STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135127	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Sandpoint	1125 North Division Avenue Sandpoint, ID 83864

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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** Based on observation, staff interview, and policy review, it was determined the facility failed to ensure residents were treated with dignity when eating in the dining room. This was true for 1 of 16 resident's (Resident #49) observed during dining observation. This deficient practice had the potential to cause psychosocial harm if the resident felt he was not as important as other residents, and physical harm if his nutritional needs were not met. Findings include: The facility's Dignity Policy, reviewed 9/26/24, documented a facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Resident #49 was admitted to the facility on [DATE], with multiple diagnoses including right side paralysis following a stroke, diabetes, and dysphagia (a medical condition characterized by difficulty or discomfort in swallowing.) On 7/24/25 the following was observed: -At 8:22 AM, Resident #49 was seated at the same table as Resident #29 and Resident #78. Resident #29 and Resident #78 received their meals at 8:22 AM. Resident #49 was not served a meal. -At 8:38 AM, Resident #49 looked at Resident #29 and Resident #78's meals while they were eating. He turned his wheelchair around, looked at the other residents eating their meal, shook his head and left the dining room. -At 8:43 AM, Resident #49 returned to the dining table to receive his meal. On 7/24/25 at 8:45 AM, the DM stated she prepares fried egg orders at the same time, and by the time they are finished and served, residents at Resident #49's table have already been served meals, and he receives his meal afterward. On 7/24/2025 at 11:53 AM, the ED stated residents seated at the same table were supposed to be served at the same time. It was not the facility's policy to have a resident served later than other residents. Resident #49 should have been served when the other residents at his table were served.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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 and staff interview, it was determined the facility failed to ensure residents had a homelike environment. This was true for 1 of 18 resident's (Resident #32) who were observed for homelike environment. Resident #32's room was observed to be soiled and unkept. This deficient practice created the potential for psychosocial harm if residents were not provided with the same homelike environment as other residents, and potential harm if the residents lived in unsanitary conditions. Findings include: The facility's Resident Belongings and Homelike Environment policy, reviewed 5/15/25, documented the resident has a right to a safe, clean, comfortable and homelike environment. Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used in the completion of the activities of daily living. Resident #32 was admitted to the facility on [DATE], with multiple diagnoses including protein-calorie malnutrition, right-sided paralysis after a stroke, failure to thrive, and dementia. On 7/24/25 at 2:18 PM, the following was observed with the RCM in Resident #32's room: - [NAME] liquid was pooled on the floor between Resident #32's bed and her roommate's bed. - Her roommate's trashcan was overflowing with wadded tissues.- A wadded tissue was observed on the floor near the brown liquid pool.- Resident #32's bedding was wadded up and piled at the end of her bed. On 7/24/25 at 2:20 PM, the RCM stated housekeeping had not cleaned the room at the time of the observation. Resident #32's bedding should not have been left wadded up and not tidied. The RCM stated Resident #32's roommate frequently puts food on the ground and housekeeping is aware to clean the room more frequently. On 7/24/25 at 2:50 PM, the Housekeeping Manager stated all rooms are cleaned daily; however, Resident #32's room is cleaned twice per day as the room gets dirty with food particles after lunch. He stated housekeeping had not yet been to the room to clean up after lunch, and they should have planned to clean it earlier in the afternoon.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of the Resident Assessment Instrument (RAI) Manual, record review, and staff interview, it was determined the facility failed to ensure a residents' Minimum Data Set (MDS) assessment included accurate information. This was true for 2 of 3 residents (#7 and #10) who were reviewed for accuracy of assessments. This deficient practice had the potential for negative consequences if residents were not monitored due to inaccurate assessments. Findings include:The RAI Manual, revised 10/1/24, documented section A1500, PASRR (Preadmission Screening and Resident Review), was to be coded “Yes” when a PASRR level II screening determined a resident had a serious mental illness and/or intellectual disability, or related condition. 1. Resident #10 was admitted to the facility on [DATE], with multiple diagnoses including schizophrenia, anxiety, and depression. Resident #10’s PASRR level II, dated 6/15/23, documented he had a primary diagnosis of schizophrenia with medication management. An Annual MDS assessment dated [DATE], documented “No” at A1500 a PASSR level II was not completed. On 7/23/25 at 2:44 PM, the MDS Coordinator #1 stated, “The MDS is inaccurate as Resident #10 does have a PASSR level II.” She stated the MDS should have been marked “Yes” at A1500 a PASSR level II was completed. 2. Resident #7 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including bipolar disorder (a mental health condition that causes extreme swings. These include emotional highs also known as mania or hypomania, and lows, also known as depression). Resident #7’s PASRR Level 1, dated 5/14/24 documented he had a diagnosis of “Bipolar and depression.” Resident #7’s PASRR Level II, dated 5/15/24 documented he had been diagnosed with bipolar and depression and supporting documents suggested his mental illness was being managed with medication, and no further evaluation was needed. Resident #7’s Annual MDS dated [DATE], documented on section A1500 PASRR “Has the resident been evaluated by Level II PASRR and determined to have serious mental illness and/or mental retardation or a related condition?” The answer for this question was documented as “No. ” On 7/23/25 at 2:35 PM, the MDS Coordinator #1 reviewed Resident #7’s Annual MDS assessment and stated Resident #7’s Annual MDS assessment was not accurate and should have been answered “Yes” on section A1500.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to refer residents with a diagnosed mental disorder to the appropriate state-designated authority for a re-evaluation and determination. This was true for 1 of 3 residents (Resident #3), reviewed for PASRR level II evaluations. This deficient practice had the potential to cause harm if resident's specialized services for mental health needs were not evaluated by an appropriate state-designated authority. Findings include: Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including PTSD (Post Traumatic Stress Disorder), and anxiety.Resident #3's PASRR level I dated 6/14/23, documented she did not have any mental illnesses.An admission MDS assessment dated [DATE], documented No Resident #3 did not have an MMI. No other PASRR's were found in Resident #3's medical record.On 7/23/25 at 3:42 PM, the ED stated Resident #3's PASRR level I was inaccurate and should have been updated when Resident #3 was admitted . She said Resident #3 should have had a PASRR level II completed.

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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 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 record review, staff interview, and observation it was determined the facility failed to update resident's care plans and provide care conferences. This was true for 2 of 18 residents (#6 and #11), whose care plans were reviewed for accuracy and care conference planning. This deficient practice had the potential to cause harm if a resident's care plan was not updated to reflect current medical conditions, or if their care plan was not discussed with residents or their representatives. Findings include: 1.Resident #6 was admitted to the facility on [DATE], with multiple diagnoses including a brain injury with brain bleeding and right-side paralysis. On 7/21/25 at 2:35 PM, the DON and the IP verified Resident #6 tested positive for COVID-19 on 7/12/25. A review of Resident #6’s care plan did not document he had a respiratory infection. On 7/24/25 at 10:50 AM, in a joint interview with the DON and the ADON, they stated Resident #6’s care plan was not updated when he tested positive for COVID-19 on 7/12/25, and it should have been. 2. Resident #11 was admitted to the facility on [DATE], with multiple diagnoses including cancer of duodenum (part of the small intestine) and heart failure. On 7/21/25 at 3:36 PM, Resident #11 stated she did not think she had attended a care plan conference meeting. Resident #11 stated, “I don’t remember any meeting at all. I never had a meeting with the staff.” Resident #11’s record documented care conferences were held on 3/28/24 and 11/21/24. There were no other care conferences held between December 2024 to July 2025. On 7/23/25 at 2:57 PM, the DON stated care conferences were being held quarterly and as needed. The DON stated she would look for other documentation of Resident #11’s care conferences. On 7/24/25 at 10:21 AM, the DON stated Resident #11 should have had two more care conferences after the 11/21/24 care conference. The DON stated she was unable to find documentation a care conference was held after the 11/21/24 care conference.

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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 observation, record review, Incident and Accident report, and staff interview, it was determined the facility failed to ensure professional standards of practice were followed for 1 of 18 sampled residents (Resident #35) reviewed for quality of care. These failed practices had the potential to adversely affect or harm residents whose care and services were not delivered according to accepted standards of clinical practices. Findings include:Resident #35 was admitted to the facility on [DATE], with multiple diagnoses including diabetes, right hip fracture, and cognitive communication deficit.Resident #35's care plan documented she expressed pain related to chronic back pain, right hip fracture and impaired mobility; including a goal that resident will express pain relief.On 7/21/25 at 5:00 PM, Resident #35 stated she was in pain 99% of the time in her back and right hip, and pain medication was inconsistent with relief. Resident #35's physicians orders were as follows:-Administer 5 mg Oxycodone (an opioid pain medication) every 4 hours as needed for pain-Administer 10 mg Oxycodone every 4 hours as needed for pain-Administer 15 mg Oxycodone every 4 hours as needed for pain The physician orders did not include parameters for when to administer the 5mg, 10mg, and 15mg doses of Oxycodone. Resident #35's MAR documented she received the Oxycodone as follows: Oxycodone 5 mg administered with pain level rated as a 5 out of 10.Oxycodone 10 mg administered with a pain level rate ranging between 4-6 out of 10.Oxycodone 15 mg administered with a pain level rate ranging between 2-8 out of 10. On 7/24/25 at 2:03 PM, the ADON reviewed Resident #35's records and confirmed the nurses were inconsistent when administering these medications and they should have contacted the physician for parameters to be added to the orders.

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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 and staff interview, it was determined the facility failed to provide respiratory care for 1 of 2 residents (Resident #8) reviewed for respiratory care. This deficient practice created the potential for harm if respiratory care was not provided. Findings Include:Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including dissection of thoracoabdominal aorta (a severe medical emergency characterized by a tear in the inner lining of the aorta, the main artery that carries blood from the heart through the chest and abdomen), asthma, and dementia. On 7/24/25 at 2:23 PM, it was observed with the RCM, Resident #8's humidifier reservoir was empty, his nebulizer tubing was not stored correctly, and his oxygen tubing was not dated. On 7/24/25 at 2:25 PM, the RCM stated oxygen tubing was replaced weekly, and should have been dated when it was changed. She also stated she was not sure when the humidifier reservoir had last been changed, but it was supposed to be monitored every shift and should not be empty. The RCM stated the nebulizer tubing should have been stored in the plastic bag.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and resident and staff interviews, it was determined the facility failed to ensure post dialysis assessments were completed and accurate. This was true for 1 of 2 residents (Resident #15) who received dialysis. This created the potential for Resident #15 for adverse outcomes such as blood loss and infection from the access site. Findings include:The facility's policy revised 3/18/20, documented the facility should provide immediate monitoring and documentation of the status of resident's access site upon return from the dialysis treatment to observe for bleeding or other complications such as redness or edema. Obtain vital signs of resident upon return from dialysis and complete the Pre/Post dialysis Communication Form.Resident #15 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including Wegener's Granulomatosis (swelling also called inflammation of small blood vessels, mainly affecting the blood vessels in the nose, sinuses throat, lungs and kidneys) with renal involvement and morbid obesity.Resident #15's Pre/Post Dialysis Communication Form documented on the Post Dialysis Section (Completed by SNF [Skilled Nursing Facility] of the form the following assessments to be completed: Vital Signs, Condition of the Access Site, Bruit Present, and Change of Site.Resident #15's Post Dialysis section of his Dialysis Communication form dated 6/2/25, 6/4/25, 6/6/25, 6/11/25, 6/13/25, 6/16/25, 6/23/25, 6/25/25, 7/4/25, 7/7/25, and 7/15/25, did not include documentation the appropriate assessments were completed.On 7/24/25 at 10:48 AM, the ADON reviewed Resident #15's Pre/Post Dialysis Communication form. The ADON stated the post dialysis sections were not completed by the staff and should have included the vital signs and condition of Resident #15's access site upon her return from dialysis.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **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 residents were protected from significant medication errors. This was true for 3 of 7 residents (#9, #15, and #81) reviewed for medication errors. This deficient practice created the potential for harm if residents received the wrong dosage of medications. Findings include:The online Nursing 2025 Drug Handbook accessed on 7/30/25, stated the eight rights of medication administration were: - Right drug - Right patient - Right dose - Right time - Right route - Right reason - Right response - Right documentation 1. Resident #9 was admitted to the facility on [DATE], with multiple diagnoses including fracture of right femur, pain and cognitive communication deficit. Resident #9’s record documented a physician's order for Oxycodone (an opioid pain medication) with the following instructions: -Oxycodone 2.5 mg every 4 hours as needed for pain rated at (3-6/10) -Oxycodone 5 mg every 4 hours as needed for severe pain rated at (6-10/10) Resident #9's July 2025 MAR documented the following: -7/6/25 at 1:54 PM, pain was rated at a 5/10 and was administered Oxycodone 5 mg. -7/6/25 at 8:20 PM, pain was rated at 2/10 and was administered Oxycodone 2.5 mg. -7/14/25 at 4:17 PM, pain was rated at 5/10 and was administered Oxycodone 5 mg. On 7/24/25 at 2:11 PM, the ADON confirmed Resident #9 was administered the incorrect dose of Oxycodone twice on 7/6/25 and again on 7/14/25 when the physician's order was not followed regarding pain scale and dosage. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #81 was admitted to the facility on [DATE], for orthopedic aftercare, with multiple diagnoses including diabetes and cognitive communication deficit. Resident #81’s record documented a physician's order for Oxycodone with the following instructions: -Oxycodone 5 mg every 4 hours as needed for moderate pain rated at (4-6/10) -Oxycodone 10 mg every 4 hours as needed for severe pain rated at (7-10/10) Resident #81's July 2025 MAR documented the following: -7/11/25 at 8:23 PM, pain was rated at 5 and was administered 10 mg. -7/12/25 at 5:33 PM, pain was rated at a 4 and was administered 10 mg. On 7/24/25 at 2:11 PM, the ADON confirmed Resident #81 was administered the incorrect dose of Oxycodone on 7/11/25 and on 7/12/25 when the physician's order was not followed regarding pain scale and dosage. 3. Resident #15 was admitted to the facility on 10/2524 and readmitted [DATE], with multiple diagnoses including Wegener’s Granulomatosis (swelling also called inflammation of small blood vessels, mainly affecting the blood vessels in the nose, sinuses throat, lungs and kidneys) with renal involvement and morbid obesity. A physician’s order dated 4/24/25, documented Resident #15 was to receive 5 mgs of Midodrine (a low blood pressure medication) HCL (hydrochloride) two times a day for low blood pressure. Hold for systolic blood pressure (the top number in blood pressure reading) greater than 120. Resident #15’s June - July 2025 MAR documented she was administered Midodrine 5 mg tablet when her systolic blood pressure was greater than 120 as follows: June 2025 AM (day shift): - 6/5/25: 134/68 - 6/10/25: 128/60 - 6/11/25: 128/55 - 6/17/25: 152/72 - 6/22/25: 138/62 - 6/29/25: 195/55 June 2025 HS (at bedtime): (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-6/15/25: 148/84 - 6/16/25: 128/60 - 6/17/25: 152/72 - 6/28/25: 130/72 July 2025 AM (day shift): -7/3/25: 122/60 - 7/14/25: 125/60 - 7/18/25: 133/60 - 7/20/25: 130/70 July 2025 HS (night shift) -7/11/25: 129/60 On 7/24/25 at 10:18 AM, the DON reviewed Resident #15’s record and stated “Yes” Midodrine was administered to Resident #15 when her systolic blood pressure was greater than 120 systolic and it should not have been administered.

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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. Based on observation and staff interview, it was determined the facility failed to ensure pharmacy labels matched the physician's order. This was true for 1 of 8 residents (Resident #15) whose medications administration was observed. This failure created the potential for harm should Resident #15 be administered the wrong dose of her medications. Findings include:On 7/24/25 at 7:39 AM, LPN #1 was observed as she administered one tablet of Sevelamer Carbonate to Resident #15. The Sevelamer Carbonate pharmacy label documented Sevelamer Carbonate 800 mgs two tablets before meals and at bedtime LPN #1 stated the physician's order was changed to administer one tablet of Sevelamer Carbonate to Resident #15. LPN #1 stated the label on the bottle should have been changed to match the physician's order.On 7/24/25 at 10:29 AM, the DON stated Resident #15's Sevelamer Carbonate order came from the dialysis center and Yes the label should have been changed to match the physician's order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the kitchen was cleaned, the resident freezer was cleaned, and staff food was not stored with resident food. These deficiencies had the potential to affect the 71 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:1.FDA Food Code Section 3-303.12 Storage or Display of Food in Contact with Water or Ice, documented packaged food may not be stored in direct contact with ice or water if the food is subject to the entry of water because of the nature of its packaging, wrapping, or container or its positioning in the ice or water.FDA Food Code Section 4-602.11 Equipment Food-Contact Surfaces and Utensils, documented: (E) Surfaces of utensils and equipment contacting food that is not time/temperature control for food shall be cleaned: (4) In equipment such as ice bins . and enclosed components of equipment such as ice makers. (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold.On 7/21/25 at 9:55 AM, and 7/24/25 at 10:55 AM, during the initial and follow-up kitchen inspection, the walk-in freezer was observed to have water droplets on the ceiling, some frozen, some dripping, with a layer of ice on the open boxes of ice cream sandwiches and other closed boxes of food. Ice droplets had accumulated to 2-inch ice piles on the floor. On 7/21/25 at 9:57 AM, the DM stated maintenance had been working on fixing the condenser for the past month, but it had yet to be resolved. She stated water should not be dripping onto the food boxes or the floor creating a coating of ice. 2. The FDA Food Code Section 6-501.12 Cleaning, Frequency and Restrictions, documented: Cleaning of the physical facilities is an important measure in ensuring the protection and sanitary preparation of food. A regular cleaning schedule should be established and followed to maintain the facility in a clean and sanitary manner. Primary cleaning should be done at times when foods are in protected storage and when food is not being served or prepared. On 7/21/25 at 9:55 AM, and 7/24/25 at 10:55 AM, during the initial and follow-up kitchen inspection, the walk-in refrigerator was observed to have a layer of dust particles blowing from the fan covers and hanging from the ceiling. On 7/24/25 at 10:56 AM, the DM stated maintenance had been in to clean the dust from the refrigerator fans and replaced the filters on 7/23/25, but they had missed areas of the refrigerator ceiling and fans which were visibly covered in dust. On 7/24/25 at 3:05 PM, during the follow-up kitchen inspection, it was observed the main ice machine for the facility had an accumulation of black residue on the inner upper area of the ice machine. On 7/24/25 at 3:07 PM, the DM stated quarterly cleanings are completed by facility maintenance for both the fans and ice machine, and the last cleaning for the ice machine was in June 2025. The ice machine should not have any black residue. On 7/24/25 at 3:25 PM, the Facility Manager stated the ice machine had been cleaned on 6/4/25, and it should not be dirty.On 7/24/25 at 3:20 PM, the LTC Resident Refrigerator was observed to have physical food residue in the freezer area. On 7/24/25 at 3:20 PM, the Housekeeping Supervisor stated the LTC Resident freezer should have been cleaned more frequently. He did not know when it was last cleaned. 3. FDA Food Code Section 6-403.11 documented areas designated for employees to eat, and drink . shall be located that so that food . [is] protected from contamination. On 7/24/25 at 3:20 PM, the LTC Resident Refrigerator was observed to have leftover fried chicken in the refrigerator drawer belonging to facility staff. On 7/24/25 at 3:25 PM, the RCM stated staff food is not to be stored with resident food and should not have been in the LTC Resident Refrigerator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135127	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Sandpoint	1125 North Division Avenue Sandpoint, ID 83864

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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 clinical records were maintained for each resident. This was true for 1 of 18 residents (Resident #42) whose record was reviewed. This deficient practice created the potential for Resident #42 to experience harm if she received inappropriate care and/or treatment. Findings include:The State Operations Manual Appendix PP issued 4/25/25 documented the facility must maintain medical records of each resident that are complete and accurate.Resident #42 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (COPD - a progressive lung disease characterized by increasing breathlessness) and diabetesA physician's order included the following:- Insulin Glargine 100 units/ml, inject 30 units subcutaneously one time a day for diabetes, ordered 12/9/24.- Insulin Glargine 100 units/ml, inject 5 units subcutaneously at bedtime for diabetes, ordered 12/9/24.-If blood glucose is greater than 360, give the highest sliding scale dose and recheck in one hour.-If blood glucose greater than 360 for 2 consecutive tests, call the physician and document unless otherwise directed by the physician, ordered 9/7/22.The physician's order did not include an order for the sliding scale for insulin.On 7/23/25 at 11:49 AM, the DON with the ADON present stated Resident #42 was no longer on sliding scale dose of insulin because she refused the injections when needed. Resident #42 was placed on long-acting insulin. The DON stated Resident #42's record should have been updated to reflect the current physician's order.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, record review, CDC guidance review, and interviews it was determined the facility failed to ensure infection control and prevention practices were maintained to provide a safe and sanitary environment, and to help prevent the transmission of communicable diseases and infection. Specifically the facility did not perform a facility wide testing for COVID 19 as advised by their local Health Department, personal protective equipment (PPE) was not don properly, hand hygiene was not performed during residents' cares, and medical equipment was not stored in a sanitary manner. Findings include:1.On 7/21/25 at 12:14 PM, the IP together with the DON present stated the facility had residents who tested positive for COVID-19. The IP stated Resident #6 and Resident #60 tested positive for COVID-19 on 7/12/25 and were placed on isolation. The DON stated Resident #6’s roommate and Resident #60’s roommate was informed of their COVID positive results and were encouraged to wear mask. The DON stated there were no rooms available for Resident #6 and Resident #60 to move them to. Since their roommates have already been exposed, they were kept in the same room. On 7/21/25 at 12:29 PM, the SDC stated she informed their local health department of their positive COVID results via email. On 7/22/25 at 2:22 PM, the DON, IP and SDC were present and a copy of the local Health Department email, dated 7/16/25 at 12:07 PM was provided to the Surveyors and it documented “Your facility is in COVID outbreak as of 7/12/25.” The email also documented the facility should be testing facility - wide (both staff and residents) and to wear a mask or respirator at all times while in the facility at any time they could come into contact with another staff or resident. The IP with the ADON and SDC present stated 100 Hall was divided into Team 3 and Team 4. Resident #6 and Resident #60 were in Team 3, and all residents in Team 3 were tested for COVID 19 on day 1, 3 and 5. The IP stated residents on Team 4 were not tested for COVID 19. When asked why the residents on Team 4 were not tested for COVID 19, the ADON stated a decision was made to test only the residents on Team 3. When asked if all the staff were tested for COVID 19, the SDC stated only those staff who had contact with residents with COVID 19 and symptomatic were tested for COVID 19. When asked why the facility wide testing for COVID 19 was not conducted as per their local Health Department advised on the email, SDC stated, We did not look at the email until today. 2. The CDC website article titled Sequence for Donning Personal Protective Equipment (PPE) accessed on 7/29/25, documented the gown should fully cover the torso from neck to knees to end of wrist, wrap around the back and fasten in back or neck and waist. The facility’s Personal Protective Equipment (PPE) for SARS-COV-2 policy reviewed 7/12/24, documented the facility will provide and utilize the appropriate PPE for the care of residents with COVID-19 in accordance with CMS and CDC guidance. The policy documented the following should be worn before entering the patient’s room with suspected or confirmed COVID-19, N95 respirator, eye protection such as goggles or face shield, gloves, and gown. The N95, eye protection, gloves and gown should be removed and discarded after exiting the patient’s room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/22/25 at 10:03 AM to 10:11 AM, Housekeeper #1 wearing a facemask, gloves and disposable gown which was tied only around her neck was observed entering and collecting the dirty linen in rooms #s 119, 110, 114 and 104 on isolation due to COVID 19. Housekeeper #1 was also observed entering the Day room which was being used by COVID 19 positive residents for their activity and dining. Housekeeper #1 was not observed to remove her gown and mask as she exited the resident’s room on isolation, and she was not observed to change her facemask and disposable gown as she entered the rooms on isolation. She was observed changing her gloves and put on new gloves without performing hand hygiene as she exited Room #s 119 and 110. On 7/22/25 at 10:15 AM, Housekeeper #1 stated she often put her gown on and did not think of tying it completely around her waist. When asked if she removed her gown as she exited the resident’s room on isolation and put on a new gown and mask as she entered the isolation room. Housekeeper #1 stated she did not know she was supposed to remove/put on gown and facemask when she exited/entered the resident’s room on isolation. Housekeeper #1 was also informed by the surveyor that she was not observed to perform hand hygiene when she changed her gloves upon exiting room #s 119 and 110. Housekeeper #1 stated, “Yes, I am supposed to perform hand hygiene when I change my gloves. ” 3. The facility’s Hand Hygiene policy, revised 12/8/20, documented the facility should assist either physically or through reminders to residents to perform hand hygiene after toileting and before meals. On 7/21/25 between 11:55 AM and 12:35 PM, it was observed in the main dining hall residents were not offered hand hygiene before being given their drinks, soups, or main meal. On 7/24/25 at 12:02 PM, the DON and the ADON stated residents should be offered hand hygiene before meals. The ADON, who was in the dining room on 7/21/25 at 11:55 AM, stated she was unsure whether residents had been offered hand hygiene before receiving their first course, soup. 4. Resident #18 was admitted to the facility on [DATE] with multiple diagnoses including schizoaffective disorder (a mental health condition characterized by a combination of schizophrenia symptoms [like hallucinations and delusions] and mood disorder symptoms [like depression or mania]), PTSD, depression, and cognitive communication limitations. On 7/21/25 at 2:35 PM, the DON and the IP verified Resident #18 tested positive for COVID-19 on 7/19/25. Resident #18’s care plan, initiated on 7/21/25, documented she had a COVID-19 respiratory infection precautions and treatment plan including requiring the resident’s room door to remain closed, and to encourage her to wear a mask when out of her room. On 7/21/25 at 3:10 PM, Resident #18 was observed leaving her room with a face mask placed below her nose, walking down the hallway to the nurses’ station, and then returning to her room. Facility staff did not stop Resident #18 to properly adjust her face mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/22/25 at 11:37 AM, Resident #18 was observed leaving her room without a face mask, walking down past the nurses’ station, and drinking from the community water fountain. Staff did not approach Resident #18 to encourage a face mask or to discourage her from using the community water fountain. From 7/21/25 through 7/25/25, it was observed Resident #18’s room door was left open. On 7/24/25 at 10:42 AM, in a joint interview with the DON and the ADON, they stated Resident #18’s care plan was not followed. No information was provided regarding why the community water fountain was still in use during the COVID-19 outbreak. 5. Resident #49 was admitted to the facility on [DATE], with multiple diagnoses including right side paralysis following a stroke, diabetes, and dysphagia (a medical condition characterized by difficulty or discomfort in swallowing.) On 7/21/25 at 9:32 AM, Resident #49 was listed as Resident #6’s roommate. On 7/21/25 at 11:15 AM, Resident #49 stated he has been Resident #6’s roommate since Resident #6 tested positive for COVID-19. Resident #49 then left his room, without a mask, and proceeded to the dining room to eat lunch, where he stated he has eaten all of his meals over the past two weeks. Between 7/21/25 and 7/25/25, Resident #49 was observed eating in the dining room multiple times. He was not wearing a mask, nor was he approached by staff to be encouraged to wear a mask. On 7/21/25 at 2:35 PM, the DON and the IP verified Resident #6 tested positive for COVID-19 on 7/12/25. They stated there were no other rooms to move Resident #49, so they kept him in the same room with Resident #6. The DON and the IP stated all facility residents and representatives were notified about the COVID-19 outbreak in the building. 6. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including dissection of thoracoabdominal aorta (a severe medical emergency characterized by a tear in the inner lining of the aorta, the main artery that carries blood from the heart through the chest and abdomen), asthma, and dementia. On 7/24/25 at 2:23 PM, it was observed with the RCM, Resident #8's nebulizer mask was face down on his side table, next to a portable urinal with a yellow residue inside and around the top of it. On 7/24/25 at 2:25 PM, the RCM stated the nebulizer mask should have been attached to the nebulizer stand, but it was broken so the mask was placed face down on the side table. She stated the nebulizer mask should not be near a portable urinal.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and staff interviews, it was determined the facility failed to ensure residents were offered and/or administered the appropriate pneumococcal vaccine as indicated. Additionally, the facility failed to ensure residents' refusals to receive pneumococcal vaccinations were addressed each year. This was true for 5 of 5 residents (#3, #7, #8, #60 and #78) reviewed for pneumococcal immunizations. This deficient practice placed residents at risk of developing pneumococcal pneumonia a potentially life-threatening condition. Findings include:The facility's Pneumococcal Vaccine policy for Residents reviewed 7/8/25, documented the following:- Each resident is offered a pneumococcal immunization unless the immunization is medically contraindicated, or the resident has already been immunized.- The facility should re-address the refusal with the resident and/or resident representative each year to ensure they have not changed their decision. These conversations should be captured in the medical record.- Administer PCV15, PCV20, or PCV21 for all adults 50 years or older who have never received any pneumococcal conjugate vaccine and/or whose previous vaccination history is unknown.-If PCV15 is used, administer a dose of PPSV23 one year later, if needed. Then their vaccinations are complete.-If PCV20 or PCV21 is used, a dose of PPSV23 is not indicated. Regardless of which vaccine is used (PCV20 or PCV21), their pneumococcal vaccinations are complete.-Adults 65 years or older have the option to get PCV20 or PCV21 if they have received PCV13 at any age and PPSV23 at or after the age of [AGE] years old.The facility's Informed Consent for Pneumococcal Vaccine PCV13, PCV20, or PCV21 (Pneumococcal Conjugate) and PPSV23 (Pneumococcal Polysaccharide) included the following sections:-You are being offered the following vaccine (check one): PCV15, PCV20, PCV 21 PPSV23 with a space to write the date.-The vaccine information statement provided to you is:This section has a check box for the VIS (Vaccine Information Sheet) on what type of pneumococcal vaccine was being offered to the resident, and space to write the date of the VIS and when it was provided to the resident.1. Resident #7 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including bipolar disorder (a mental health condition that causes extreme swings. These include emotional highs also known as mania or hypomania, and lows, also known as depression). Resident #7 was over the age of 65 at the time of admission.Resident #7's immunization history on his EMR did not document he had received the pneumococcal vaccine.Resident #7's Informed Consent for Pneumococcal Vaccine dated 3/26/24, documented he refused to receive the pneumococcal vaccine.There was no documentation in Resident #7's record he was offered the pneumococcal vaccine after 3/26/24.2. Resident #8 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including dissection of thoracic abdominal aorta (a condition in which a tear occurs in the inner layer of the body's main artery - aorta) and asthma. Resident #8 was over [AGE] years old on admission.Resident #8's immunization history on his EMR documented she had refused the Pneumovax 1 and 2 vaccines.There was no documentation Resident #8 was offered the pneumococcal vaccine. An Informed Consent for Pneumococcal Vaccine was not found in his record.On 7/24/25 at 5:12 PM, MDS Coordinator #2 stated she was unable to find documentation Resident #8 was offered the pneumococcal vaccines.3. Resident #60 was admitted to the facility on [DATE], with multiple diagnoses including dementia and depression. Resident #60 was over [AGE] years old on admission.Resident #60's immunization history on her EMR documented she had received the PCV13 on 4/10/23.Resident #60's Informed Consent for Pneumococcal Vaccine dated 6/27/24, documented she refused to receive the pneumococcal vaccine.There was no documentation in Resident #60's record she was offered the pneumococcal vaccine after 6/27/24.4. Resident #78 was admitted to the facility on [DATE], with multiple diagnoses including cerebral palsy and dementia. Resident #78 was over [AGE] years old on admission. Resident #78's immunization history on his EMR did not document he had received the pneumococcal vaccine.Resident #78's Informed Consent for Pneumococcal Vaccine dated 8/10/23, documented the pneumococcal vaccine was refused. Resident #78's consent form had a handwritten note which documented, Family states he has both series, but they don't have documentation.There was no documentation in Resident #78's record he was offered the pneumococcal vaccine after 8/10/23.On 7/24/25 at 11:00 AM, the IP stated pneumococcal vaccines were offered to the residents upon admission. The IP stated she would check the IRIS (Idaho Immunization Reminder Information System) a portal to find out what pneumococcal vaccine the resident needed and would offer it to the resident.On 7/24/25 at 4:27 PM, the

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, CDC guidance and interviews, it was determined the facility failed to ensure COVID vaccinations were offered, administered, and re-offered to the residents. This was true for 4 of 4 residents (#7, #8, #60 and #78) whose COVID vaccinations were reviewed. This deficient practice placed residents at risk of severe illness, hospitalization, and death due to SARS-CoV-2 (Severe Acute Respiratory Syndrome Coronavirus - the virus that cause the COVID-19 illness) and had the potential to all affect all residents in the facility. Findings include:The CDC website article titled: Staying Up to Date with COVID-19 Vaccines dated 6/6/25 and accessed on 7/30/25 documented:- Protection from COVID -19 vaccine decreases over time.- Immunity after COVID-19 infection decreases with time.-2024 -2025 vaccine is especially important if you:a. Never received a COVID-19 vaccine,b. Are ages 65 years and olderc. Are at high risk for severe COVID-19d. Are living in a long-term care facility.1. Resident #7 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including bipolar disorder (a mental health condition that causes extreme swings. These include emotional highs also known as mania or hypomania, and lows, also known as depression). Resident #7 was over the age of 65 at the time of admission.Resident #7's COVID-19 Vaccination consent dated 3/26/24, documented he refused the administration of COVID-19 vaccine. Resident #7's record did not include documentation the COVID-19 vaccine was reoffered to him after he refused on 3/26/24.2. Resident #8 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including dissection of thoracic abdominal aorta (a condition in which a tar occurs in the inner layer of the body's main artery - aorta) and asthma. Resident #8 was over the age of 65 at the time of admission.Resident #8's record did not include documentation the COVID-19 vaccine was offered to him.An Informed Consent for COVID -19 Vaccine was not on his record.3. Resident #60 was admitted to the facility on [DATE], with multiple diagnoses including dementia and depression. Resident #60 was over the age of 65 at the time of admission.Resident #60's immunization history on her EMR documented she last received the COVID-19 vaccine in 10/22/21.Resident #60's Informed Consent for COVID-19 dated 6/27/24, documented she refused the administration of COVID-19 vaccine.Resident #60's record did not include documentation the COVID-19 vaccine was reoffered to her after she refused on 6/7/24. 4. Resident #78 was admitted to the facility on [DATE], with multiple diagnoses including cerebral palsy and dementia. Resident #78 was over 65 years on admission.Resident #78's immunization history on his EMR documented he last received the COVID-19 vaccine in 8/25/23.Resident #78's Informed Consent for COVID-19 dated 8/23/24, documented his POA consented for him to receive the COVID-19 vaccine.Resident #78's record did not include documentation he received the COVID-19 vaccine in 2024.On 7/24/25 at 11:00 AM, the IP stated COVID-19 vaccine was offered to the residents on admission and if the resident declined the COVID-19 vaccine she would reoffer it to the residents. When asked when she is going to reoffer the COVID vaccines to the residents after they initially refused, the IP stated, I don't have a set time when to offer it, I don't have the clinic schedule yet.On 7/24/25 at 4:45 PM, MDS Coordinator #2 with the ED present reviewed Resident #78's record and stated she did not find documentation COVID-19 vaccine was administered to Resident #78. The MDS Coordinator stated she did not know why Resident #78 did not receive the COVID-19 vaccine in 2024. The ED stated the COVID vaccine was on back order at that time.On 7/25/25 at 9:30 AM, the ED was asked via email when the facility's last COVID vaccine clinic was held. The ED responded that the last COVID clinic was held in 2022 -2023.