STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135130	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Transitional Rehabilitation	2867 East Copper Point Drive Meridian, ID 83642

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on resident and staff interview, and review of grievances, it was determined the facility failed to file a grievance which included the date the grievance was received, steps taken to investigate the grievance, and corrective action taken to resolve the grievance. This was true for 1 of 12 residents (Resident #135) reviewed for grievances and had the potential to impact residents in the facility who may want to file a grievance. This failure created the potential for Resident #135 to experience psychological harm if her grievances were not heard or acted upon. The findings include: The facility Grievance policy and procedure, updated on 9/28/22, documented that patients or representatives can voice a grievance without discrimination or reprisal from the facility. Prompt investigations and resolutions will be made for all grievances patients may have. Patients and families may file an oral or written grievance by completing the Compliment and Concern form or by a staff member. These forms should be given to either the Administrator or Director of Nursing. Facility staff may also complete the form per patient request. Resident #135 was admitted to the facility on [DATE], with multiple diagnoses including fracture of the left thigh and Parkinson's disease. On 9/9/24 at 2:25 PM, Resident #135 stated, Last Saturday night, after I pressed the call-light, two black ladies told me to go pee in my pad and were rude after I asked them to help me go to the bathroom. When asked if she had reported the incident or filed a grievance, Resident #135 stated, I didn't file an official grievance, but I did report it to LPN #1. A review of the grievance log for September 2024 had no documentation that Resident #135's incident had been reported or filed. On 9/11/24 at 2:07 PM, during a telephone interview, LPN #1 stated on 9/7/24, Resident #135 pulled her aside during medication pass and told her she did not like the black aides that responded to her call light to go the bathroom. Resident #135 stated she was told to pee in her pad. LPN #1 stated CNA #1 was educated that she should not use those terms with the residents. All staff need to help any residents who want to use the restroom. LPN #1 further stated since CNA #1 was educated, she did not believe more had to be done about the situation.

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
	135130	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Transitional Rehabilitation	2867 East Copper Point Drive Meridian, ID 83642

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on observation, record review and staff interview, it was determined the facility failed to ensure residents were free from medication errors. This was true for 2 of 5 residents (#134 and #136) whose medication administration were observed. This failure created the potential for harm to residents who received insulin to experience low or high blood sugars when they received an incorrect amount of insulin. Findings include: The American Diabetes Association website, accessed on 9/16/24, stated Priming insulin pens is recommended to remove air from needles to ensure full dose administration. The Insulin Lispro Kwikpen website accessed on 9/16/24, documented to prime insulin pen before each injection. Priming the insulin pen means removing air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. 1. Resident #134 was admitted to the facility on [DATE] with multiple diagnoses including diabetes. A physician's order documented, Resident #134 was to receive the following: - Insulin Lispro, insulin pen 100 unit/ml (milliliter), 5 units subcutaneously. - Lantus U-100 insulin glargine 100 units/ml, 15 units subcutaneously. On 9/11/24 at 7:01 AM, LPN #3 took the insulin lispro Kwikpen, replaced the needle with a new one and dialed the pen to 5 units. LPN #3 also took the insulin glargine pen, replaced the needle with a new one and dialed the pen to 15 units. LPN #3 then went to Resident #134's room and injected the insulin to Resident #134's lower abdomen. LPN #3 was not observed to prime the insulin pens before dialing the prescribed dose of insulin for Resident #134. On 9/11/24 at 11:03 AM, when asked about the preparation of insulin pen injections, LPN #3 stated she had not primed the insulin pen. LPN #3 stated she should have primed the insulin pen before dialing the prescribed amount of insulin for Resident #134. 2. Resident #136 was admitted to the facility on [DATE] with multiple diagnoses including diabetes. A physician's order, documented Resident #136 was to receive the following: - Humalog u-100 insulin lispro 100 units/ml, 3 units subcutaneously as a sliding dose. - Lantus u-100 insulin glargine 100 units/ml, 12 units subcutaneously. LPN #3 took the insulin lispro Kwikpen, replaced the needle with a new one and dialed the pen to 3 units. LPN #3 also took the insulin glargine pen, replaced the needle with a new one and dialed the pen to 12 units. LPN #3 then went to Resident #136's room and injected the insulin to Resident #136's lower abdomen. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135130	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Transitional Rehabilitation	2867 East Copper Point Drive Meridian, ID 83642

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 11:03 AM, when asked about the preparation of insulin pen injections, LPN #3 stated she had not primed the insulin pen. LPN #3 stated she should have primed the insulin pen before dialing the prescribed amount of insulin for Resident #136.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135130	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Transitional Rehabilitation	2867 East Copper Point Drive Meridian, ID 83642

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 50603 Based on observation and staff interview, it was determined the facility failed to ensure the kitchen equipment and environment was maintained, clean, and food was stored in a safe and sanitary manner. These deficiencies had the potential to affect the 28 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: The facility's Food Storage policy, updated on 1/9/24, documented: - Date marking will be visible on all high-risk food to indicate the date by which a ready-to-eat, TCS (Time/Temperature for Safety Food) food should be consumed, sold, or discarded. - Foods will be stored and handled to maintain the integrity of the packaging until ready for use. - All food should be covered, labeled, and dated. - All freezer units will be always kept clean and in good working condition. The FDA (Food Drug Administration) Food Code Section 3-501.17 Ready-to-Eat, TCS food, Date Marking, states marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded. 1. The initial kitchen inspection was conducted on 9/9/24 at 8:26 AM with permission from [NAME] #1. The following was observed: - In the dry food pantry, baking trays, pots, and pans, were stored on the bottom shelves of a cart adjacent to a water heater pipe. The pipe insulation had flaked and peeled, with debris located on the shelves and floor around the pipe. - A box of cornmeal was open and undated. - Refrigerated green onions were opened and undated. - Frozen bread loafs and veggie sausage patties were not dated. - The lids of four large ice cream containers were covered with ice and were not completely closed. - Ice droplets were noted on the ceiling above the containers of ice cream. - A large amount of ice was on the inside of a plastic bin containing wrapped frozen bread. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135130	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Transitional Rehabilitation	2867 East Copper Point Drive Meridian, ID 83642

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Ice droplets were on the ceiling above the plastic bin and a cardboard box located on the top back shelves of the freezer. 2. A second kitchen inspection was conducted on 9/11/24 at 8:30 AM with the NSD (Nutritional Services Director). The following was observed: - The water heater pipe had a layer of dust, and the insulation was flaking, peeling, and covered in dust particles, adjacent to the shelves of the storage cart where the pots, pans, and baking dishes were stored. - The floor behind the cart had a layer of dust and more pipe insulation residue. - Two large containers of ice cream had lids that were not fully covering the ice cream. - The cardboard-type lids had water spots on them. - Ice droplets from the ceiling were located above the containers of ice cream. - Ice build-up was observed on the inside of a plastic container containing wrapped frozen bread. - An unopened cardboard box on the top shelf of the freezer had a layer of ice on it. - Ice droplets were located on the ceiling above the plastic container and cardboard box. On 9/11/24 at 8:45 AM, the NSD stated that the door to the freezer does not close well, and the facility is looking to fix it so it will remain closed. She stated the freezer door had opened and ice cream had melted. The NSD stated she believed the ice droplets on the ceiling, and the accumulation of ice in the back of the freezer, were most likely due to that same incident. When asked about the ice cream container lids, the NSD stated the lids of the paper containers frequently get warped. The NSD also stated the storage shelves affected by the pipe insulation particles contained pots, pans, and baking containers that were no longer used by the facility and should have been stored elsewhere.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135130	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Transitional Rehabilitation	2867 East Copper Point Drive Meridian, ID 83642

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on policy review, observation and staff interview, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 2 of 2 residents (#83 and #85) observed during dressing change and resident's cares when staff failed to don a gown and perform hand hygiene during dressing change and resident cares. These deficient practices placed residents at risk of infection from cross contamination. Findings include: The facility's Hand Hygiene policy and procedure, effective 11/3/23, documented handwashing should be performed before applying and removing gloves and after personal use of the toilet. 1. Resident #85 was admitted to the facility on [DATE] with multiple diagnoses including dementia. On 9/10/24 at 10:19 AM, CNA #2 assisted Resident #85 to the bathroom. After using the toilet, CNA #2 asked Resident #85 to stand up, Resident #85 was observed to hold on the hand rail and on the sink as she was standing up and being wiped by CNA #2. CNA #2 then assisted Resident #85 to her recliner. CNA #2 was not observed to assist Resident #85 to perform hand hygiene after using the restroom. On 9/10/24 at 10:30 AM, CNA #2 stated she did not assist Resident #85 to wash or sanitize her hands after using the restroom. CNA #2 stated she should have assisted the resident to wash her hands after using the restroom. 2. Resident #83 was admitted to the facility on [DATE] with multiple diagnoses including hemiplegia and hemiparesis (paralysis and weakness on one side of the body) following stroke. An MDS (Minimum Data Set) assessment, dated 9/11/24 documented Resident #83 had a feeding tube. On 9/10/24 at 4:31 PM, a signage was observed on Resident #83's door which stated, Enhanced Barrier Precautions. Everyone must clean their hands, including before entering and when leaving the room. The signage also documented providers and staff must wear gloves and a gown for the following high-contact resident care activities including device care such as for central line, urinary catheter, feeding tube, and tracheostomy. On 9/10/24 at 4:31 PM, upon entering Resident #83's room, LPN #2 was observed changing the dressing on Resident #83's percutaneous endoscopic gastrostomy (PEG) tube site. LPN #2 was not wearing a gown while performing the dressing change. LPN #2 was also not observed to perform hand hygiene in between changing her gloves during the dressing change. On 9/10/24 at 4:45 PM, LPN #2 stated she did not wear a gown before entering Resident #83's room to change the dressing on her PEG tube site. LPN #2 stated she should have worn a gown before entering Resident #83's room. When asked about the hand hygiene, LPN #2 stated she performed hand hygiene before entering Resident #83' room. LPN #2 stated she did not perform hand hygiene when she was changing her gloves during the dressing change. LPN #2 stated her hands were clean and it was the gloves which were dirty. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135130	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Transitional Rehabilitation	2867 East Copper Point Drive Meridian, ID 83642

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 9:20 AM, the IP (Infection Preventionist) stated the gown should be worn by the staff when they are performing a dressing change on a resident. The IP also stated hand hygiene should be performed in between changing gloves during the procedure.