STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135125	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Transitional Care and Rehabilitation	1351 West Pine Avenue 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Resident #183 was admitted to the facility on [DATE], with multiple diagnoses including urinary tract infection, constipation and depression. On 6/10/25 at 9:34 AM, the computer screen on top of the 500 Hall medication cart was observed to be open with Resident #183's medical information visible. On 6/10/25 at 9:47 AM, LPN #3 stated she did not realize she left the computer open. LPN #3 stated she should have made sure to log off from the computer before leaving her medication cart. Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure residents' privacy was maintained, treatment information was protected, and residents received mail and packages unopened. This was true for 3 of 24 residents (#29, #35, and #183) reviewed for privacy and confidentiality. This deficient practice placed residents at risk of embarrassment, loss of control over their personal information, diminished quality of life, and psychosocial distress. Findings include: The facility's list of Resident Rights provided to each resident at admission, dated 10/4/16, documented residents residing in the facility had the right to personal privacy and confidentiality of their personal and medical records and included the right to promptly receive unopened mail and packages. On 6/11/25 at 2:00 PM, during the Resident Council meeting with surveyors, 2 of the 9 residents in attendance stated they had received mail and packages that had already been opened. 1. Resident #29 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including stroke, diabetes, and major depressive disorder. Resident #29's Annual MDS Assessment, dated 10/13/24, documented she was cognitively intact. On 6/11/25 at 2:00 PM, Resident #29 stated her packages arrived opened all the time. She stated the packages were gifts from family and addressed to her directly. Resident #29 added her packages did not include anything illegal, like drugs, and she did not understand why the facility felt they needed to open them before delivering it to her. On 6/11/25 at 4:30 PM, the Administrator stated there was no reason he could think of that residents' packages would be opened prior to delivering them. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #35 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including, chronic obstructive pulmonary disease (COPD), heart failure, and anxiety. Resident #35's Annual MDS Assessment, dated 11/5/24, documented she was cognitively intact. On 6/11/25 at 2:25 PM, Resident #35 stated her mail arrived opened on one occasion. She added, she knew she had the right to receive her mail unopened and complained to staff. Resident #35 stated, when her mail is delivered, staff hand it to her and say with exaggeration here's your mail- unopened. Resident #35 stated this made her feel sad because the staff were retaliating against her when she exercised her rights. On 6/11/25 at 3:30 PM, the Activities Director stated she received the resident mail to deliver from the receptionist/accounts payable staff person, and at times some items had been opened. She further stated she never opened resident mail or packages herself. On 6/11/25 at 4:00 PM, the receptionist/accounts payable staff stated she got the mail and sorted it into 3 piles. 1. Resident mail 2. Billing 3. Receivables The receptionist/accounts payable staff stated the billing department and business office opened any mail that had to do with the residents insurance. She added, if she thought the mail might contain a new insurance card by feeling the envelope, she would open the envelope, make a copy of the insurance card for the billing department before giving the mail to the Activities Director. On 6/11/25 at 4:30 PM, the Administrator stated mail comes into the facility and gets sorted the following way: -Resident mail goes to resident -Payor source and social security documents goes to the business office -Office mail goes to each department -Insurance documents go to the business office The Administrator stated the staff would open mail based on a judgement call depending on where the return address stated and how the envelope felt when sorting the mail.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, record review, and resident and staff interviews, it was determined the facility failed to ensure residents were provided with a safe, clean, and homelike environment. This was true for 2 of 2 residents (#37 and #82) whose shared room was observed for a homelike environment. This deficient practice created the potential for diminished quality of life and psychosocial distress for Resident #82 when his roommate, Resident #37's, living space was not kept clean. Findings include: 1. Resident #37 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including left and right below the knee amputations, diabetes, anxiety, and muscle weakness. Resident #37's Quarterly MDS assessment, dated 4/9/25, documented he was severely cognitively impaired. Resident #37's care plan, initiated on 9/9/19, and revised on 12/24/24, indicated resident had potential for mood problems [related to] agitation with the intervention to document episodes of behavior including refusal of cares, aggression, urinating on floor. Resident #37's Behavior Monitoring Log, dated 5/12/25-6/12/25, documented he refused care 8 times during the last 30 days. 2. Resident #82 was admitted to the facility on [DATE], with multiple diagnoses including spinal cord compression, major depressive disorder, and diabetes. Resident #82's Quarterly MDS assessment, dated 5/15/25, documented he was cognitively intact. Resident #82's care plan initiated on 5/15/25, documented potential for self-care deficit related to poor awareness due to major depressive disorder with the intervention to document episodes of behavior including irritability. Resident #82's Behavior Monitoring Log, dated 5/12/25-6/12/25, documented he refused care 1 time during the last 30 days. A strong foul urine odor was observed in the hallway outside Resident #37 and Resident #82's room on the following instances: -6/9/25 at 10:00 AM -6/10/25 at 8:00 AM -6/11/25 at 8:00 AM, 10:00 AM, 1:50 PM, and 5:00 PM -6/12/25 at 10:00 AM -6/13/25 at 12:45 PM (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/9/25 at 1:45 PM, observed Resident #37's urinal was half full and uncapped, and his bedside commode was open with urine in it and splattered across the seat. The room smelled like stale urine. When asked about the odor in the room, Resident #37 stated he did not smell anything. On 6/12/25 at 10:05 AM, Resident # 82 stated he didn't like strong odor in the room, and added there's nothing I can do about it On 6/12/25 at 10:15 AM, the ADON stated Resident #37 had behaviors that keep staff from emptying the bedside commode and urinal. She added, staff would rush to clean his living space when he would leave his room. The ADON stated Resident #82 also had a history of refusing care, such as showering and changing his linens, which added to the foul odor of the living space and moving Resident #82 to another room had not been offered. The ADON was asked if she could describe the odor in the hallway coming from Resident #37 and Resident #82's room, she stated Oh yeah, it smells funky. When asked to describe the term funky, she stated just funky.

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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** 2. Resident #104 was admitted to the facility on [DATE], with multiple diagnoses including Wernicke's encephalopathy (a neurological disorder caused by a thiamine vitamin deficiency) and cognitive communication deficit. Resident #104's medical record documented on 3/14/24, he was diagnosed with delusional disorder and alcohol-induced dementia. Resident #104's Annual MDS Assessment, dated 7/18/24, documented the following: -In Section A, under A1500, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? This question was answered no. -In Section I, under I5950, Resident #104 had an active diagnosis of a psychotic disorder other than schizophrenia. On 6/13/25 at 11:43 AM, the MDS Coordinator, stated Resident #104's Annual MDS Assessment was not accurate because his diagnoses had been updated but the PASRR Level I and Level II had not been updated when he received new mental health diagnoses. Based on review of the Resident Assessment Instrument (RAI) Manual, record review, and staff interview, it was determined the facility failed to ensure residents' Minimum Data Set (MDS) Assessments included correct assessment information. This was true for 2 of 2 residents (#53 and #104) whose MDS records were reviewed for accuracy. This deficient practice had the potential for negative outcomes if residents were not assessed and/or monitored due to inaccurate assessments. Findings include: The RAI Manual, revised 10/1/2024, documented section A1500, PASRR (Preadmission Screening and Resident Review), was to be coded yes when a PASRR Level II screening determines a resident had a serious mental illness and/or intellectual disability, or related condition. 1. Resident #53 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including post traumatic stress disorder (PTSD), major depressive disorder, and anxiety. Resident #53's Annual MDS Assessment, dated 3/13/25, documented under A1500 in Section A, no for the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? However, there was a PASRR Level II observed in his electronic medical record, dated 6/21/19. On 6/13/25 at 11:38 AM, the MDS Coordinator stated Resident #53's MDS assessment was coded that the resident did not receive a PASRR Level II, and it should have been coded yes.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure a Pre-admission Screening and Resident Review (PASRR) was accurately completed when new mental health diagnoses were identified for 1 of 2 residents (Resident #104), whose records were reviewed for PASRR screenings. This failure created the potential for harm if the resident required, but did not receive, specialized services for mental health while residing in the facility. Findings include: Appendix PP of the State Operations Manual, revised 8/8/24, documented any resident with newly evident or possible serious mental disorder, intellectual disability, or a related condition must be referred by the facility to the appropriate state-designated mental health or intellectual disability authority for review. Resident #104 was admitted to the facility on [DATE], with multiple diagnoses including Wernicke's encephalopathy (a neurological disorder caused by a thiamine vitamin deficiency) and cognitive communication deficit. Resident #104's medical record documented on 3/14/24, he received 2 new mental health diagnoses, delusional disorder and alcohol-induced dementia. On 6/12/25 at 5:05 PM, the ADON stated Resident #104 should have had a new PASRR Level I conducted when he was diagnosed with delusional disorder and alcohol-induced dementia on 3/14/24.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **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 resident's medications were administered according to professional standards of practice. This was true for 1 of 3 residents (Resident #184) whose insulin administrations were observed. This failed practice created the potential for Resident #184 to receive an incorrect dose of insulin and experienced hypoglycemia. Findings include: The Lantus Insulin Glargine website, accessed on 6/16/25, documented to always perform a safety test (prime) before each injection as follows: - Dial a test dose of two units. - Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. - Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. The Lantus website also documented when you inject the insulin to slowly count to ten before removing the needle to make sure the full insulin dose was administered. Resident #184 was admitted to the facility on [DATE], with multiple diagnoses including diabetes. A physician's order, dated 6/5/25, documented Resident #184 was to receive 10 units of Insulin Glargine 100 units/ml subcutaneously one time a day for diabetes. On 6/12/25 at 11:48 AM, LPN #1 took the Insulin Glargine from the medication cart and prepare the insulin pen as follows: LPN #1 removed the cap, sanitized the tip of the insulin pen, placed a new needle and dialed the pen to 10 units. LPN #1 was not observed to prime the insulin pen. LPN #1 then went to Resident #184's room, sanitized Resident #184's left upper arm, and administered the insulin. LPN #1 was not observed to hold the insulin pen for at least 10 seconds before withdrawing the needle from Resident #184's left upper arm. On 6/12/25 at 11:54 AM, when asked about the preparation of insulin pen injections, LPN #1 stated she did not prime the insulin pen prior to giving it to Resident #184. When asked about the insulin administration, LPN #1 stated it was only 10 units and it does not take long to administer 10 units. LPN #1 stated she held the needle to Resident #184's arm for about 3 seconds. On 6/12/25 at 2:45 PM, the ADON stated the facility followed the manufacturers direction for insulin administration. ADON stated after sanitizing the tip of the insulin pen and replacing the needle, she would prime the insulin pen and then dial the required amount of insulin as ordered by the physician. The ADON also stated she would inject the insulin and leave the needle for about ten seconds before withdrawing the needle.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview it was determined the facility failed to ensure residents were provided with assistance to meet their needs. This was true for 1 of 24 residents (Resident #92) who were reviewed for activities of daily living. This failed practice created the potential for embarrassment and psychosocial harm when Resident #92's toenails were not maintained. Findings include: Resident #92 was admitted to the facility on [DATE], with multiple diagnoses including muscle weakness and unsteadiness on her feet. On 6/9/25 at 9:46 AM, Resident # 92 stated she had asked the nurses, doctors, and CNA's to cut her toe nails but no one had helped her. She also stated her toenails have not been trimmed since she was admitted to the facility. On 6/11/25 at 11:02 AM, both of Resident #92's great toenails were noted to be long and thick and yellow. On 6/11/25 at 11:53 AM, the SDC stated Resident #92's left, and right great toenails measured ¼ of an inch long. She also stated Resident #92's toenails were long and should have been trimmed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure professional standards of practice were followed for 1 of 15 residents (Resident #18) reviewed for bowel and bladder care. This failed practice created the potential for Resident #18 to experience discomfort when his medications were not administered according to the physician's order. Findings include: Resident #18 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including multiple sclerosis (a disease that affects the brain and spinal cord), malnutrition, and dementia. A physician's order, documented Resident #18 was to receive the following bowel medications as needed: -Miralax Powder, give 17 grams by mouth every 24 hours as needed for bowel care if no bowel movement for 3 days. -Dulcolax suppository 10 mg, insert one suppository rectally every 24 hours as needed for bowel care if no results from Miralax. -Fleets enema, insert one dose rectally every 24 hours as needed for bowel care if no results from Dulcolax. Resident #18's bowel movement records, dated 5/13/25 through 6/13/25, documented he did not have a bowel movement from: 6/1/25 through 6/5/25 (5 days). Resident #18's MAR, dated 6/1/25 through 6/4/25, did not include documentation he had received any of his bowel care medications as ordered for 4 days. On 6/13/25 at 11:04 AM, the ADON confirmed Resident #18 did not have a bowel movement from 6/1/25 through 6/5/25 and should have been given an as needed bowel medication on day 4 and he wasn't given one until day 5.

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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, record review, and interview, it was determined the facility failed to ensure the CPAP water chamber was kept clean. This was true for 1 of 1 resident (Resident #119) reviewed for respiratory care. This deficient practice created the potential for respiratory infection due to growth of bacteria in respiratory equipment. Findings include: Resident #119 was admitted to the facility on [DATE], with multiple diagnoses including obstructive sleep apnea (temporary cessation of breathing). Resident #119's physician's order included the following: - CPAP: Settings 10 cm at 30% oxygen. Place CPAP mask on night shift, remove CPAP mask on AM shift every day. The physician' order also directed staff to wash Resident #119's CPAP tubing and reusable filter weekly with warm soapy water and let it dry. On 6/9/25 at 9:09 AM, a CPAP machine was observed on top of Resident #119's bedside table. When asked if he used his CPAP machine, Resident #119 stated probably a week ago. On 6/12/25 at 9:32 AM, Resident #119 stated he did not use his CPAP the night before. RN #3 was asked to check the CPAP water chamber. When RN #3 opened the water chamber, it was very dry and noted to have a whitish residue on the bottom of the water chamber. When asked what it was, RN #3 looked at the bottom of the water chamber and did not answer the Surveyor's question. RN #3 then washed the water chamber and put it back inside the CPAP machine. RN #3 stated if Resident #119 used the CPAP the night before, the night shift staff shouldhave noticed the whitish residue inside the chamber and cleaned it before setting up the machine for Resident #119.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to assess, monitor, and identify potential triggers for 1 of 1 resident (Resident #53) reviewed for trauma-informed care. This failure created the potential for further trauma and psychosocial harm when the residents Post-Traumatic Stress Disorder (PTSD- a mental health condition that is triggered by a terrifying event) triggers were not assessed. Findings include: The CMS SOM, Appendix PP, dated 8/8/24 documented, a facility must ensure the residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Resident #53 was admitted to the facility on [DATE], with multiple diagnoses including PTSD, paraplegia (paralysis of the lower limbs), anxiety, and major depressive disorder. Resident #53's Annual MDS Assessment, dated 3/13/25, documented he had little interest or pleasure in doing things. Further review of the MDS documented Resident #53 takes antianxiety and antidepressant medications daily. Resident #53's care plan documented a diagnosis of PTSD. The interventions included administration of medications as ordered. On 6/13/25 at 10:32 AM, the ADON stated she did not know what Resident #53's triggers were for his PTSD. The ADON further confirmed there were no interventions in the care plan for triggers from PTSD and there should have been.

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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, and staff interview, it was determined the facility failed to ensure food was stored in a safe and sanitary manner. This deficient practice had the potential to affect the 129 residents who consumed food prepared by the facility. This placed residents at risk for adverse health outcomes, including food-borne illnesses. Findings include: On 6/9/25 at 8:41 AM, during a kitchen inspection, a sack of potatoes and sack of onions were observed on a wire rack. The potatoes were observed to be mushy with bulging sprouts. The onions were observed to be green, soft, and mushy. On 6/9/25 at 8:42 AM, the CDM stated the potatoes and onions were not fresh and should have been disposed of.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview it was determined the facility failed to ensure infection control practices were implemented for a Pure Wick (female external catheter system). This was true for 1 of 1 resident (Resident #75) who used a Pure Wick. This failure created the potential for infection when Resident #75's Pure Wick tubing and canister was not maintained in sanitary conditions. Findings include: Resident #75 was admitted to the facility on [DATE], with multiple diagnoses including need for assistance with personal care and pressure ulcer to left buttocks. On 6/9/25 at 2:24 PM, Resident #75 was observed sitting in her wheelchair with her Pure Wick sitting on her nightstand. The canister was observed to be full with foul smelling, dark, cloudy urine and clear tubing connected to it. The tubing with visible urine inside it was observed to be resting on the nightstand. On 6/9/25 at 2:58 PM, LPN #2 confirmed the room smelled like urine and stated the Pure Wick canister and tubing should be emptied and rinsed after use. She added the tube should then be placed inside a clean bag to prevent cross contamination.