STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135136	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quinn Meadows Rehabilitation and Care Center	1033 W Quinn Road Pocatello, ID 83202

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on policy review, record review, and staff interview, it was determined the facility failed to ensure residents resuscitation code status was up to date in their medical records and residents and their representatives received assistance to exercise their right to formulate an advanced directive. This was true for 1 of 12 residents (Resident #188) whose records were reviewed for advanced directives. This deficient practice created the potential for harm or adverse outcomes if residents' wishes were not followed or documented. Findings include: The facility's Residents' Rights Regarding Treatment and Advance Directives policy dated [DATE], documented under Policy Explanation and Compliance guidelines: On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. Any decisions made regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care. Resident #188 was admitted to the facility on [DATE], with multiply diagnoses including chronic respiratory failure with hypoxia (a condition where the body is unable to effectively exchange oxygen and carbon dioxide in the lungs over a prolonged period, leading to persistently low levels of oxygen in the blood) and multiple fractures of bilateral ribs. Resident #188's medical record had conflicting documentation related to his resuscitation status as listed below. - Resident 188's face sheet documented DNR. - His POST (Physician Orders for Scope of Treatment) dated [DATE], documented YES to CPR, attempt resuscitation. - His care plan dated [DATE], documented DNR. Resident #188's medical record did not contain documentation of the following; - an advance directives. - of the facility offering to assist the resident to formulate an advance directive. (continued on next page)

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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- the resident declined to formulate an advanced directive. On [DATE] at 2:25 PM, the DON and Regional Support Nurse stated the POST was the most up to date document and it did conflict with the other documents in Resident #188's record and should not have. On [DATE] at 2:30 PM, the DON and Regional Support Nurse stated Resident #188 did not have an advance directive in the medical record and should have.

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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** 49552 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with a clean, safe, homelike environment. This was true for all 37 residents who resided in the facility whose equipment and environment were observed for cleanliness and proper lighting in their rooms. This deficient practice created the potential for harm if residents were embarrassed by and/or felt the disrepair in the facility was unacceptable, disrespectful, or undignified or residents were injured due to inadequate lighting in resident rooms. Findings include: The facility's Cleaning and Disinfecting of Resident-Care Equipment policy dated 12/6/24, documented direct care staff are responsible for cleaning single-resident equipment when visibly soiled, and according to routine schedule. The following areas were observed: a) On 2/3/25 at 9:21 AM, in room [ROOM NUMBER]A, the right bed rail was observed with a dried brown substance in the curve of the railing and across the railing. The bedside table base was observed with a dry white substance. On 2/5/25 at 10:46 AM, the Director of Housekeeping/Laundry stated the bed rail, and the bedside table are to be cleaned daily and should have been cleaned. b) On 2/3/25 at 8:28 AM, observed a Hoyer lift stored in the hallway in front of room [ROOM NUMBER] with a dirty cushion on the cross bar. On 2/3/25 at 8:32 AM, the ADON stated the cushion was dirty and should have been getting changed or cleaned between resident transfers. On 2/3/25 at 10:04 AM, observed CNA #2 remove a Hoyer lift from room [ROOM NUMBER] and did not clean/disinfect the Hoyer lift. On 2/3/25 at 10:08 AM, CNA #2 stated there is no set time frame for cleaning the Hoyer lifts. On 2/3/25 at 10:13 AM, CNA #1 stated he didn't know who cleans the Hoyer lift or when it gets cleaned. c) Resident #32 was admitted to the facility on [DATE], with multiple diagnoses including heart failure and diabetes. On 2/3/25 at 1:41 PM, Resident #32 stated the lights were off in his room because he could not reach any of the light switches in the room when in bed. On 2/4/25 at 10:30 AM, the Administrator stated that residents might have problems with room light access due to the location of room light switches. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/25 at 11:45 AM, the Administrator provided the results of a Potential Building Wide Grievance survey he had just completed. This survey documented four residents stated access to the light switch from their bed was identified as a potential barrier at times. On 2/4/25 at 11:48 AM, the Administrator stated the light switches in resident rooms seemed to be an issue for some residents and needed to be addressed. 51121

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on review of the State Operations Manual, record review, and staff interviews, it was determined the facility failed to ensure a Significant Change of Status Assessment (SCSA) MDS was completed when residents were newly diagnosed with a major mental disorder. This was true for 2 of 12 residents (#27 and #33), whose MDS records were reviewed for accuracy. This had the potential for harm if the facility staff did not recognize changes in the resident's health status and mental health needs. Findings include: Appendix PP of the State Operations Manual dated 8/8/24, documented a SCSA must be completed within 14 days after a determination has been made that a significant change in the resident's status from baseline occurred. 1. Resident #27 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including primary adrenocortical insufficiency (a condition where the adrenal glands fail to produce sufficient amounts of the hormones cortisol and aldosterone) and Alzheimer's disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior). Resident #27's Level 1 PASARR dated 8/21/24, documented he had schizophrenic disorder. The quarterly MDS dated [DATE], had not documented Resident #27 had a schizophrenic disorder. On 2/5/25 at 2:31 PM, the DON and the RSN stated Resident #27's MDS should have been updated within 14 days of the schizophrenic disorder diagnosis identified on 8/23/24 PASARR I but was not. 2. Resident #33 was admitted on [DATE], with multiple diagnoses including fractured pelvis, anxiety disorder, and depression. Resident #33's Level I PASRR screening dated 12/30/24, documented she was suspected to have a mental disorder of mild/situational depression. Resident #33's Level II PASRR evaluation dated 12/30/24, documented her depression and anxiety diagnosis was identified as mild or situational and does not meet the criteria for major mental illness. Resident #33's medication orders dated 1/2/25, documented the following. - Quetiapine Furnate (antipsychotic medication) 25 MG. Give 1 tablet by mouth at bedtime for depression. - Citalopram Hydrobromide Oral Tablet (antidepressant medication) 20 MG. Give 1 tablet by mouth one time a day for depression. Resident #33's Admission MDS dated [DATE], documented in section A1500, Resident #33 was not considered to have a serious mental illness. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #33's physician documented on 1/11/25, Resident #33 had a diagnosis of major depressive disorder (a major mental illness) and she will continue to meet with Resident #33 on a regular basis to provide supportive counseling and monitor medication need. On 2/5/25 at 2:14 PM, the DON and RSN stated a SCSA MDS was not completed for Resident #33 after her newly identified diagnosis of major depressive disorder, and there should have been one completed. 51121

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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** 49552 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 1 of 12 residents (Resident #16) whose care plans were reviewed. This placed resident 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: The facility's Comprehensive Care Plans policy, dated 12/13/24, documented the comprehensive care plan would be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. Resident #16 was initially admitted to the facility on the 11/23/22, and readmitted to the facility on [DATE], with multiple diagnoses including spinal stenosis (spinal narrowing) and heart failure. a) A Progress Note dated 1/23/25 at 1:27 PM, documented the staff were called outside to the front of facility. Resident #16 was observed laying on the driveway near the sidewalk, on his left side. Resident #16 stated his wheelchair tire went off the curb and he fell out of the wheelchair. Resident #16 received a bruise and a cut to his left elbow, a cut to the bridge of his nose and forehead. Resident #16's care plan was not updated with new fall interventions. On 2/5/25 at 11:11 AM, the DON stated there was no interventions for Resident #16's fall on 1/23/25, in his care plan. The care plan should have been updated. b) Resident #16's TAR documented he did not have skin breakdown/wounds. On 2/4/25 at 11:44 PM, Resident #16's care plan documented he recently had lumbar spinal fusion surgery. Resident #16's goal was for his surgical site to heal without signs and symptoms of complications by next review date. His care plan directed the facility staff to: - Allow me to rest when my pain is worse. - Assist me with turning and repositioning. - Encourage me to report pain. - Encourage me to turn, cough and breathe deeply to help prevent pneumonia. - Ensure I am eating to promote healing. - Diet per my physician order. - Encourage diet high in protein to promote healing. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Monitor my intake. - Offer snacks. - Have dietician assess my nutritional status. - Assess for my likes and dislikes. - Monitor and change my bandages per my physician orders. - Monitor my pain. Perform pain scale every shift. Administer pain medication as ordered. Assist me to comfortable positions. - Monitor my surgical site for s/s of infection: redness, increased temperature, Drainage, etc. On 2/5/25 at 11:11 AM, the DON stated Resident #16 does not have any wound issues, his lumbar surgery was a while ago, and his care plan should have been updated.

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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** 51121 Based on policy review, Up-To-Date review, observation, record review, and interviews, it was determined the facility failed to provide respiratory services as ordered by the physician. This was true for 1 of 2 residents (Resident #189) whose records were reviewed for respiratory services. This failure created the potential for residents to experience increased fatigue, poor sleep quality, and low oxygen levels. Findings include: The facility's Noninvasive Ventilation (CPAP, BiPAP, AVAPS, Trilogy) policy dated 12/16/24, documented under Policy Explanation and Compliance Guidelines, document use of the machine, resident's tolerance, any skin, respiratory or other changes and response(s). Up-To-Date (Sleep-related breathing disorders in COPD - Up-To-Date), Sleep-related breathing disorders in COPD dated 12/8/23, documented heated humidification is generally recommended for patients receiving CPAP. Resident #189 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including diabetes and obstructive sleep apnea (a sleep disorder characterized by repeated episodes of complete or partial blockage of the upper airway during sleep, leading to reduced or absent breathing). On 2/3/25 at 2:43 PM, Resident #189 stated she had not used the CPAP since the humidifier water ran dry 3 days ago. Additionally, Resident #189 stated no one had been back to help her with the CPAP. Resident #189's physician's orders documented CPAP with setting of 6 to 15 cmH20 at bedtime. Add distilled water every night and as needed every night shift. On 2/5/25 at 10:15 AM, with RN #2 present, Resident #189 stated she had not used her CPAP the last three nights because they had not filled the CPAP humidifier with distilled water. On 2/5/25 at 11:06 AM, the DON stated nursing staff should have been filling the humidifier each night and as needed but nursing staff had not.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49552 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure controlled medications were tracked and kept secure from potential theft and/or diversion. This was true for 1 of 2 medication carts reviewed. This failure created the potential for undetected misuse and/or diversion of controlled medications and had the potential to affect all residents who received controlled medication in the facility. Findings include: The facility's Controlled Substance Administration & Accountability policy dated 12/16/24, documented it is the policy of the facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place to prevent loss, diversion, or accidental exposure. On 2/4/25 at 12:26 PM, during hall 100's medication cart audit, observed the narcotic accountability record, dated 1/1/25 to 2/4/25, did not document a licensed nurse signature on each shift for 11 out of 35 days. On 2/4/25 at 12:33 PM, RN #1 stated the nurses should have signed the sheet when they accepted or released the medication cart.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on record review, policy and State Operations manual review, and staff interview, the facility failed to ensure physician ordered psychotropic medications were necessary to treat a specific diagnosed condition documented in resident's medical records. This was true for 1 of 6 residents (Resident #27) reviewed for psychotropic medication administration. This failure created the potential for Resident #27 to experience negative side effects related to receiving psychotropic medication without a proper diagnosis. Findings include: The facility's Unnecessary Drugs-Without Adequate Indication for Use policy dated 12/16/24, documented under Policy Explanation and Compliance Guidelines, documentation will be provided in the resident's medical record to show adequate indications for the medication's use and the diagnosed condition for which it was prescribed. State Operations Manual Appendix PP S483.45(e)(1) documented residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. Resident #27 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including primary adrenocortical insufficiency (a condition where the adrenal glands fail to produce sufficient amounts of the hormones cortisol and aldosterone) and Alzheimer's disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior). Resident #27's physician's order documented Risperdal (antipsychotic medication) oral tablet 1 mg at bedtime for schizophrenia. Resident #27's medical record had not documented schizophrenia as a medical diagnosis. Resident #27's MDS dated [DATE], under I6000 documented NO for schizophrenia. On 2/5/25 at 2:28 PM, the DON and the RSN stated the schizophrenic diagnosis should have been in the record before the Risperdal was ordered and administered but was not.

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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. 49552 Based on observation, policy review, and staff interview, it was determined the facility failed to maintain the kitchen in a sanitary manner. This deficiency had the potential to affect the 37 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. The facility's Sanitation Inspection policy revision date 12/3/24, documented it was the policy of the facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations. All food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies, and other insects. On 2/3/25 at 8:10 AM, during the initial kitchen tour, the following was observed in the kitchen: - dust between handles of the refrigerator and freezer. - the ice machine floor drain had a large hard water stain. The drain pipes for the ice machine had a thick, dark gray, dry, substance. - the right side of the ice machine had a build up of a white substance. - the inside lip of the ice machine had a red, dry substance. - under the handwashing sink observed a fuzzy, gray substance on the pipes/tubing and hard water stain on the floor. - the dish rack was observed with a thick, fuzzy, gray, and yellow substance around the base and wheels. Observed dried chunks of different colors one the poles of the rack. - the serving table was observed with a white substance on the lower edge. - the wheels and lower part of the poles of the dish racks had a thick, gray, fuzzy substance covering them. - the front of the stove, on the bottom, observed a brown/orange, thick substance. - the vents in dish room and above the serving table were observed with a black substance. - the inside of the refrigerator, the left corner was observed with a dry, yellow substance. The right side of refrigerator wall was observed to have a dry, white substance. On 2/5/25 at 8:29 AM, the DM stated the kitchen has a daily and weekly cleaning schedule and the kitchen equipment should have been cleaned. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/25 at 12:59 PM, the Administrator stated the kitchen equipment and floor should have been clean.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 49552 Based on observation, interview, Idaho Administrative rules, and U.S. Food and Drug Administration 2022 Food Code review, the facility failed to ensure garbage cans were properly closed with lids to minimize attracting pests and rodents into the kitchen. This deficient practice had the potential to affect all residents and staff in the facility. Findings include: Idaho Administrative Rules 16.03.02. Environmental Sanitation 108. Garbage and Refuse 03a. All containers used for storage of garbage and refuse shall be constructed of durable, nonabsorbent material and shall not leak or absorb liquids. Containers shall be provided with tight-fitting lids unless stored in vermin-proof rooms or enclosures, or in a waste refrigerator. U.S. Food and Drug Administration 2022 Food Code, 5-501.113 Covering Receptacles. Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered: (A) Inside the FOOD ESTABLISHMENT if the receptacles and units: (1) Contain FOOD residue and are not in continuous use; or (2) After they are filled. On 2/3/25 at 8:10 AM, observed in the kitchen, next to the clean dish rack, a large garbage can without a lid. On 2/5/25 at 1:13 PM, the cook stated they had never had a lid on their garbage can. He did not know they needed one. On 2/5/25 at 2:54 PM, the RSN stated the garbage can should have had a lid on it.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 51121 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure infection control and prevention practices were maintained to provide a safe and sanitary environment. This was true for 1 of 6 residents (Resident #28) reviewed for IV medication administration. This failure had the potential of placing residents at risk for cross-contamination and infection. Findings include: The facility's Intravenous Therapy policy dated 12/13/24, documented under IV push. - Disinfect needleless connector/IV port with appropriate antiseptic agent (e.g., chlorhexidine, povidone iodine, an iodophor, or 70 percent alcohol) as per facility protocol. - Attach 10mL syringe normal saline and confirm patency of vascular access device as per protocol. - Disinfect needleless connector again with appropriate antiseptic agent. - Attach medication/solution syringe and administer slowly as per medication guidelines. - Observe infusion site for any adverse reactions and stop infusion, if so noted, and notify practitioner. - Detach medication syringe and disinfect needleless connector with appropriate antiseptic agent again. - Flush vascular access device with normal saline at same rate drug was injected. - Disinfect the needleless connector again and attach locking solution and inject into device, if warranted. On 2/3/25 at 11:01 AM, observed RN #1 during IV push medication administration do the following. - use Resident #28's bedside table without cleaning or disinfecting it before putting the IV push antibiotics syringe and flush syringes on the bedside table without any protective barrier. - uncap and clean first IV port with an alcohol pad before connecting the flush syringe to the port and recap the port. - uncap and clean the second IV port with an alcohol pad before connecting the flush syringe to the port. - without wiping the second IV port with an alcohol pad, connected the antibiotic syringe and instill the antibiotic. - After the antibiotic syringe was empty, RN #1 again wiped the second port with an alcohol wipe and connected the flush syringe to the port. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135136	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quinn Meadows Rehabilitation and Care Center	1033 W Quinn Road Pocatello, ID 83202

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 2/3/25 at 11:19 AM, RN #1 stated she should have disinfected the bedside table before using it and she should have cleaned the second IV port before connecting the antibiotic syringe to the port, but did not. On 2/5/25 at 3:08 PM, the RSN stated RN #1 should have cleaned Resident #27's bedside table and the IV port prior to connecting each syringe to the IV port.