| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135125 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Creekside Transitional Care and Rehabilitation | 1351 West Pine Avenue<br>Meridian, ID 83642 |

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 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28604<br><br>Based on observation, record review, and resident and staff interview, it was determined the facility failed to honor residents' choices to have a pitcher of water on the bedside table in the resident's room. This was true for 1 of 1 resident (Resident #86) reviewed for choices. This failure created the potential for psychological harm when resident preferences were not honored. Findings include:<br><br>The facility's Resident Rights policy and procedure, revised 12/2023, documented You have the right to self-determination through support of your choice, including the right to make choices about aspects of your life in the facility that significant to you.<br><br>Resident #86 was admitted to the facility on [DATE], with multiple diagnoses including end stage renal disease and congestive heart failure (weakness of the heart leading to a buildup of fluid in the body).<br><br>An annual MDS assessment, dated 6/6/24, documented Resident #86 was cognitively intact.<br><br>A physician's order, dated 2/21/24, documented Resident #86 was to have a1,200 ml (milliliters) fluid restriction daily.<br><br>On 6/26/24 at 9:12 AM, Resident #86 while lying in bed, stated last week he had a water pitcher in his room and yesterday evening a nursing assistant sat a pitcher of water on his bedside table. Resident #86 stated when he woke up this morning, the water pitcher was gone. Resident #86 stated he did not know who removed the water pitcher from his bedside table. Resident #86 stated he knew he was on a water restriction which he followed; however, he wanted the water pitcher in his room so that he did not have to keep pressing the call light to request water throughout the day.<br><br>On 6/26/24 at 10:02 AM, CNA #5 stated she removed Resident #86's water pitcher around 6:30 AM while he was sleeping as directed by LPN #2 due to him being on a fluid restriction. CNA #5 stated LPN #2 was the only nurse that requested the water pitcher be removed from Resident #86's room.<br><br>On 6/26/24 at 10:05 AM, LPN #2 stated she knew Resident #86 wanted a water pitcher in his room, but she asked CNA #5 to remove the water pitcher from his room because he was on a fluid restriction. LPN #2 stated it was Resident #86's choice to have the water pitcher in his room but he had requested a lot of water over the weekend. LPN #2 stated she was trying to ensure Resident #86 would not exceed the fluid restriction as ordered by the physician.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/26/24 at 12:08 PM, LPN #3 stated residents had the right to drink from a water pitcher and it was their choice and the staff should honor their choices. LPN #3 stated Resident #86 was on fluid restrictions, but the nurses could provide him with the amount of water he could have in the morning in the water pitcher and if he wanted more, they could educate him on the risks and benefits of exceeding the 1,200 ml restriction.<br><br>On 6/26/24 at 2:44 PM, the ADON stated Resident #86 had the right to have a water pitcher in his room and she expected the staff to honor his choices. |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679<br><br>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a bed hold notice was provided to residents and/or their representatives upon transfer to the hospital. This was true for 2 of 5 residents (#81 and #99) reviewed for hospital transfers. This deficient practice created the potential for harm if residents and/or their representatives were not informed of the residents' rights to return to their former bed/room at the facility within a specified time. Findings include:<br><br>The facility's Admission/Discharge/Transfer policy and procedure, revised 10/2023, documented the resident or their representatives shall be informed in writing, of their right to exercise the bed hold provision in the event of a transfer from the facility to a general acute care hospital or for a therapeutic leave.<br><br>1. Resident #81 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including dementia, diabetes, and metabolic encephalopathy (disorders where medical problems such as infections, organ dysfunction, or electrolyte imbalance impair brain function).<br><br>A progress note, dated 5/14/24 at 1:37 PM, documented Resident #81 was sent to the hospital via EMS (Emergency Medical Services) and a report was made to the nurse of the receiving facility. Resident #81's record did not include documentation a bed hold notice was provided to her and/or to her representative.<br><br>On 6/27/24 at 9:53 AM, the ADON stated she was unaware a written bed hold notice was to be provided to a resident and/or their representative upon or as soon as practicable during a resident's transfer to the hospital. The ADON stated Resident #81 and/or her representative did not receive a bed hold notice when she was transferred out of the facility to the emergency department.<br><br>2. Resident #99 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including hypertension, congestive heart failure (a chronic progressive condition affecting the pumping power of the heart muscles).<br><br>A progress note, dated 5/12/24 at 2:52 AM, documented Resident #99 was transported to the hospital. Resident #99's record did not include documentation a bed hold notice was provided to her and/or to her representative.<br><br>On 6/27/24 at 9:53 AM, the ADON stated she was unaware a written bed hold notice was to be provided to a resident and/or their representative upon or as soon as practicable during a resident's transfer to the hospital. The ADON stated Resident #99 and/or her representative did not receive a bed hold notice when she was transferred out of the facility to the emergency department. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679<br><br>Based on record review and staff interview, it was determined the facility failed to ensure residents' MDS assessments had correct assessment information. This was true for 1 of 1 resident (Resident #116) whose record was reviewed. This failure created the potential for residents to not have their care needs met due to inaccurate assessments. Findings include:<br><br>The RAI Manual, dated 10/23 indicated .It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT (Interdisciplinary Team) completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.<br><br>Resident #116 was admitted to the facility on [DATE], with multiple diagnoses including stroke.<br><br>A quarterly MDS assessment, dated 11/6/23, documented Resident #116 was cognitively intact. The assessment also documented Resident #116 had no upper/lower body impairments.<br><br>On 6/27/24 at 8:36 AM, the Therapy Program Manager stated Resident #116 had both upper and lower bi-lateral extremity impairments.<br><br>On 6/27/24 at 10:07 AM, the Minimum Data Set Coordinator (MDSC) 1 stated Resident #116 had a history of multiple strokes and confirmed the 11/6/23 MDS was coded inaccurately. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>12679<br><br>Based on observation, policy review and staff interview, it was determined the facility failed to use appropriate personal protective equipment (PPE) while working in food preparation areas. The facility failed to ensure chemical level testing supplies were available to test the quaternary (sometimes called quat - a group of chemicals used for sanitization) in the sanitation compartment of a three-compartment sink. The facility failed to ensure clean pans were air dried prior to storage. These failures increased the risk of food borne illness for the 118 residents that consumed food prepared by the facility. Findings include:<br><br>1. The facility policy titled, Sanitary Standards- Dietary Personnel, dated 12/2023, documented the dietary personnel will wear hair restraints, such as hair nets, hats, and/or beard net coverings at all times while in food preparation areas.<br><br>On 6/24/24 at 8:30 AM, [NAME] #2 was observed to have a beard and mustache and did not have a covering over their facial hair while working in a food preparation area.<br><br>On 6/24/24 at 8:34 AM, Dietary Aide #1 was observed to have a goatee and did not have a covering over their facial hair while standing next to a cooktop.<br><br>On 6/25/24 at 2:07 PM, the Certified Dietary Manager (CDM) stated the kitchen staff with facial hair must have their facial hair covered while in food preparation areas.<br><br>2. The facility policy and procedure for dishwashing chemical checks, dated 3/2024, documented the dietary manager was responsible for the monitoring of the sanitizing chemical levels and the chemical levels are to be checked daily following meal service but prior to the washing of dishes and meal preparation equipment.<br><br>On 6/24/24 at 8:30 AM, [NAME] #1 was asked to demonstrate how they monitored the sanitization chemical level in the sanitization compartment of the three-compartment sink. [NAME] #1 was unable to locate the chemical level testing supplies to demonstrate the testing.<br><br>On 6/25/24 at 2:07 PM, the CDM stated the chemical testing supplies were not available.<br><br>3. The facility procedure for dishwashing and sanitizing, dated 12/2023, documented to always air-dry the dishes and putting dishes away while they are still wet- known as wet nesting or stacking- creates a moist environment that encourages the growth of bacteria.<br><br>On 6/26/24 at 11:25 AM, 7 pans were observed to be stacked and stored before they had air-dried. The CDM unstacked the pans and noted the pans were still wet. The CDM stated they're wet and added, they need to be re-washed and allowed to air-dry before being stacked. |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Dispose of garbage and refuse properly.<br><br>12679<br><br>Based on observation,policy review, and staff interview, it was determined the facility failed to ensure garbage was contained and disposed of properly. This failure put all residents, staff, and guests in danger of illness or harm due to the increased the risk for pests and rodents to be present on the property. Findings include:<br><br>A facility policy titled Garbage and Rubbish Disposal, dated 10/2023, documented garbage will be stored to be inaccessible to vermin and the dumpsters outside must be kept closed and free of litter around the dumpster area.<br><br>On 6/24/24 at 8:37 AM, two dumpsters were observed outside the facility. Dumpsters #1 and #2 had two lids each, both lids on both dumpsters were open and exposed the garbage within. The lid on the right side of dumpster #2 had bags of garbage preventing the lid from closing. [NAME] #2 was observed placing flattened cardboard into the right side of dumpster #2 then began to walk toward the facility; at this time, [NAME] #1 directed [NAME] #2 to close the dumpster and reminded them the dumpster lids must always be closed.<br><br>On 6/24/24 at 3:26 PM, the Administrator stated the dumpsters were supposed to have their lids closed. |