.Resident #34's MAR documented Lactulose, Dulcolax, and Fleet Enema were not given during the month of June 2025. Resident #34's medical record contained no documentation that the physician had been notified after 87 hours without a BM.Resident #34 was documented as eating 75 to 100 percent of his meals 6/8-13/25. On 6/14 Breakfast - 51 to 75%, Lunch - 100%, Dinner - 26 to 50%On 6/15 all meals eaten at 51 to 75%.Resident #34's medical record documented no behavioral related issues or refusals of care related to toileting during June or July 2025.On 7/8/25 at 2:20 PM, the DON stated nursing staff should have followed physician's orders and the facility standing order for Resident #34's bowel care and had not. b. Resident #41 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including fracture of left and right femur and heart failure. Resident #41 had a BIMS of 15.Review of Resident #41's medical record contained a signed facility standing order for bowel care.Resident #41's had documented bowel movement (according to B&B CNA task) on 6/11/25 at 3:46 PM, and not again until 6/14/25 at 9:32 PM, 77 hours later.Resident #41's had documented bowel movement (according to B&B CNA task) on 6/18/25 at 9:08 PM, and not again until 6/22/25 at 1:12 AM, 76 hours later.Resident #41's had documented bowel movement (according to B&B CNA task) on 6/27/25 at 1:51 AM, and not again until 6/30/25 at 9:59 PM, 92 hours later.Resident #41's physician's orders related to bowel care were as follows:- Lactulose Solution 10 GM/15ML dated 6/13/23, Give 30 ml by mouth as needed for No BM x72 hours Step ONE. If no results within 8 hours, proceed to step TWO, - Step TWO, Dulcolax Suppository 10 MG (Bisacodyl) dated 7/5/23, Insert 10 mg rectally as needed for constipation - if no results from Lactulose Step TWO. If no results within 8 hours, proceed to Fleet enema, step THREE, - Step THREE Fleet Enema 7-19 GM/118ML (Sodium Phosphates) dated 6/13/23, Insert 1 application rectally as needed for constipation - no results from suppository Step THREE. If no results, notify MD.Resident #41's MAR documented Dulcolax was given on 6/11/25, while Lactulose and Fleet Enema were not given during the month of June 2025. Resident #41's medical record contained no documentation that the physician had been notified of BM related issues during the month of June 2025.Resident was documented as eating the following percentage of his meals of the following dates.- 6/11/25 - Dinner 26 to 50%- 6/12/25 - Lunch 51 to 75%, Dinner 76 to 100%- 6/13/25 - None listed- 6/14/25 - None listed - 6/18/25 - Lunch 50 to 75%, Dinner 76 to 100%- 6/19/25 to 6/20/25 Lunch 76 to 100%, Dinner 76 to 100% - 6/27/25 - to 6/30/25 Dinner 76 to 100% Resident #41's medical record documented no behavioral related issues or refusals of care related to

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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** Based on observation, policy review, record review, and interviews, it was determined the facility failed to provide respiratory services as ordered by the physician. This was true for 2 of 5 residents (#34 and #43) whose records were reviewed for respiratory services. This failure created the potential for residents to experience increased fatigue and low oxygen levels. Findings include: a. Resident #34 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including acute respiratory failure with hypoxia (a condition where the lungs cannot adequately oxygenate the blood, leading to dangerously low levels of oxygen in the body) and cellulitis of right lower limb (a bacterial infection affecting the skin and underlying tissues of the right leg, causing redness, swelling, pain, and warmth).On 7/6/25 at 2:52 PM, observed Resident #34 was not using his oxygen concentrator located in his room. Resident #34 stated he uses it when he feels he needs it.Resident #34's physician's order dated 1/27/25, documented oxygen at 3 liters per minute continuously via nasal canula. Document every shift.Resident #34's care plan documented OXYGEN SETTINGS: O2 via nasal cannula at 3 LPM continuously and humidified. Date Initiated: 9/13/2024 Resident's medical record documented the following:Date & Time O2 SpO2 Staff- 7/7/25 at 7:07 96.0% Room Air RN #1 - 7/6/25 at 22:48 91.0% Room Air RN #1 - 7/6/25 at 22:47 91.0% Room Air RN #1 - 7/6/25 at 16:08 93.0% Room Air LPN #1 - 7/6/25 at 6:52 94.0% Room Air LPN #4 - 7/5/25 at 9:42 94.0% Room Air LPN #3 - 7/5/25 at 7:14 94.0% Room Air MAC #2 - 7/4/25 at 11:45 96.0% Room Air LPN #2 - 7/4/25 at 11:45 96.0% Room Air LPN #2 - 7/4/25 at 1:01 92.0% Room Air MAC #3 - 7/4/25 at 1:01 92.0% Room Air MAC #3 - 7/3/25 at 6:50 97.0% Room Air LPN #2 - 7/3/25 at 6:49 97.0% Room Air LPN #2 - 7/2/25 at 23:21 92.0% Room Air MAC #3 - 7/2/25 at 23:21 92.0% Room Air MAC #3 - 7/2/25 at 6:38 93.0% Room Air RN #1 - 7/1/25 at 23:54 91.0% Room Air MAC #3 - 7/1/25 at 23:54 91.0% Room Air MAC #3 - 7/1/25 at 14:29 91.0% Room Air LPN #6- 7/1/25 at 14:29 91.0% Room Air LPN #6 - 7/1/25 at 6:37 97.0% Room Air RN #1 On 7/8/25 at 2:25 PM, the DON stated nursing staff should have contacted Resident #34's physician to either cancel or update the oxygen order and had not.b. Resident #43 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and need for assistance with personal cares.Facility BiPAP / CPAP Administration policy dated 9/3/24, documented humidifier reservoir should be filled daily with sterile or distilled water to the fill-line. Each day when the patient is removed from the machine the reservoir should be emptied and left to air dry. Once weekly, the reservoir should be washed with warm soapy water and rinsed well, then left to air dry. Weekly cleaning should be documented in the patient record.On 7/6/25 at 1:17 PM, observed Resident #43's CPAP nasal pillows sitting on the bed side table uncovered. Resident #43 stated it had been a while since the facility staff had cleaned the mask and she had never seen staff clean the humidifier.Resident #43's TAR documented CPAP / BiPAP: Clean PAP nasal mask with warm soapy water and allow to air dry every dayshift. Order date 10/2/23. There was no documentation that Resident #43's CPAP mask had been cleaned on 6/19/25.RN #2 and LPN #5 documented in June 2025, they had cleaned the CPAP mask per physician's order and the care plan.RN #1 and LPN #2, #3, #4 documented in July 2025, they had cleaned the CPAP mask per physician's order and the care plan.On 7/8/25 at 2:24 PM, the DON stated she interviewed the nurses regarding the cleaning of Resident #43's CPAP mask. The nurses were not cleaning the mask or humidifier according to the physician's order and care plan and should have been.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and staff interview, it was determined the facility failed to ensure controlled medications were tracked and kept secure from potential theft and/or diversion. This was true for 2 of 2 medication carts reviewed. This failure created the potential for undetected misuse and/or diversion of controlled medications and had the potential to affect all residents who received controlled medication in the facility. Findings include:On 7/8/25 at 8:57 AM, during Sawtooth Hall medication cart audit, observed the narcotic accountability record, dated 5/3/25 to 7/8/25, with 3 licensed nurse signatures not documented. On 7/8/25 at 9:01 AM, LPN #1 stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart. On 7/8/25 at 9:10 AM, during Sun Valley Hall medication cart audit, observed the narcotic accountability record, dated 5/28/25 to 7/8/25, with 5 licensed nurse signatures not documented. On 7/8/25 at 9:36 AM, RN #1 stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart. On 7/8/25 at 3:37 PM, the DON stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart.

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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** Based on observation, policy review, and staff interview, it was determined the facility failed to ensure medications were secure and inaccessible to unauthorized staff and residents. This was true for 1 of 19 Residents (Resident #28). This failure created the potential for harm to a resident if they were to obtain medications which were left unattended and unsecured by staff. Findings include:The facility’s Storage and Expiration Dating of Medications and Biologicals policy revision date 8/1/24, documented the following: - the facility should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is not accessible by residents and visitors. Resident #28 was admitted to the facility on [DATE], with multiple diagnoses including spinal stenosis, lumbar region (condition where spaces narrow, putting pressure on the spinal cord and nerves) and diabetes. On 7/8/25 at 8:47 AM, the following was observed in Resident #28’s room; LPN #1 administered oral medications to resident then left insulin pen on resident’s overbed table when leaving the room to get a needle for the insulin pen. LPN #1 reentered resident’s room and administered the insulin. On 7/8/25 at 8:54 AM, LPN #1 stated she should not have left the insulin pen at Resident #28's bedside. On 7/8/25 at 10:05 AM, the DON stated medications should not have been left at Resident #28's bedside unattended. The facility's General Dose Preparation and Medication Administration policy dated 12/1/07, documented the facility staff should ensure that medication carts are always locked when out of site or unattended. On 7/7/25 at 1:48 PM, observed an unattended and unlocked medication cart next to the nurses’ station. MAC #1 stated the medication cart should have been locked when I was not at the cart. On 7/7/25 at 2:27 PM, the DON stated the medication carts are to be locked when staff are not next to the cart.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 2022 FDA Food Code, resident and staff interviews, it was determined the facility failed to ensure resident meals were palatable and maintained their correct temperature. This deficient practice had the potential to affect all residents who dined in the facility. This failed practice had the potential to negatively affect residents' nutritional status and psychosocial well-being. Findings include: The 2022 FDA Food Code states hot food will be maintained at 135 degrees F (Fahrenheit) or above and cold food will be maintained at 41 degrees F or below. The following comments were obtained during resident interviews. On 7/6/25 at 2:45 PM, Resident #46 stated meals are cold, with over or undercooked vegs that are often tasteless and mushy. On 7/6/25 at 2:52 PM, Resident #34 stated food is always cold and horrible, poorly fixed. Turkey and rice in last night’s dinner was horrible and tasted old. Resident #6 was admitted to the facility on [DATE], with multiple diagnoses including Multiple Sclerosis (disease in which the immune system attacks the protective covering of the nerve cells) and depression. On 7/6/25 at 10:04 AM, Resident #6 stated food is not good. The meat is tough, and the vegetables are soggy most of the time. The meal quality is worse on the weekends. On 7/8/25 at 3:00 PM, Resident #6 stated lunch was not too good, and the hot food was often cold. On 7/8/25 at 1:12 PM, a lunch meal taste tray was provided and the following issues with the quality of the food and temperatures are listed below. - The chicken temp was 135 degrees F, the chicken did have an acceptable temp but there was a strong spicy taste in the gravy that took away from the meal. - The pudding was 65.1 degrees F which should have been much colder and the taste was off. - The peas were 132.2 degrees F and acceptable. - The carrots were 129 degrees F, these were overcooked, mushy, and had a foul taste to them. The Holding Temperature log for the pudding on 7/8/25 lunch was 53 degrees F and should have been 41 degrees or lower. On 7/9/25 at 9:02 AM, the Facility Food Service Manager stated the holding temp for that dessert should have been 50 degrees F or colder and was not. On 7/9/25 at 9:02 AM, observed the kitchen Holding temperature logs for each meal were not legible for the following dates. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135113	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeview Estates	1828 Bridgeview Blvd Suite 2 Twin Falls, ID 83301

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- June 14, 15, 16, 21, 22, 23, 2025 all dinner meals. On 7/9/25 at 9:35 AM, the Facility Food Services Manager stated those Hold Temperature logs should have legible data entered and they were not on those dates.

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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. Based on observation, interview, and review of the Idaho Food Code, the facility failed to appropriately store, distribute, and label foods. This deficient practice had the potential to affect all residents who received meals prepared in the facility's kitchen. This placed residents at risk for potential contamination and use of spoiled foods, and adverse health outcomes including food-borne illnesses. Findings include: The Idaho Food Code, revised February 2021, stated, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking . refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.On 7/6/25 at 10:11 AM, observed the following issues in the Walk-in Refrigerator. - a large container of cooked turkey in liquid, partially covered with plastic wrap that was down in the liquid and not properly covered.- several trays of desserts and drinks that were not dated.- various zip-lock type bags containing peanut butter and jelly sandwiches, which were not dated.On 7/6/25 at 10:15 AM, observed the following issues in the Walk-in Freezer.- a large cardboard box of green beans, opened to the air and not properly covered.- a large cardboard box of chicken opened to air not properly covered.- a large cardboard box of hamburger patties opened to air not properly covered.On 7/6/25 at 10:22 AM, the Food Service Manager stated the food items should have been properly covered and dated when opened and were not.On 7/6/25 at 10:25 AM, reviewed the kitchen dish washer logs noting they were not completed with some missing data in July on the following dates: July 4 and 5 breakfast and lunch. On 7/6/25 at 10:27 AM, reviewed the kitchen sanitizing bucket PPM log which was missing data on July 3, 4 and 5 at the following times, 7 AM, 9 AM, 11 AM, and 1 PM.The Food Service Manager stated those dates should have been documented as completed and were not.On 7/6/25 at 12:27 PM, observed containers of lemonade and iced tea that were not labeled or dated, were being served in the dining room for lunch by the DON. The DON stated the containers don't have dates on them, but they just came from the kitchen.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, Department of Health and Welfare - Idaho Administrative rules, and U.S. Food and Drug Administration 2022 Food Code review, the facility failed to ensure garbage cans were properly closed with lids to minimize attracting pests and rodents into the kitchen. This deficient practice had the potential to affect all residents and staff in the facility. Findings include: Department of Health and Welfare - Idaho Administrative Rules 16.03.02. Environmental Sanitation 108. Garbage and Refuse 03a. All containers used for storage of garbage and refuse shall be constructed of durable, nonabsorbent material and shall not leak or absorb liquids. Containers shall be provided with tight-fitting lids unless stored in vermin-proof rooms or enclosures, or in a waste refrigerator.U.S. Food and Drug Administration 2022 Food Code, 5-501.113 Covering Receptacles. Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered: (A) Inside the FOOD ESTABLISHMENT if the receptacles and units: (1) Contain FOOD residue and are not in continuous use; or (2) After they are filled.On 7/6/25 at 10:30 AM, observed various trash cans in the kitchen food prep area were not sealable, with round holes cut in the center to keep open.On 7/6/25 at 10:35 AM, the Food Services Manager stated she was not aware of the requirement to have closed garbage can lids in the food prep areas.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure accurate and complete clinical records were maintained for each resident. This was true for 1 of 1 resident (Resident #12) whose records were reviewed. This deficient practice resulted in incomplete documentation and created the potential for harm if inappropriate care and/or treatments were provided to the resident. Findings include:Resident #12 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including COPD (a type of lung disease marked by permanent damage to tissues in the lungs, making it hard to breathe), congestive heart failure, and repeated falls.A physician's order dated 1/30/25, documented Resident #12's inappropriate sexual comments towards staff were to be documented on the TAR and include number of episodes, intervention, and outcome.A care plan dated 2/21/25, documented Resident #12 makes sexually inappropriate comments to staff and a behavior tracking document is in place for this behavior.On 7/8/25 at 9:30 AM, the DON with the Executive Director present stated Resident #12 did not receive a shower on 6/14/25, 6/28/25, and 7/2/25 due to his inappropriate sexual comments towards staff. The Administrator stated Resident #12 has had these behaviors for a long time and was documented in his medical record.A review of Resident #12's TAR and progress notes from 2/1/25 - 7/8/25, did not document any sexually inappropriate comments or behaviors.On 7/9/25 at 11:45 AM, the DON stated Resident #12's inappropriate sexual behaviors towards staff should have been documented on the TAR and a behavior note written on 6/14/25, 6/28/25, and 7/2/25, but was not.