STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135138	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Teton Healthcare of Cascadia	3111 Channing Way Idaho Falls, ID 83404

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on record review and staff interview, it was determined the facility failed to provide the Advance Beneficiary Notice (CMS-10055 form) for 2 of 2 residents (#60 and #62) and Notice of Medicare Non-Coverage (NOMNC) (CMS- 10123 form) for 1 of 1 resident (Resident #232) reviewed for beneficiary protection notification. This deficient practice had the potential to cause financial harm or distress for residents when they were not informed of their potential liability for payment when their Medicare Part A benefits ended. Findings include: 1. Resident #60 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including left femur fracture and traumatic brain injury. A Skilled Nursing Facility Beneficiary Notification Review documented Resident #60's Medicare A benefit ended on 11/20/24 and she continue to stay in the facility. Resident #60's record did not include an Advance Beneficiary Notice (ABN). 2. Resident #62 was admitted to the facility on [DATE], with multiple diagnoses including dementia and kidney failure. A Skilled Nursing Facility Beneficiary Notification Review documented Resident #62's Medicare A benefit ended on 11/21/24 and he continue to stay in the facility. Resident #62's record did not include an Advance Beneficiary Notice (ABN). 3. Resident #232 was admitted to the facility on [DATE], with multiple diagnoses including urinary tract infection and chronic obstructive pulmonary disease (a progressive lung disease that causes breathing problems by restricting airflow). A Skilled Nursing Facility Beneficiary Notification Review documented Resident #232 signed the NOMNC on 6/13/24, however; his Medicare A benefit ended on 6/12/24. On 12/19/24 at 1:42 PM, the Administrator stated they did not have ABNs for Residents #60 and #62 and the NOMNC for Resident #232 should have been signed 48 hours prior to the end of covered skilled nursing services.

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

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on observation, staff interview, and policy review, it was determined the facility failed to ensure resident's privacy was maintained during cares, treatment information was protected, and residents had unrestricted access to review mail in a timely manner. This was true for 1 of 4 medication carts, 1 of 18 residents (Resident #53) reviewed for privacy and confidentiality, and all residents who receive mail at the facility. This deficient practice placed residents at risk of embarrassment, loss of control over their personal information, diminished quality of life, and psychosocial distress. Findings include: The facility's Resident Rights policy, dated 10/15/22, documented the facility would take measures to ensure that each resident has the right to personal privacy. 1. On 12/16/24 at 8:00 AM, observed on hall 400, a computer on top of the medication cart opened to resident information, the medication cart keys were in the lock, and the cart was unlocked. On 12/16/24 at 8:02 AM, RN #1 stated she should have shut the screen to the computer, locked the medication cart, and taken the keys with her. 2. Resident #53 was admitted to the facility on [DATE], with multiple diagnoses including osteomyelitis (inflammation of bone caused by infection) of the right ankle and foot and diabetes. On 12/16/24 at 8:20 AM, RN #1 entered Resident #53's room to draw labs. RN #1 left Resident #53's room to get more supplies. When she reentered Resident #53's room, RN #1 had not shut the door to provide Resident # 53 with privacy during her lab draw or when she had administered her insulin. On 12/16/24 at 8:27 AM, RN #1 stated she should have shut Resident #53's door before drawing labs and giving her the insulin. 3. On 12/18/24 at 2:00 PM, during a Resident Council meeting, residents stated that mail had not been delivered on Saturdays. On 12/18/24 at 3:00 PM, the Administrator stated mail was delivered on Saturdays to the facility but confirmed it had not been delivered to the residents. 51121

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 74 residents who resided in the facility whose equipment and environment were observed. This deficient practice created the potential for harm if: a) residents were embarrassed by and/or felt the disrepair in the facility was unacceptable, disrespectful, or undignified and b) residents were injured due to unsafe areas in the facility. Findings include: The facility's Resident's Environment policy, revision date 11/28/19, documented: - The facility would provide a safe, clean, comfortable, and homelike environment. - Housekeeping and maintenance services would provide services to maintain a sanitary, orderly, and comfortable interior. The following areas were observed: - On 12/16/24 at 9:54 AM, observed in room [ROOM NUMBER], the baseboard by the shower stall was loose and sticking out from the wall. On 12/16/24 at 10:01 AM, Resident #36 stated the wall had been that way for a while. - On 12/16/24 at 10:34 AM, observed in room [ROOM NUMBER], the inside of the bathroom door with an approximately 4 inch by 2 inch hole and the lower part of the bathroom door had deep gouge marks and missing paint. - On 12/16/24 at 10:35 AM, observed in room [ROOM NUMBER], the right side of the bathroom door frame and wall had deep gouge marks and missing paint. - On 12/16/24 at 10:45 AM, observed in room [ROOM NUMBER], behind the door was an approximately 3.5 inch round hole in the wall. On 12/20/24 at 9:03 AM, the Maintenance Director stated the walls should be repaired when it is reported or when the resident had moved out. On 12/20/24 at 1:11 PM, the Administrator stated the walls and doors are to be fixed when they need repaired. - On 12/17/24 at 7:37 AM, the sharps container in room [ROOM NUMBER]'s bathroom was observed to be overfilled with needles sticking out of the top. On 12/17/24 at 7:41 AM, LPN #2 stated the sharps container should have been changed sooner. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/20/24 at 8:39 AM, the CRN stated the sharps containers should have been changed when they were full.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on record review and staff interview, it was determined the facility failed to ensure resident's hospital discharge instructions were reviewed upon readmission to the facility to assure physician orders were in place to meet their medical needs. This was true for 1 of 1 resident (Resident #53) whose records were reviewed. This failure placed Resident #53 at risk of delayed care and assessments for a foley catheter. Findings include: Resident #53 was admitted to the facility on [DATE], with multiple diagnoses including osteomyelitis (inflammation of bone caused by infection) of the right ankle and foot and diabetes. Resident #53's discharge Physician Orders & Plan of Care from the hospital dated 9/18/24, documented in the Physician Order section, bladder train and discontinue foley when able. Resident #53's Admissions MDS, dated [DATE], documented under Section H, Yes for indwelling catheter. On 12/19/24, a review of Resident #53's physician orders did not document an order for her to have a foley catheter, foley catheter care, or to discontinue the foley catheter. On 12/19/24, a review of Resident #53's progress notes and care plan did not document foley catheter care or removal. On 12/19/24 at 10:43 AM, the CRN stated Resident #53 had an order for a foley catheter on her hospital discharge orders. The CRN stated she was not sure if Resident #53 had been readmitted with a foley catheter but if she had, the order for the foley catheter and care should have been on her facility orders. On 12/20/24 at 12:55 PM, the MDS Coordinator #1 stated Resident #53 did have a catheter when she was readmitted .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on record review and staff interview, it was determined the facility failed to ensure residents' Minimum Data Set (MDS) had correct assessment information. This was true for 3 of 5 residents (#27, #41, and #52) whose records were reviewed for accuracy. This deficient practice had the potential for negative outcomes if residents were not assessed and/or monitored due to inaccurate assessments. Findings include: The Resident Assessment Instrument (RAI), revised 10/1/2024, documents if a PASRR (Preadmission Screening and Resident Review) Level II determines a resident has a serious mental illness then section A1500 of the MDS should be marked yes. 1. Resident #27 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including depression, bipolar disease, and schizophrenia. Resident #27's record documented a PASARR level II, dated 10/12/18, was completed. Resident #27's Significant Change MDS, section A1500, dated 2/20/23, documented no, he did not have a completed PASARR level II. Resident #27's Annual MDS, section A1500, dated 1/4/24, documented no, he did not have a completed PASARR level II. Resident #27's Annual MDS, section A1500, dated 11/11/24, documented no, he did not have a completed PASARR level II. On 12/19/24, at 11:50 AM, the CRN stated section A1500 of Resident #27's MDS's, dated 2/20/23, 1/4/24, and 11/11/24, was coded incorrectly and should have been marked yes. 2. Resident #41 was admitted to the facility on [DATE], with multiple diagnoses including heart failure, respiratory failure, and diabetes. Resident #41's Significant Change MDS, dated [DATE], documented he had an active diagnosis of pneumonia. Resident #41's Quarterly MDS's, dated 7/24/24, 8/19/24, and 11/4/24, continued to document he had an active diagnosis of pneumonia. On 12/19/24, at 11:50 AM, the CRN stated Resident #41 did not have an active diagnosis of pneumonia on 7/24/24, 8/19/24, or 11/4/24. She stated Resident #41's pneumonia had resolved and his MDS's were coded incorrectly. 3. Resident #52 was admitted to the facility on [DATE], with multiple diagnoses including chronic venous insufficiency (occurs when your leg veins do not allow blood to flow back to the heart), muscle weakness, and pressure-induced deep tissue damage. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #52's Significant Change MDS, dated [DATE], documented he had an active diagnosis of pneumonia. Resident #52's Quarterly MDS's dated, 8/21/24 and 11/6/24, continued to document he had an active diagnosis of pneumonia. On 12/19/24 at 11:50 AM, the CRN stated Resident #52 did not have an active diagnosis of pneumonia on 8/21/24 and 11/6/24. She stated Resident #52's pneumonia had resolved and his MDS's were coded incorrectly.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on observation, policy review, record review, and staff interview, it was determined the facility failed to develop and implement comprehensive person-centered care plans. This was true for 4 of 18 residents (#33, #34, #220, and #226) whose care plans were reviewed. These failures placed residents at risk of negative outcomes if services were not provided or provided incorrectly due to lack of information in their care plans. Findings include: The facility's Care Plans policy revision date 10/15/22, documented the facility develops and implements a comprehensive person-center care plan for each resident, consistent with the residents' rights and include measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment. 1. Resident #33 was admitted to the facility on [DATE], with multiple diagnoses including fractured pelvis and need for assistance with personal care. On 12/16/24 at 3:06 PM, Resident #33 stated she had not received oral care and she had not seen a dentist. Resident #33's Clinical Evaluation Admission assessment dated [DATE], documented: - Section V. Sensory, Resident #33 had her natural teeth, in good repair. - Section V.1d. Oral Care Plan, documentation was blank. - Section VII. B. Musculoskeletal, 3. ADL Self Care Plan Intervention for Oral Hygiene did not document what oral care that was to be provided to Resident #33. Resident #33's care plan dated 7/25/24, did not document oral care to be provided. Resident #33's record review did not document that she had been offered or had completed oral care. On 12/19/24 at 12:09 PM, the CRN stated oral care was not on Resident #33's care plan and had not been documented as completed. 2. Resident #34 was admitted to the facility on [DATE], with multiple diagnoses including dementia and kidney failure. Resident #34's physician's orders documented unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Resident #34's care plans did not include any focus, goals, or interventions related to dementia. Resident #34 Multidisciplinary Care Conference dated 11/14/24, had not documented any reference to dementia. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/20/24 at 10:30 AM, the Administrator and CRN stated Resident #34's dementia diagnosis should have been care planned. 3. Resident #220 was admitted to the facility on [DATE], with multiple diagnoses including right tibia fracture and end stage renal disease. Resident #220's physician's orders documented knee high TED hose (hosiery used to prevent blood clots), on in the morning and off at bedtime for edema control. Resident #220's care plan instructed staff to monitor and document any edema and notify MD. Resident #220's care plan did not document the use of TED hose. On 12/20/24 at 10:32 AM, the Administrator and CRN stated Resident #220's knee high TED hose should have been care planned. 4. Resident #226 was admitted to the facility on [DATE], with multiple diagnoses including irritable bowel syndrome with diarrhea and polyneuropathy (a disease that affects peripheral nerves in similar areas on both sides of the body causing weakness, numbness and burning pain). On 12/16/24 at 1:01 PM, Resident #226 stated he has had frequent and unexpected diarrhea for months. Resident #226's MDS dated [DATE], documented irritable bowel syndrome with diarrhea and frequent bowel incontinence. Resident #226's care plan had not documented or addressed his diarrhea related issues. On 12/20/24 at 10:34 AM, the Administrator and CRN stated Resident #226's irritable bowel syndrome with diarrhea and frequent bowel incontinence should have been care planned. 49552

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 3 of 74 residents (#1, #33, and #226) 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 resident's needs changed. Findings include: The facility's Care Plan policy, revision date 10/15/22, documented the team of qualified persons monitor the resident's condition and effectiveness of the care plan interventions and revises the care plan quarterly, annually, with a significant change assessment or more frequently as needed with input by the resident and/or the representative, to the extent possible based on the following: a. Achieving the desired outcome. b. Resident failure or inability to comply with or participate in a program to attain or maintain the highest practicable level of well-being. c. Change in the residents' condition, ability to make decisions, cognition, medications, behavioral symptoms, or visual problems. 1. Resident #1 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including fracture of the lower end of the left Tibia (shin bone) and need for assistance with personal care. Resident #1's record documented he had a fall on 10/29/24, and he was now a 2 person assist when toileting. Resident #1's care plan dated 7/7/23, documented for his toilet use: extensive assistance with assist of 1-2 staff. On 12/19/24 at 12:44 PM, the CRN stated the care plan should have been updated to reflect that he is now a 2 person assist with toileting. 2. Resident #33 was admitted to the facility on [DATE], with multiple diagnoses including fracture of the pelvis and need for assistance with personal care. Resident #33's care plan dated 7/25/24, documented the facility staff were to provide a shower or bed bath twice a week and hospice staff were to provide a shower or bed bath once a week. On 12/16/24 at 3:12 PM, the CRN stated Resident #33 had come off hospice on 12/12/24 and her care plan should have been updated. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #226 was admitted to the facility on [DATE], with multiple diagnoses including irritable bowel syndrome with diarrhea and polyneuropathy (a disease that affects peripheral nerves in similar areas on both sides of the body causing weakness, numbness and burning pain). Resident #226's care plan initiated on 12/5/24, did not document any individualized care plan focus, goals, or interventions. On 12/20/24 at 10:34 AM, the Administrator and CRN stated the care plan should have been individualized to Resident #226's care and not left as a template. 51121

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents were given the appropriate treatment and services to maintain or improve ability to carry out activities of daily living. This was true for 1 of 3 residents (Resident #1) reviewed for restorative nursing services. This failure placed residents at risk for decreased range of motion, functional ability, and decreased quality of life. Findings include: The facility's Quality of Life policy, revision date 10/15/22, documented the facility provides the appropriate treatment and services to maintain or improve his/her ability to carry out activities of daily living and their abilities do not diminish unless circumstances of the individual's clinical condition demonstrate such decline was unavoidable. Resident #1 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including fracture of the lower end of the left Tibia (shin bone) and need for assistance with personal care. Resident #1's Annual MDS dated [DATE], Section GG documented he was able to walk 150 feet with touch assistance. Resident #1's Quarterly MDS dated [DATE], Section GG documented walking 10 feet had not been attempted due to his medical condition or safety concerns. On 12/18/24 at 10:47 AM, the CRN stated Resident #1 was not on a restorative program and should have been.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on observation, policy review, record review, staff interview, and review of the facility's investigation report, it was determined the facility failed to ensure proper storage and use of Hoyer lift equipment to prevent resident falls or injury. This was true for 1 of 1 resident (Resident #233) whose record was reviewed for falls. This resulted in harm to Resident #233 when proper use of a Hoyer lift was not provided. Findings include: The facility Space and Equipment policy revision date 12/4/19, documented under Procedure 6. Resident care equipment is stored after use in an area out of egress while maintaining availability. Licensed nursing and plant operations will validate proper storage and availability of resident care equipment when not in use. On 12/17/24 at 10:13 AM, observed a Hoyer lift being stored in room [ROOM NUMBER] which created a potential fall hazard when residents try to leave the room with their walker or wheelchair. On 12/18/24 at 11:40 AM, the CRN stated Hoyer lifts should not have been stored in resident's rooms. Resident #233 was admitted to the facility on [DATE], with multiple diagnoses including necrosis of left femur and dementia. On 6/26/24 the facility incident report documented during a Hoyer lift transfer for Resident #233, the Hoyer lift tipped over, causing a laceration to his head and bruising on his cheek. A nursing note dated 6/26/24, documented CNA #2 was transferring Resident #233 using an improper technique, when the Hoyer lift tipped over, hitting the resident in the head. On 6/26/24 at 7:23 PM, Resident #233 was transferred via ambulance, to a hospital emergency department where he received 3 staples to his scalp to close the laceration. On 12/20/24 at 10:38 AM, the CRN stated all CNAs should have been properly trained and had competencies completed on safe Hoyer lift transfers before use.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on observation, interview, and record review, it was determined the facility failed to notify the physician with resident's significant weight loss. This was true for 3 out of 18 residents (#34, #59 and #62) whose medical records were reviewed. This deficient practice had the potential to cause cognitive and functional decline. Findings include: 1. Resident #34 was admitted to the facility on [DATE], with multiple diagnoses including dementia and kidney failure. Resident #34's record documented on 11/13/24, he weighed 167 pounds. On 11/28/24, Resident #34 weighed 151 pounds which was a -9.58% weight loss. Resident #34's care plan directed staff to notify MD for weight change. On 12/20/24 at 10:43 AM, the CRN stated, the physician should have been notified of Resident #34's weight loss. 2. Resident #59 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including kidney failure and nutritional deficiency. Resident #59's record documented on 9/7/24, he weighed 199.2 pounds. On 11/16/24, Resident #59 weighed 177 pounds which was a -11.14% weight loss. Resident #59's Nutrition Evaluation Comprehensive for 9/12/24 and 11/14/24, identified weight loss less than 5% and to continue as is. Resident #59's care plan directed staff to notify RD and physician of significant weight changes. Resident #59's medical record did not include documentation that the physician had been notified of his significant weight loss. On 12/20/24 at 10:40 AM, the CRN stated the physician should have been notified of Resident #59's significant weight loss. 3. Resident #62 was admitted to the facility on [DATE], with multiple diagnoses including dementia and kidney failure. Resident #62's record documented on 11/1/24, he weighed 172.4 pounds. On 12/13/24, Resident #62 weighed 150 pounds which was a -12.99% weight loss. Resident #62's record had no documentation that the physician had been notified of his significant weight loss. On 12/20/24 at 10:40 AM, the CRN stated, the physician should have been notified of Resident #62's significant weight loss.

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F 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on observation, review of policy, record review, and interviews, it was determined the facility failed to ensure a) Certified Nursing Assistants (CNAs) were trained and had documented competencies to operate the facility Hoyer lifts and b) Licensed nurses had appropriate competencies and skills sets to provide respiratory related services to residents. This was true for all nursing staff employed by the facility. This had the potential for adverse effects and harm to residents who are transferred with Hoyer lifts or had an order for respiratory therapy. Findings include: The facility Competency Verification of Nursing Staff policy revised on 3/1/24, documented that completed competencies and education plans should be filed in employee's education file to include new hires' competency verification and annual competency review. 1. Resident #233 was admitted to the facility on [DATE], with multiple diagnoses including necrosis of left femur and dementia. On 6/26/24 at 5:30 PM, during a Hoyer lift transfer for Resident #233, the Hoyer lift tipped over, causing a laceration to his head, and bruising on his cheek. Resident #233's nursing note dated 6/26/24 at 7:30 PM, documented CNA #2 was attempting to load Resident #223 from the side of the Hoyer lift using an improper technique for the Hoyer when the Hoyer tipped over hitting the resident in the head. On 12/19/24 at 3:39 PM, the Administrator stated there were no CNA competencies documented for Hoyer lift usage prior to 7/2/24. On 12/20/24 at 11:35 AM, CNA #8, stated she had been at the facility for 5 years and had not been competency tested on the Hoyer lift. On 12/20/24 at 11:37 AM, CNA #9, stated she received training at a different facility but had not been competency tested on the Hoyer lift at this facility prior to 7/2/24. On 12/20/24 at 11:36 AM, CNA #10, stated she had not been competency tested on the Hoyer lift. On 12/20/24 at 11:36 AM, CNA #11, stated she received training on Hoyer lifts in CNA school but had not been competency tested on the Hoyer lift at this facility prior to 7/2/24. On 12/20/24 at 3:45 PM, the CRN stated all CNAs should have had a signed competency to operate the Hoyer lift but did not. 2. Resident #41 was admitted to the facility on [DATE], with multiple diagnoses including heart failure, respiratory failure, and diabetes. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	Resident #41's physician's order prescribed the use of AVAP (non invasive ventilation mode that automatically adjusts the inspiratory pressure support to deliver a set title volume) at 23 cmH2O inspiratory and 12 cmH2O expiratory for tidal volume of 550 cc with oxygen at 3 liters per minute with humidification. Resident #41's care plan instructed nursing staff to maintain ventilator settings as ordered - Trilogy AVAP at 55% FIO2 with 20 cmH2O. On 12/17/24 at 7:30 AM, Resident #41 stated he was having an issue with the AVAP, not able to get a deep enough breath and the machine seemed to be breathing too fast for him. He also stated, the air was too cold, causing his throat to be sore. On 12/17/24 at 7:34 AM, observed Resident #41's AVAP settings were 25 cmH2O inspiratory and 12 cmH2O expiratory with no set tidal volume, and set respiratory rate of 20 breaths per minute. Also, the humidify heater had not been turned on. There was no set AVAP respiratory rate documented in Resident #41's physician orders or care plan. On 12/17/24 at 7:48 AM, LPN #2, stated she had only been trained to turn the AVAP on and off and help Resident #41 put his full-face PAP mask on. She also stated she did not know how to turn on the humidifier. On 12/19/24 at 11:50 AM, the CRN stated there were no competencies or training documentation for the AVAP machine for the nursing staff. 50983

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 49552 Based on staff interview and review of employee personal files, it was determined the facility failed to provide a minimum of 12 hours of in-service education per year for 1 of 2 CNAs (CNA #1), failed to ensure each CNA's performance was evaluated at least once every 12 months and annual evaluations were performed for 2 of 2 CNAs (CNA #1 and #4) whose personnel records were reviewed for sufficient and competent staffing. This failure created the potential for incompetent CNAs providing care and increased the risk for harm for all residents living in the facility. Findings include: The following were reviewed for 12 hours of in-service education: 1. On 12/20/24 at 9:45 AM, review of CNA #1's employee file documented her hire date was 2/1/22. Review of CNA #1's Employee in-service hours, documented she had 6 hours for 2022-2023. CNA #1 had no documented in-service training hours for 2023-2024. On 12/20/24 at 10:04 AM, the HR/Payroll coordinator stated CNA #1 had not completed her training and should have. The following were reviewed for annual performance reviews: 1. On 12/20/24 at 9:45 AM, review of CNA #1's employee file documented her hire date was 2/1/22. CNA #1's employee file did not have documentation that an annual evaluation had been completed. 2. On 12/20/24 at 10:06 AM, review of CNA #4's employee file documented her hire date was 6/17/2023. CNA #4's employee file did not have documentation that an annual evaluation had been completed. On 12/20/24 at 9:58 AM, the Administrator stated the CNAs had not received their evaluations and their evaluations should have been done annually.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 49552 Based on observation and staff interview, it was determined the facility failed to ensure nurse staffing information was accurate and posted daily for each shift. This failed practice had the potential to affect all residents residing in the facility and their representatives, visitors, and others who wanted to review the facility's staffing levels. Findings include: On 12/16/24 at 7:13 AM, observed the Daily Staffing form dated 12/14/24. On 12/16/24 at 7:22 AM, the Administrator stated the Daily Staffing form should have been changed every morning.

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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** 49552 Based on record review, policy review, and staff interview, the facility failed to ensure the medical necessity for psychotropic medication administration. This was true for 1 of 3 residents (Resident #40) reviewed for psychotropic medication administration. This failure created the potential for negative side effects related to receiving psychotropic medications that are not necessary. Findings include: The facility's Psychoactive Drug Use policy revision date 10/15/22, documented psychoactive drugs are used only when necessary to treat a specific condition. Resident #40 was initially admitted on [DATE], and readmitted on [DATE], with multiple diagnoses including dementia and dysphagia (difficulty swallowing). Resident #40's Acknowledgement of Psychoactive Medication Use form for Risperdal (antipsychotic used to treat schizophrenia, bipolar, and autism spectrum disorder) dated 12/28/22, did not document the medical symptom treated/basis for use. A Pharmacy Medication Regimen Review form dated 7/27/23, documented Resident #40 was prescribed Risperdal for major depressive disorder. Resident #40 had a physician order dated 4/3/24, for Risperdal for dementia with agitation and distress. An Interdisciplinary Team Meeting note dated 6/28/24, documented Resident #40 was on Risperdal for the diagnosis of dementia with agitation and distress. Risperdal remained clinically necessary for treatment of distress behaviors associated with progressing dementia. Resident #40's care plan documented she uses anti-psychotic medications related to dementia with agitation and distress demonstrated by delusions and yelling out. Review of Resident #40's Behavioral Documentation for June 1, 2024 - December 19, 2024, documented the following episodes of delusions: - June 2024: 1 episode resolved by allowing resident to rest and 1 episode resolved with reassurances. - July 2024: 1 episode resolved with reassurances. - August 2024: 1 episode resolved with reassurances. - September 2024: 1 episode resolved with reassurances. - October 2024: 1 episode resolved with reassurances. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- November 2024: 1 episode resolved with reassurances. - December 1 -19, 2024: 1 episode resolved with reassurances. On 12/19/24 at 9:31 AM, the CRN stated dementia was not an appropriate diagnosis for the use of Risperdal and Resident #40 should have had the proper diagnosis or the Risperdal should have been discontinued.

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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. 49552 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure medications available for residents were stored appropriately and properly labeled; this was true for 3 of 74 residents (#1, #50, and #223) rooms inspected and 1 of 4 medication carts observed. This failure created the potential for adverse effects if residents self-administered medications inappropriately or receive the wrong medication due to improper labeling. Findings include: The facility's Medication Management policy revision date 10/15/22, documented: - medications are labeled in accordance with facility requirements, State and Federal regulations. - medications are provided in packaging to facilitate proper storage and administration of the medication using the agreed upon distribution system. The following was observed for medication in resident rooms: a) On 12/16/24 at 10:36 AM, observed in Resident #1's bathroom, another resident's tube of Calcipotriene ointment 0.005% (a prescription ointment to treat psoriasis). On 12/16/24 at 10:41 AM, the MDS Coordinator #2 stated that resident had discharged , and the tube of ointment should not have been in Resident #1's bathroom. b) On 12/16/24 at 2:28 PM, observed in Resident #50's room, on her bedside table a bottle of Tums. Resident #50 stated she took the Tums as needed. Review of Resident #50's medical record did not document an order for the TUMS, no self-administration assessment documented, and her care plan did not document self-administration of medication. c) On 12/17/24 at 8:42 AM, observed in Resident #223's room, on her bedside table, a tube of generic brand hemorrhoid ointment. On 12/17/24 at 9:00 AM, RN #3 stated Resident #223 did not have an order for the hemorrhoid ointment and it should not have been on the bedside table. On 12/20/24 at 10:24 AM, the CRN stated residents with medications at bedside need a self-administration assessment completed, an order to self-administer the medication, and it needed to be care planned. The medication should not have been in the resident's rooms. The following was observed in the medication cart: a) On 12/18/24 at 10:09 AM, observed in the 100-hall medication cart, in the top drawer, a bottle of tablets labeled in black marker as Sodium bicarb. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) On 12/18/24 at 10:12 AM, observed in the 100-hall medication cart: - 1 Tylenol tablet lying on the bottom of the cart, right side 3rd drawer. - 1/2 Metoprolol 25 mg tab on the bottom of the cart, second drawer on the left. On 12/18/24 10:17 AM, LPN #1 stated the tablets should not be on the bottom of the cart. She also stated the facility had a big bottle of the sodium bicarbonate that must be shared between the carts. The facility should have separate bottle for each cart that have the original label. On 12/18/24 at 10:56 AM, the CRN stated the sodium bicarbonate should not have been in the bottle without proper labeling.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50983 Based on observation and resident and staff interview, it was determined the facility failed to ensure resident meals were palatable and maintained correct temperatures. This failed practice affected 3 residents (#15, #45, and #226) and had the potential to negatively affect all residents' nutritional status and psychosocial well-being. Findings include: The 2022 FDA Food Code, states hot food will be maintained at 135 degrees F or above and cold foods will be maintained at 41 degrees F or below. On 12/16/24 at 10:00 AM, resident #15 stated the food is cold and the cream of wheat is one big lump most days. On 12/16/24 at 12:58 PM, resident #226 stated the food is barely warm and soggy. On 12/16/24 at 3:15 PM, resident #45 stated the food is cold. On 12/20/24 at 8:20 AM, a tray from the last meal cart delivered on the 200 hall was tested for palatability and serving temperature with the following results: - Gravy = 120 degrees F - Scrambled eggs = 115 degrees F On 12/20/24 at 10:30 AM, the DM stated the temperature for the gravy and the scrambled eggs should be at 135 degrees F.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on records review and interviews, it was determined the facility failed to ensure resident food intolerances and preferences were accommodated. This was true for 1 of 1 resident (Resident #229). This had the potential for adverse health effects and possible harm to residents with food intolerances or allergies. Findings include: Resident #229 was admitted to the facility on [DATE] with multiple diagnoses including surgical aftercare, lactose intolerance, and gluten sensitivity. On 12/16/24 at 1:24 PM, Resident #229 stated her family had to bring her food in over the weekend because she needed a gluten and lactose free diet and the facility kept serving her gluten and lactose type foods. When she complained the facility brought her a grilled cheese sandwich. The menu for 12/14/24 included the following; - Breakfast - Coffee Cake, Cinnamon Baked Apple Slices, Fried Egg, Sausage Links, - Lunch - Ham & Cheese Croissant Sandwich, Shredded Lettuce/tomato, Barley Beef Vegetable Stew, Peanut Butter Oatmeal Cookie, - Dinner - Cheese Enchilada, Salsa and Sour Cream, Refried Beans, Spanish Rice, Tailgate Fruit Salad. The menu for 12/15/24 included the following; - Breakfast - Sausage Patty, Fried Egg, Hashbrown, Baked Cinnamon Toast, - Lunch - Maple Glazed Ham, Creamed Peas and Potatoes Brussel Sprouts, Frosted Chocolate Cake, Bread. On 12/17/24 at 8:00 AM, the culinary manager stated the cooks should be monitoring the dietary notes for the residents. He also stated the substitute grill cheese sandwich should not have been delivered to the resident who is gluten and lactose free.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on observation and staff interview, it was determined the facility failed to ensure a) the kitchen equipment and environment was maintained and clean, and b) food was served in a safe and sanitary manner. These deficiencies placed all residents who consumed food prepared by the facility at risk for potential contamination of food and adverse health outcomes, including food-borne illnesses. Findings include: The FDA Food Code Section ,d+[DATE].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. The FDA Food Code Section ,d+[DATE].14 When to Wash. Food employees shall clean their hands and exposed portions of their arms as specified: (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; a) A kitchen inspection was conducted on [DATE] at 10:17 AM, with the Culinary Manager (CM) and Registered Dietician (RD) present. The following was observed: - A temperature log for the dish machine was was missing recorded temperatures for the dish machine on [DATE] and [DATE]. - A sanitizer log was missing recorded santitation readings on [DATE] and [DATE]. On [DATE] at 10:25 AM, the CM stated he did not know why the logs were not filled out. - The ice machine was observed to have a significant amount of calcified water build up on the outside, right front edge and top near the lid. On [DATE] at 10:30 AM, the CM stated the build-up was from the hard water. When asked how often the ice machine is cleaned, the CM did not know, and stated maintenance was who cleans the ice machine. On [DATE] at 12:25 PM, the Administrator stated the water had hardened and calcified on the outside of the ice machine. - The floor between the kitchen and dishwashing area, had a layer of dirt and grime along the threshold. On [DATE] at 10:35 AM, The CM stated the threshold was loose and the dirt could be the glue that was holding the threshold in place. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 12:25 PM, the Administrator stated the floor does need cleaned but they need to find the right chemicals to clean it with. b) On [DATE] at 7:42 AM, observed RNA #1 pour orange juice into 4 cups for residents, however the orange juice was dated to expire [DATE]. On [DATE] at 7:44 AM, RNA #1 stated the kitchen should not have sent out expired orange juice and she should not have poured it into resident cups. On [DATE] at 7:46 AM, observed RNA #1 put her fingers in the resident's cups to pick them up and filled them with juice and then served them to the residents. On [DATE] at 7:52 AM, RNA #1 stated she was trying to pick up 3 cups with one hand and put her fingers in the cups by accident. On [DATE] at 1:05 PM, the CM stated the RNA should not have put her fingers in the resident's drink cups and the outdated orange juice should not have been served. On [DATE] at 8:23 AM, observed the cook cracked raw eggs on a grill with gloved and non-gloved hands, sometimes leaving the serving line to wash his hands and other times he just kept serving foods on to resident plates. On [DATE] at 8:46 AM, the cook stated that he should be washing hands after working with raw food, like eggs, and before touching the ready to eat foods. On [DATE] at 1:25 PM, the CM stated the cook should be washing hands after cracking eggs on to the grill and before returning to the serving line. 51121

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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** 49552 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure infection control prevention practices were maintained to provide a safe and sanitary environment. These failures had the potential to impact all residents in the facility by placing them at risk for cross contamination and infection. Findings include: The facility's Hand Hygiene Policy revision date 2/11/22, documented staff are to assist residents to wash their hands after toileting, when leaving their room, prior to eating or entering the dining room, and when soiled and/or potentially soiled. ABHR may be used as directed. The facility's Resident's Environment policy, revision date 11/28/19, documented the facility would provide a safe, clean, comfortable, and homelike environment. The following were observed for hand hygiene: a) On 12/16/24 at 7:52 AM, Resident #3's meal tray was served to him in his room by the IP nurse. Resident #3 was not offered or encouraged to perform hand hygiene before eating. On 12/16/24 at 7:58 AM, the IP nurse stated they usually have a little packet of hand wipes on their tray, but they did not today, and she should have offered hand hygiene. b) On 12/17/24 at 10:53 AM, observed CNA #5 and CNA #6 provide incontinent care to Resident #49. After CNA #5 and CNA #6 provided incontinent bowel care for Resident #49, CNA #5 placed a clean brief under her without changing her gloves or performing hand hygiene. On 12/17/24 11:23 AM, CNA #6 stated hand hygiene should be performed before and after tasks, between glove changes, and change glove after each task. She also stated they should have changed gloves and washed their hands after cleaning stool and putting on Resident #49's new brief. The following were observed for enhanced barrier precautions: a) On 12/18/24 at 6:24 AM, observed Enhanced Barrier Precaution signage on Resident #3's door. On 12/18/24 at 6:31 AM, observed RN #4 enter Resident #3's room and administered his IV medication. RN #4 had not donned proper PPE before entering Resident 3's room to administer IV medication. On 12/18/24 at 6:34 AM, RN #4 stated she should have had a gown and gloves on when entering Resident #3's room due to his IV. b) On 12/19/24 11:49 AM, observed Enhanced Barrier Precaution signage on Resident #62's door. On 12/19/24 at 11:51 AM, observed CNA #7 enter Resident #62's room and provide foley catheter care for him. CNA #7 had not donned proper PPE before entering Resident #62's room to provide catheter care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135138	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Teton Healthcare of Cascadia	3111 Channing Way Idaho Falls, ID 83404

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 - Some	On 12/19/24/at 11:55 AM, CNA #7 stated she did not see the sign on the door, and she should have worn a gown. The following was observed for proper storage of oxygen supplies: a) On 12/16/24 at 10:36 AM, observed in Resident #30's room, his nebulizer mouthpiece and tubing had been lying on the floor. b) On 12/17/24 at 7:31 AM, observed Resident #44's CPAP mask lying on the floor. On 12/20/24 at 8:59 AM, the CRN stated the resident's oxygen supplies should not have been on the floor. On 12/16/24 at 2:45 PM, observed in room [ROOM NUMBER]'s bathroom an unbagged bed pan between the railing and the wall. On 12/17/24 at 10:40 AM, in room [ROOM NUMBER]'s bathroom a bed pan was observed on the floor, unbagged. On 12/20/24 at 8:51 AM, the CRN stated the bed pans should not have been stored on the floor or between the rail and wall in the bathroom. On 12/16/24 at 10:49 AM, observed CNA #1 transfer Resident #203 with the sit to stand (medical device used to assist individuals with limited mobility in transitioning from a seated to a standing position) from her bed to the commode. After the transfer was completed, CNA #1 was observed taking the sit to stand out of Resident #203's room without cleaning it. On 12/16/24 at 11:12 AM, CNA #1 stated the sit to stand should be cleaned after every use. On 12/17/24 at 8:17 AM, during medication administration observed RN #1 place Resident #8's Carbidopa-Levodopa tablet in a pill splitter. She then used her bare finger to push half of the tablet into Resident #8's pill cup and then administered the the tablet to him. On 12/17/24 at 8:20 AM, RN #1 stated she should not have touched the pill.