

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER Discovery Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Shanafelt Street Salmon, ID 83467	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>49552</p> <p>Based on observation, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with a safe, clean, and homelike environment. This was true for 1 of 1 shower/tub room observed. This deficient practice created the potential for harm if: a) the holes in the floors caused a resident to fall and b) cross-contamination from spread of microorganisms. Findings include:</p> <p>The facility's Environmental Safety policy, revised August 2024, documented the facility would provide a safe environment, free from physical hazards to protect the health and safety of residents, personnel, and the public.</p> <p>The following were observed for safety concerns:</p> <p>On 9/10/24 at 1:40 PM, the shower/tub room, across from the nurses' station, was observed with:</p> <ul style="list-style-type: none"> - 3 different areas of missing tiles, varying in different sizes, to the left of the entrance into the shower room. - a 17 X 15 area with missing floor tiles, in the shower area, to the right of the drain. - a 7 X 5 area with missing floor tiles, in the shower area, to the left of the drain. <p>On 9/10/24 at 1:40 PM, the Maintenance Supervisor stated the floor in the shower room was a fall hazard and the facility had been working on getting the tiles in the shower room fixed.</p> <p>On 9/10/24 at 1:47 PM, the Administrator stated the shower room did need to be repaired and they are working on getting the remodeling approved.</p>

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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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552</p> <p>Based on policy and record review, and staff interview it was determined the facility failed to ensure pertinent health information was provided to the receiving hospital for 1 of 1 resident (Resident #20) reviewed for transfers/discharge. This deficient practice had the potential to result in adverse outcomes if residents were not treated in a timely manner due to a lack of information provided upon transfer. Findings include:</p> <p>The facility's Transfer or Discharge policy, revised 2020, documented for an emergency transfer/discharge, staff were to complete transfer/discharge documentation and attach copies of:</p> <ul style="list-style-type: none"> - Face sheet - Advance Directive - Current physician's orders, H&P, copies of pertinent labs/x-rays - Patient representative information, including contact information <p>Staff were to document the entire process in the Nursing Notes.</p> <p>Resident #20 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including COPD (a lung disease that causes breathing problems and restricted airflow) and hypertension.</p> <p>A nurse's note dated 2/16/24 at 1:33 AM, documented Resident #20 was transported to the ER.</p> <p>On 9/11/24 at 1:34 PM, the DON stated, the resident's face sheet, POST, H&P, are to be sent with the resident when they are transferred to the hospital. She also stated what was sent to the hospital with the resident should have been documented in the progress note.</p> <p>Resident #20's record did not include documentation that pertinent medical information was provided to the receiving hospital.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552</p> <p>Based on policy review, record review, and staff interview, it was determined the facility failed to ensure a bed hold notice was provided to residents or their representatives upon transfer to the hospital. This was true for 1 of 1 resident (Resident #20) reviewed for transfer/discharge. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time. Findings include:</p> <p>The facility's Bed Hold policy, revision date December 2023, documented the facility will inform the resident or resident's representative in writing of the right to exercise the Bed Hold provision of 7 days upon admission and provide a second notice before transfer to a hospital. In the event of an emergency transfer, the second notice will be provided within 24 hours. A copy of this notification shall become part of the resident's health record at the time of transfer.</p> <p>Resident #20 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including COPD (a lung disease that causes breathing problems and restricted airflow) and hypertension.</p> <p>A nurse's note dated 2/16/24 at 1:33 AM, documented Resident #20 was transported to the ER.</p> <p>On 9/11/24 at 11:31 AM, a review of Resident #20's medical record did not have documentation that a Bed Hold had been provided to her or her representative.</p> <p>On 9/11/24 at 1:32 PM, the DON stated there was no Bed Hold in Resident #20's medical record.</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121</p> <p>Based on observation, record review, and staff interview, the facility failed to follow physician's orders for 1 of 4 residents (Resident #8) for Occupational Therapy (OT), Physical Therapy (PT), and Speech Therapy (SP) to evaluate and treat as needed. This failure created the potential for harm, adverse outcomes, and reduced opportunity for independence when residents did not receive ordered specialized therapy treatment. Findings include:</p> <p>Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including nontraumatic subarachnoid hemorrhage (a condition that occurs when blood leaks into the space between the brain and the arachnoid membrane), dysphagia (difficulty swallowing), right shoulder joint fracture, and diabetes.</p> <p>On 9/11/24, observed in Resident #8's medical record, physician's orders, dated 7/23/24, for OT, PT, and SP to evaluate and treat as indicated .</p> <p>Resident #8's care plan documented interventions for Occupational, Physical, and Speech-Language Therapy evaluation and treatment per physician orders.</p> <p>No documentation was observed in Resident #8's medical record that OT or SP had been notified to evaluate or treat.</p> <p>On 9/12/24 at 8:47 AM, the DON stated, the referrals should have been made to Therapy and documented but had not been made.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552</p> <p>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure resident's care plans were revised to reflect current needs and interventions. This was true for 2 of 13 residents (Resident #5 and #8) whose care plans were reviewed. This placed residents at risk of adverse outcomes if care and services were not provided due to care plans not being revised as residents' needs changed. Findings include:</p> <p>The facility's Care Plan policy, dated [DATE], documented care plans will be reviewed quarterly, annually, and with change of status to ensure that they are current for the resident's care.</p> <p>1. Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including herpes zoster (a viral infection that causes a painful rash) and COPD (a lung disease that causes breathing problems and restricted airflow).</p> <p>A quarterly MDS, dated [DATE], documented Resident #5 had an application of a non-surgical wound.</p> <p>Resident #5's care plan, dated [DATE], directed staff to use contact transmission-based precautions and follow posted transmission-based signs. Care plan also documented Resident #5's left hand lesions was to be covered at all times until resolved.</p> <p>On [DATE] at 9:13 AM, Resident #5 was observed without a wound dressing to her left hand.</p> <p>On [DATE] at 3:07 PM, the IP stated Resident #5's open wound to the left hand had resolved. The orders to treat the wound and the order for isolation were discontinued. She also stated Resident #5's care plan should have been updated to reflect that her herpes wound was resolved and she no longer needed to be on isolation.</p> <p>2. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including nontraumatic subarachnoid hemorrhage (a condition that occurs when blood leaks into the space between the brain and the arachnoid membrane), dysphagia (difficulty swallowing), right shoulder joint fracture, and diabetes.</p> <p>On [DATE], observed page 3 of Resident #8's care plan which documented, she desired to have cardiopulmonary resuscitation (CPR) and call 911, while on page 6 it documented she desired to be a DNR (Do not resuscitate).</p> <p>On [DATE] at 8:37 AM, the DON stated they had been updating resident care plans and both CPR and DNR should not have been in Resident #8's care plan.</p> <p>51121</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121</p> <p>Based on observation, interview, and record review, the facility failed to obtain physician's orders for 1. diabetic toenail and fingernail checks and 2. follow care plan for wound care for 1 of 4 residents (Resident #8). This deficient practice created the potential for harm or adverse outcomes related to diabetic skin and nail infection, skin breakdown, and development of pressure ulcers. Findings include:</p> <p>Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including nontraumatic subarachnoid hemorrhage (a condition that occurs when blood leaks into the space between the brain and the arachnoid membrane), dysphagia (difficulty swallowing), right shoulder joint fracture, and diabetes.</p> <p>1. On 9/9/24 at 10:34 AM, observed Resident #8's legs and feet to be red, slightly swollen, and unkept long toenails.</p> <p>On 9/11/24, a physician's order dated 5/31/24, for a Podiatrist to evaluate and treat as indicated. No documentation in Resident #8's record that a referral was made.</p> <p>On 9/11/24, Resident #8's care plan had no interventions in place for diabetic nail care.</p> <p>On 9/12/24 at 8:30 AM, the DON stated they no longer had a Podiatrist that would serve the rural facility and the nursing staff should have care planned resident diabetic nail care.</p> <p>2. On 9/11/24 at 8:30 AM, review of Resident #8's TAR did not document wound care on 9/6/24 on the following areas:</p> <ul style="list-style-type: none"> - to right upper inner arm - to right elbow, which is schedule for every three days - each shift to check skin under the clamshell brace on right arm - for left lower extremity, not completed on mid-day shift <p>On 9/12/24 at 8:33 AM, the DON stated sometimes nurses have missed wound care. If the day shift had not completed wound care, the next shift should have completed and documented wound care.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552</p> <p>Based in policy review, observation, and staff interview, it was determined the facility failed to ensure respiratory equipment was changed and stored as indicated. This was true for 1 of 2 residents (Resident #2) observed for respiratory equipment. This created the potential for respiratory infections due to growth of pathogens (organisms that cause illness) in respiratory treatment equipment. Findings include:</p> <ol style="list-style-type: none"> 1. Resident #2 was admitted to the facility on [DATE], with multiple diagnoses including COPD (a lung disease that causes breathing problems and restricted airflow) and kidney disease. <p>A quarterly MDS assessment, dated 8/30/24, documented Resident #2 received oxygen therapy.</p> <p>A physician's order dated 12/18/23, documented Resident #2 was to receive Ipratropium - Albuterol 0.5mg-2.5 (a liquid medication used to help control the symptoms of lung diseases), give 3mg/3ml via nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) every 6 hours as needed for shortness of breath or wheezing.</p> <p>A physician's order dated 1/16/24, documented Resident #2's oxygen tubing, nasal cannula, or mask was to be changed every Sunday.</p> <p>A physician order dated 6/10/24, documented Resident #2 was to receive oxygen at 2 liters a minute via nasal cannula.</p> <p>On 9/9/24 at 10:16 AM, Resident #2's oxygen tubing was observed with paper tape dated 8/14/24, and her nebulizer tubing was not dated. Resident #2's nebulizer tubing and mouthpiece were observed lying on her nightstand, not properly stored.</p> <p>On 9/11/24 at 10:21 AM, the DON stated the resident's nebulizer should have been cleaned after use, dried, and stored in their personal belonging bag. The oxygen tubing and nebulizer tubing should be changed every week and dated. The date should be written on the tubing but sometimes it gets rubbed off.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>49552</p> <p>Based on observation, policy review, and staff interview, it was determined the facility failed to ensure medications available for residents were labeled and had not expired. This was true for 1 of 1 medication carts inspected. This failure created the potential for residents to receive medication used for another resident, presenting a risk for cross-contamination or to receive expired medications, with decreased efficacy. Findings include:</p> <p>The facility's Storing and Controlling Medications policy, revision date July 2018, documented:</p> <ul style="list-style-type: none"> - the pharmacy provider dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices where applicable. Medications are kept and stored in these containers. - Medications that are discontinued, expired, contaminated, or deteriorated, and those that are in containers that are cracked, soiled, or without secure closures are immediately removed from the locked medication storage area and disposed of in accordance with the facility policy and procedures. <p>The facility's Disposal of Wasted or Expired Medications policy, revision date, August 2020, documented:</p> <ul style="list-style-type: none"> - Facility staff should destroy and dispose of medications in accordance with facility policy and applicable law, and applicable environmental regulations. - Once an order to discontinue a medication is received, the facility staff should remove this medication from the resident's medication supply. - Facility should place all discontinued or outdated medication in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction. - Facility should dispose of discontinued medications, outdated medications, or medications left in the facility after a resident has been discharged in a timely fashion or no more than 90 days of the date the medication was discontinued by Physician/Prescriber, or sooner per applicable law. <p>On 9/10/24 at 9:56 AM, the medication cart was inspected with LPN #1 present. The following were observed:</p> <ul style="list-style-type: none"> - An Atrovent inhaler, 17mg/ACT, was laying in the top drawer of the medication cart without a label. - 22 normal saline vials with expiration date of April 2024. - 1 levothyroxine tablet loose in the top drawer. <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 1 unidentified half of a white tablet loose in the top drawer.</p> <p>On 9/10/24 at 10:36 AM, LPN #1 stated she was not sure if the Atrovent inhaler should have been in the original package. She also stated the expired normal saline should not have been in the medication cart and there should not be any loose pills in the medication cart.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983</p> <p>Based on observation, policy review, and resident and staff interview, it was determined the facility failed to ensure resident meals were palatable and maintained their correct temperature. This directly impacted 7 residents (#2, #3, #5, #8, #14, #16, and #28) who were interviewed about food services, and had the potential to affect all 31 residents who dined in the facility. This failed practice had the potential to negatively affect residents' nutritional status and psychosocial well-being. Findings include:</p> <p>The 2022 FDA Food Code states hot food will be maintained at 135 degrees F or above and cold food will be maintained at 41 degrees F or below.</p> <p>On 9/9/24 at 12:53 PM, the lunch meal service observation was conducted with the following observations:</p> <ul style="list-style-type: none"> - The menu documented the main entree was honey mustard pork chops, scalloped potatoes, mixed vegetable blend, peach crunch, and milk. - Some residents were observed to have small, cubed potatoes which appeared dry. - There were no garnishes or condiments served with the meal. <p>On 9/9/24 at 1:39 PM, the Dietary Aide (DA) approached the Dietary Manager (DM) in the main dining room, with the surveyor present, and stated there were complaints the pork chops were dry. The DM stated, That is the problem with pork chops, they are terrible.</p> <p>On 9/11/24 at 7:40 AM, observed the following during breakfast meal preparation:</p> <ul style="list-style-type: none"> - Seasonal fruit was canned diced pears served at 71 degrees F and should have been chilled to 41 degrees F or below. - Yogurt served at 44 degrees F and should have been 41 degrees F or below. <p>On 9/11/24 at 10:30 AM, during the Resident Council meeting, 4 of 7 residents stated the food served was cold and tasteless.</p> <p>On 9/11/24 at 12:26 PM, the RD stated the temperature of the canned pears and the yogurt should have been served at 41 degrees or below. The temperature of the yogurt at 44 degrees F was too high.</p> <p>On 9/11/24 at 1:30 PM, the last tray from the meal cart delivered to the small dining room, was tested for serving temperature, taste, and presentation with the following observations:</p> <ul style="list-style-type: none"> - Mashed potatoes were served at 125 degrees F and should have been 135 degrees F, and tasted bland. <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Monte [NAME] vegetables were served at 108 degrees F and should have been 135 degrees F, and tasted bland.</p> <p>- Chocolate peanut butter parfait was served at 48 degrees F and should have been 41 degrees F or below.</p> <p>- Milk was served at 46 degrees F and should have been 41 degrees F or below.</p> <p>1. Resident #2 was admitted to the facility on [DATE], with multiple diagnoses including COPD (a lung disease that causes breathing problems and restricted airflow) and kidney disease.</p> <p>On 9/9/24 at 4:10 PM, Resident #2's representative stated the food did not taste good and had no nutritional value.</p> <p>2. Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including stroke, anemia, and diabetes.</p> <p>On 9/10/24 at 10:38 AM, Resident #3 stated the food does not taste good and she does not like it.</p> <p>3. Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including herpes zoster (a viral infection that causes a painful rash) and COPD (a lung disease that causes breathing problems and restricted airflow).</p> <p>On 9/9/24 at 1:43 PM, Resident #5 stated the food did not taste good.</p> <p>4. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including nontraumatic subarachnoid hemorrhage (a condition that occurs when blood leaks into the space between the brain and the arachnoids membrane), dysphagia (difficulty swallowing), right shoulder joint fracture, and diabetes.</p> <p>On 9/9/24 at 10:33 AM, Resident #8 stated the food is often late, cold, and not tasty. She stated she had told staff about the issues with the food, but nothing ever changes.</p> <p>5. Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including anemia, heart failure, and dementia.</p> <p>On 9/9/24 at 11:04 AM, Resident #14 stated the food is cold.</p> <p>6. Resident #16 was admitted to the facility on [DATE], with multiple diagnoses including hypertension, peripheral vascular disease, and renal failure.</p> <p>On 9/9/24 at 12:35 PM, Resident #16 stated the food is terrible and tastes bad.</p> <p>7. Resident #28 was admitted to the facility on [DATE], with multiple diagnoses including hypertension, renal insufficiency, and malnutrition.</p> <p>On 9/9/24 at 11:21 AM, Resident #28 stated the food is not so good. It is cold, no taste, and not prepared that great.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 9/11/24 at 2:00 PM, the Administrator stated the facility had been working on food quality and thought there had been improvements. She was not aware the residents had complaints about the food.</p> <p>On 9/11/24 at 3:27 PM, the DM stated they use garnish and gravies to make the food palatable and attractive. She stated she was not aware the residents had complaints about the food.</p> <p>49552</p> <p>51121</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER Discovery Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Shanafelt Street Salmon, ID 83467	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50983</p> <p>Based on observation, staff interview, and policy review, 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 31 residents residing in the facility 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:</p> <p>The facility's Food Storage Policy documented:</p> <ul style="list-style-type: none"> - All food must be labeled and dated immediately after opening or being prepared. All dates must be in a visible location and easily readable. - All foods will be labeled with the name of the product and the use-by date. The day of opening or production counts as the first day. <p>The FDA Food Code Section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking, states 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 41 F or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.</p> <p>The initial kitchen inspection was conducted on 9/9/24 at 9:45 AM, with the DM present. The following was observed:</p> <ol style="list-style-type: none"> 1. In the walk-in refrigerator <ul style="list-style-type: none"> - Large stainless-steel bowl of salad was uncovered and not dated. - Sliced cheese wrapped in saran wrap with no use by date. - 8 individual containers of sour cream which was uncovered and not dated. <p>On 9/9/24 at 9:50 AM, the DM stated the salad and the individual containers of sour cream should have been covered and had a use by date on them. She stated the cheese should have had a use by date on it.</p> <ol style="list-style-type: none"> 2. In the dry storage closet <ul style="list-style-type: none"> - Open cocoa package with no use by date. - Open vanilla pudding package with no use by date. - Multiple open gelatin packages with no use by date. <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 9/9/24 at 10:00 AM, the DM stated there should be use by dates written on the opened packages.</p> <p>On 9/9/24 at 12:51 PM, during the lunch meal in the main dining room, observed an open gallon of milk that was not dated.</p> <p>On 9/9/24 at 1:00 PM, the DM stated they have not put an open and use by date on the milk because the facility goes through almost a gallon a day.</p> <p>On 9/11/24 at 7:40 AM, during a follow-up inspection of the walk-in refrigerator, with the DM present, the following was observed:</p> <ul style="list-style-type: none"> - an box of brussel sprouts with a best by date of 7/23/24. - an opened container of sour cream with a use by date of 8/23/24. <p>On 9/11/24 at 7:50 AM, the DM stated the food should have been properly rotated following the first in first out method.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983</p> <p>Based on observation, policy review, and staff interview, the facility failed to ensure adherence to infection control and prevention practices to provide a safe and sanitary environment when, 1. staff did not clean resident's equipment properly, 2. perform hand hygiene, 3. change gloves when going from dirty to clean areas, and 4. hairnet and glove use in the kitchen. Findings include:</p> <p>The facility's Infectoin Prevention and Control Program policy, revision date December 2023, documented the facility will provide areas, equipment and supplies to implement its infection control program with the goal of effective cleaning and disinfecting equipment as needed, to include bathing areas, between each resident use.</p> <p>The facility's Glucometer, Cleaning and Decontamination policy, revised August 2020, documented the glucometer is to be placed on a barrier after use, then disinfected. The glucometer is disinfected after each use using a cloth/wipe with either an EPA-registered detergent/germicide with a tuberculocidal or HBV/HIV label claim.</p> <p>The facility's Hand Hygiene policy, undated, documented the facility considers hand hygiene the primary means to prevent the spread of infections. Use an alcohol-based hand rub containing at least 62% alcohol or soap and water for the following situations:</p> <ul style="list-style-type: none"> - Before and after direct contact with residents - Before handling clean or soiled dressings, gauze pads, ect. - Before moving from a contaminated body site to a clean body site during resident care - After handling used dressings, contaminated equipment, ect. - After removing gloves - Before and after eating or handling food - Before and after assisting a resident with meals <p>1. The following resident equipment was observed:</p> <p>a. Resident #12 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and heart disease.</p> <p>On 9/9/24 at 12:52 AM, LPN #1 used the glucometer (a device used to measure the amount of glucose in your blood) to check Resident #12's blood sugar. LPN #1 brought the glucometer to the medication cart and was observed wiping the glucometer off with a Sani-Hands instant hand sanitizing wipe (disinfecting wipes for hands) and then placed the glucometer on a tissue on top of the medication cart. LPN #1 did not use the proper disinfecting wipe to clean the glucometer.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 9/10/24 at 3:28 PM, the administrator stated the glucometer should have been cleaned with the EBP Sani-Wipes (disinfecting wipes). She also stated the Sani-wipes for hands were only to be used to clean hands. The glucometer should have been cleaned with the purple top wipes (Sani-Wipes).</p> <p>b. Resident #11 was admitted to the facility on [DATE], with multiple diagnoses including Parkinsonism (umbrella term that refers to brain conditions that cause slowed movements, rigidity or stiffness and tremors), dislocation of left hip prosthesis, emphysema, and dementia.</p> <p>On 9/09/24 at 1:12 PM, observed DON moving Hoyer lift out of Resident #11's room. When the DON was asked if the Hoyer lift had been cleaned, the DON stated yes, she had just used the last of the purple top wipes in the room. When asked to see the empty container, the DON stated it could not be found so the CNA must have forgotten to clean the Hoyer lift.</p> <p>2. The following was observed for hand hygiene:</p> <p>a. Resident #2 was admitted to the facility on [DATE], with multiple diagnoses including COPD (a lung disease that causes breathing problems and restricted airflow) and kidney disease.</p> <p>b. Resident #7 was admitted to the facility on [DATE], with multiple diagnoses including Myocardial Infarction, Atherosclerotic heart disease (a chronic disease that causes plaque to build up in the arteries, narrowing and stiffening them), and Autoimmune Lymphoproliferative Syndrome (characterized by the production of an abnormally large number of lymphocytes).</p> <p>c. Resident #12 was admitted to the facility on [DATE], with multiple diagnoses including heart disease and diabetes.</p> <p>d. Resident #18 was admitted to the facility on [DATE], with multiple diagnoses including Diverticulosis of large intestine (a clinical condition in which multiple sac-like protrusions develop along the gastrointestinal tract), muscle weakness, and difficulty walking.</p> <p>e. Resident #20 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including COPD (a lung disease that causes breathing problems and restricted airflow) and hypertension.</p> <p>On 9/9/24 at 12:48 PM, observed CNA #1 and CNA #3 had not offered residents hand hygiene prior to serving lunch meal trays in Resident #7 and Resident #18's rooms.</p> <p>On 9/9/24 at 12:52 PM, CNA #1 delivered Resident #2's meal to her in her room. CNA #1 did not offer hand hygiene to Resident #2.</p> <p>On 9/9/24 at 12:55 PM, CNA #1 stated she does wash the resident's hands, but she must have forgot Resident #2's hands.</p> <p>On 9/9/24 at 12:58 PM, CNA #3 was observed passing meal trays to residents eating in their room. She did not offer to wash the resident's hands before setting up their meals.</p> <p>On 9/9/24 at 1:00 PM, CNA #3 stated she had not offered to wash the resident's hands and she should have. She also stated, she should be asking the residents if they want their hands washed.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. The following was observed for proper glove changes:</p> <p>Resident #20 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including COPD (a lung disease that causes breathing problems and restricted airflow) and hypertension.</p> <p>Resident #20 physician's order, dated 9/5/24, directed staff to flush the wound on her left lower leg, place a telfa (non-adherent dressing) on the wound and wrap with Kling (rolled gauze) for protection. Change dressing daily and as needed.</p> <p>On 9/11/24 at 11:47 AM LPN #1 was observed providing wound care to Resident #20. LPN #1 placed the wound care supplies on a barrier on Resident 20's bed. LPN #1 washed her hands using soap and water prior to donning gown and gloves. LPN #1 then removed the soiled dressing. LPN #1 removed the soiled gloves and performed hand hygiene using hand gel and donned a new pair of gloves. LPN #1 cleaned Resident #20's wound with normal saline and gauze. She then placed a telfa dressing on the wound and wrapped Resident #20's left lower leg with Kling. LPN #1 did not perform hand hygiene or don new gloves after cleaning the wound and before applying a new dressing.</p> <p>On 9/11/24 at 11:57 AM, LPN #1 stated she removed her gloves and cleaned her hands when she first started wound care, between old and new dressing change, and after wound care. She also stated after she cleaned the wound she should have put on new gloves before applying a new dressing.</p> <p>4. The following was observed for proper hairnet and glove use in the kitchen:</p> <p>On 9/9/24 at 9:45 AM, during the initial kitchen tour, [NAME] #1 was observed not wearing a hairnet while in the kitchen, preparing resident meals.</p> <p>On 9/9/24 at 1:15 PM, observed [NAME] #1 leaving the kitchen to deliver a hall tray with gloves on and without a hairnet.</p> <p>On 9/9/24 at 1:18 PM, observed [NAME] #1 returning to the kitchen. He had not applied a hairnet, washed his hands, or donned new gloves before prepping resident food.</p> <p>On 9/11/24 at 7:20 AM, with the DM present, observed [NAME] #1 in the kitchen preparing and serving resident breakfast meals without a hairnet on.</p> <p>On 9/11/24 at 7:30 AM, the DM stated everyone who comes in the kitchen should be wearing a hairnet and should be changing gloves in between tasks.</p> <p>49552</p> <p>51121</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121</p> <p>Based on observation and interviews, it was determined the facility failed to ensure all call light strings in resident restrooms were proper length and easily accessible to residents. This issue was observed for 1 of 12 residents (Resident #8) call lights. This failure had the potential for harm if residents were not able to summon staff for assistance. Findings include:</p> <p>The facility's Environmental Safety policy, revision date August 2024, documented the facility will provide a resident call system to allow residents to call for staff assistance. These are provided at each resident's bed and toilet/bathing areas.</p> <p>Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including nontraumatic subarachnoid hemorrhage (a condition that occurs when blood leaks into the space between the brain and the arachnoid membrane), dysphagia (difficulty swallowing), right shoulder joint fracture, and diabetes.</p> <p>On 9/9/24 at 10:56 AM, Resident #8 stated when she fell in the bathroom, she was not able to reach the call light in the bathroom because it was wrapped around the grab bar.</p> <p>On 9/9/24 at 11:00 AM, observed the call light string in the bathroom, wrapped around the grab bar thereby shortening the call light string length so it was not accessible from the ground.</p> <p>On 9/12/24 at 8:51 AM, the DON stated the facility conducts rounds throughout the building, to ensure call lights are accessible to residents in rooms and bathrooms. This should have been corrected in Resident #8's room.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121</p> <p>Based on observation and interview, the facility failed to provide accessible closet doors handles in all resident rooms to meet their physical needs. This was true for 1 of 12 residents (Resident #8) whose closet door handles were 58 inches high, and not accessible from a wheelchair. This deficient practice had the potential to cause harm and distress for residents wanting to remain independent. Findings include:</p> <p>Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including nontraumatic subarachnoid hemorrhage (a condition that occurs when blood leaks into the space between the brain and the arachnoid membrane), dysphagia (difficulty swallowing), right shoulder joint fracture, and diabetes.</p> <p>On 9/9/24 at 10:41 AM, observed Resident #8 attempting to open the closet door in her room by pushing her finger between the two doors and trying to pry the door open. Resident #8 was unable to reach the closet door handles.</p> <p>On 9/12/24 at 2:10 PM, the DON stated that height of the closet door handles related to a resident confined to a wheelchair is an issue and should have been corrected.</p>		