| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135145 | A. Building<br>B. Wing | 04/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cascadia of Lewiston | 2852 Juniper Drive<br>Lewiston, ID 83501 |

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 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193<br><br>Based on observation, record review, policy review, and resident and staff interviews, it was determine the facility failed to ensure residents were assessed to determined if they were safe to self-administer medication. This was true for 2 of 2 residents (#5 and #7) reviewed for self-administration of medication. This failure created the potential for adverse outcomes if Resident #5 and #7 self-administered their inhaler inappropriately. Findings include:<br><br>The facility's Self-Administration of Medications policy and procedure, released 11/28/17 documented the resident may self-administer drugs if the interdisciplinary team has determined that this practice is safe. Qualified nursing staff administers drugs until the determination is made.<br><br>1. Resident #5 was admitted to the facility on [DATE], with multiple diagnoses including chronic pulmonary disease (COPD - a progressive lung disease characterized by increasing breathlessness.)<br><br>A physician's order, dated 3/11/25 documented Resident #5 was to receive one inhalation of Advair Diskus powder Breath Activated 100-50 mcg (micrograms)/dose (a steroid and bronchodilator combination medicine that is used to prevent flare-ups of COPD), inhale orally every 12 hours for shortness of breath. The order included an instruction for the resident to rinse her mouth with water and spit in cup after use.<br><br>On 4/2/25 at 9:10 AM, during Medication Pass observation, Medication Assistant Certified (MAC) #1 administered Resident #5's oral medications. When the MAC was about to give the Advair Diskus to Resident #5, Resident #5 stated she already used the inhaler.<br><br>On 4/2/25 at 9:20 AM, MAC #1 stated he forgot that Resident #5 had the inhaler at her bedside.<br><br>On 4/2/25 at 9:47 AM, the Nurse Manager #1 reviewed Resident #5's record and stated Resident #5 was not assessed to self-administer her Advair Diskus.<br><br>2. Resident #7 was admitted to the facility on [DATE], with multiple diagnoses including COPD.<br><br>A physician's order, documented Resident #7 was to receive Albuterol Sulfate HFA (90 Base) mcg/act Aerosol solution, two puff inhale orally every four hours as needed for asthma.<br><br>On 3/31/25 at 3:39 PM, Resident #7 was in his room sitting on his recliner. An inhaler was observed on top of his overbed table. Resident #7 stated he was using the inhaler two times a day.<br><br>(continued on next page) |



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

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| Cascadia of Lewiston | 2852 Juniper Drive<br>Lewiston, ID 83501 |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/31/25 at 3:43 PM, LPN #1 and the surveyor went to Resident #7's room. LPN #1 took the inhaler and reviewed Resident #7's physician's order. LPN #1 stated the physician's order did not state Resident #7 could keep the inhaler in his room.<br><br>On 3/31/25 at 6:13 PM, the CNO reviewed Resident #7's record and stated Resident #7 did not have an assessment to self-administer his inhaler. The CNO stated Resident #7 should have been assessed first prior to having his inhaler at his bedside. |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50981<br><br>Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to promote and facilitate a resident's ability to make food choices. This was true for 1 of 16 residents (Resident #24) reviewed for accommodation of food choices. This deficient practice placed Resident # 24 at risk for decreased sense of wellbeing and self-worth, and frustration when her food preferences were not accommodated. Findings include:<br><br>The facility's Resident Rights policy dated, 10/15/22 documented residents will be cared for in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.<br><br>Resident #24 was admitted to the facility on [DATE] with multiple diagnoses, including macular degeneration (a chronic eye disease that affects the macula, the central part of the retina responsible for sharp, central vision- meaning one cannot see right in front of them) and nutritional deficiency (this occurs when the body doesn't get enough of a specific nutrient, leading to various health problems, and can be caused by poor diet, malabsorption, or increased needs.)<br><br>An admission MDS assessment, dated 3/12/25 documented Resident #24 was cognitively intact and had impaired vision - sees large print, but not regular print in newspapers/ books.<br><br>A care plan dated 3/8/25, documented, resident was to be provided feeding/dining assistance as needed.<br><br>On 4/1/25 at 10:41 AM, when asked if resident #24 was given choices about her food, she stated no. When asked if she was provided a menu with meal choices, she stated yes, but it did her no good because she was blind and could not read it. Resident #24 stated she has been served eggs every morning since admission and has informed the CNA's several times she would like an alternative but still gets served eggs every day. When asked if resident #24 has been offered any assistance in filling out her menu, she stated no one has offered to help her.<br><br>There was no documentation in Resident #24's medical record she was asked about her diet preferences.<br><br>On 4/02/25 at 9:20 AM, the facility's Registered Dietician, stated she was unaware of Resident #24's meal choices was not assessed.<br><br>On 4/02/25 at 10:07 AM, the CNO stated the facility's process for residents to make meal choices are as follows:<br><br>-Dining provides menu option cards once a week for residents to choose meals.<br><br>-Residents, family member, or staff can assist with filling out the menu choices.<br><br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The expectation is that the resident would circle the main dish or alternate choice, if no choice is circled then the assumption would be that they want the main dish.<br><br>On 4/02/25 at 10:26 AM, the Dietary Manager stated he keeps all resident's menu choices for the whole week and if no menu returned to the kitchen the staff should go check with residents to see what their choices are. The Kitchen Manager could not locate resident #24's menu choices for this week and he stated he did not know why it was not addressed. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193<br><br>Based on policy review, record review, review of facility's Grievances, and staff interview, it was determined the facility failed to ensure residents grievances were thoroughly investigated for 1 of 1 resident (Resident #77) whose grievance was reviewed. This failure created the potential for Resident #77 to be subjected for ongoing abuse without detection and intervention. Findings include:<br><br>The facility's Identification and Investigation of Abuse, Neglect, Misappropriation, and Injuries of Unknown Origin policy and procedure, revised 8/1/23 documented the facility has processes in place to assist in preventing abuse, neglect, misappropriation of resident property and exploitation. The policy documented residents, the accused and all witnesses would be interviewed. If there are no witnesses, consider interviewing all employees on the shift or the unit as appropriate as well as other residents on the unit. Upon the conclusion of the investigation, prepare a summary report of the findings and conclusions.<br><br>Resident #77 was admitted to the facility on [DATE] with multiple diagnoses including chronic pulmonary disease (COPD - a progressive lung disease characterized by increasing breathlessness) and congestive heart failure (weakness of the heart leading to a buildup of fluid in the body).<br><br>A Grievance Report, dated 11/27/24 documented Resident #77's representative filed a grievance report to the facility documenting Resident #77 had cash in his wallet and it was missing. Resident #77 and his representative were unable to identify how much money was missing. A comprehensive search was completed to locate the money. No money was found. The report also documented other residents were interviewed and none of the residents reported missing items. Resident #77's representative was asked if they would like the opportunity to speak to a police officer, they said yes. The police came and conducted their interviews.<br><br>The Grievance report did not include staff interviews, the police report, and the facility's conclusion of the investigation.<br><br>On 4/1/25 at 1:49 PM, the CEO stated he did not have a copy of the police report.<br><br>On 4/3/25 at 8:43 AM, the CNO with the CEO present stated Resident #77 was aware he had money in his wallet, but he did not know how much it was. The CNO stated Resident #77 had many friends visiting him in the facility, and sometimes he goes out with them. When asked why none of the staff were interviewed, the CNO stated the staff were interviewed, but she did not document the interviews. When asked what the conclusion of their investigation was, the CEO stated he thought Resident #77 was potentially spending the money with his friends. When asked about the police report, the CNO stated the police officer told them they were unable to determined how much money was missing. The CNO stated Resident #77 did not want to pursue on the investigation of his missing money.<br><br>A Police report, dated 12/30/24, obtained by the facility on 4/3/25 documented the CNO and Resident #77 were informed that It was unlikely we would find out where the money went due to the amount of people that come and go from the room coupled with no cameras. |

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| Cascadia of Lewiston | 2852 Juniper Drive<br>Lewiston, ID 83501 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193<br><br>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure staff rinsed and stored the nebulizer mouthpiece appropriately after each use. This was true for 5 of 5 residents (#7, #13, #15, #78, and #80). This failure placed residents at risk of respiratory infection due to growth of pathogens (organism that cause illnesses) in the respiratory equipment. Findings include:<br><br>An article from American Heart Association website, accessed on 4/9/25 at https://www.lung.org, titled ABCs of Using a Nebulizer documented the following:<br><br>- After each treatment, disassemble and wash the nebulizer parts in warm soapy water or in the dishwasher.<br><br>- Rinse and let the pieces air dry and store in clean dry place.<br><br>- Once a week soak them in a vinegar solution for 30 to 60 minutes to disinfect them.<br><br>- The tubing and compressor for a jet nebulizer should never be put into water. They can be wiped with a damp soapy towel or disinfectant wipe if they get soiled.<br><br>1. Resident #7 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including chronic pulmonary disease (COPD - a progressive lung disease characterized by increasing breathlessness).<br><br>A physician's order, dated 12/3/24 documented Resident #7 was to receive Olodaterol HCL (Hydrochloride) Inhalation Aerosol Solution 2.5 mcg(microgram)/actuation.<br><br>On 3/31/25 at 2:39 PM, Resident #7's nebulizer mouthpiece was observed on top of his nebulizer machine.<br><br>On 3/31/25 at 5:10 PM, LPN #1 and the surveyor went to Resident #7's room. LPN #1 stated the nebulizer mouthpiece should be rinsed, air dried and placed inside a plastic bag.<br><br>2. Resident #13 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including acute respiratory failure with hypoxia (low levels of oxygen in the body tissue).<br><br>A physician's order, dated 3/20/25 documented Resident #13 was to receive Ipratropium-Albuterol Solution 0.5-2.5 mg/ml (milligram per milliliter), three ml inhale orally every four hours as needed for shortness of breath.<br><br>On 3/31/25 at 5:15 PM, Resident #13's nebulizer mouthpiece was observed on top of his bedside table next to his nebulizer machine.<br><br>On 3/31/25 at 5:17 PM, LPN #1 and the surveyor went to Resident #13's room. LPN #1 stated the nebulizer mouthpiece should be rinsed, air dried and placed inside a plastic bag.<br><br>(continued on next page) |

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| Cascadia of Lewiston | 2852 Juniper Drive<br>Lewiston, ID 83501 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. Resident #15 was admitted to the facility on [DATE], with multiple diagnoses including emphysema (a lung disease that causes shortness of breath due to damage to the air sacs [alveoli] in the lungs).<br><br>A physician's order, dated 2/14/25 documented Resident #15 was to receive Ipratropium-Albuterol Solution 0.5-2.5 mg/ml (milligram per milliliter), three ml inhale orally every six hours as needed for shortness of breath.<br><br>On 3/31/25 at 5:20 PM, LPN #1 and the surveyor observed Resident #15's nebulizer mouthpiece on top of his bedside table. LPN #1 stated the nebulizer mouthpiece should be rinsed, air dried and placed inside a plastic bag.<br><br>4. Resident #78 was admitted to the facility on [DATE], with multiple diagnoses including chronic pulmonary disease (COPD)<br><br>A physician's order, dated 3/25/25 documented Resident #78 was to receive Ipratropium-Albuterol Solution 0.5-2.5 mg/ml (milligram per milliliter), three ml inhale orally via nebulizer before meals and at bedtime for shortness of breath.<br><br>On 3/31/25 at 4:35 PM, Resident #78's nebulizer mouthpiece was observed on top of his bedside table next to the nebulizer machine. Resident #78 stated he used the nebulizer three times a day.<br><br>On 3/31/25 at 5:23 PM, LPN #1 and the surveyor went to Resident #78's room. LPN #1 stated Resident #78's nebulizer mouthpiece should be rinsed, air dried and placed inside a plastic bag.<br><br>5. Resident #80 was admitted to the facility on [DATE], with multiple diagnoses including hypertension and diabetes.<br><br>A physician's order, dated 4/2/25 documented Resident #80 was to receive Duoneb Solution 0.5-2.5 mg/3 ml, three milliliters inhale orally via nebulizer every six hours as needed for shortness of breath/cough.<br><br>On 4/2/25 at 8:41 AM, RN #1 prepared Resident #80's Duoneb Solution, turned on the nebulizer machine, and handed the mouthpiece to Resident #80. Resident #80 took the nebulizer mouthpiece and started to inhale the medication.<br><br>On 4/2/25 at 9:30 AM, Resident #80 was inside her bathroom being assisted by CNA #1 and CNA #2. Resident #80's nebulizer mouthpiece was observed inside the plastic bag on top of her bedside table. When asked about the nebulizer mouthpiece, CNA #1 stated the mouthpiece was empty and she placed it inside the plastic bag, and turned off the nebulizer machine.<br><br>On 4/2/25 at 11:45 AM, the Nurse Manager #1 stated the nebulizer mouthpiece should be rinsed after each use and placed inside a plastic bag.<br><br>On 4/2/25 at 12:17 PM, the Infection Preventionist (IP) stated the nebulizer mouthpiece should be rinsed, air dried and placed inside a plastic bag after each use. |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50981<br><br>Based on record review, review of the facility's policy and procedure, review of Incidents and Accidents (I&A's) reports, and staff interview, it was determined the facility failed to ensure residents were free from significant medication errors. This was true for 2 of 2 residents (#133 and #134) reviewed for medication errors. Resident #134 was harmed when his J-tube had to be surgically replaced after being administered medications through it instead of by mouth per the physician's order and Resident #133 was potentially harmed when he was found to have 2 Fentanyl patches on his body instead of the ordered one patch. Findings include:<br><br>The facility's Eight Rights of Medication Administration procedure, undated, directed the licensed nurse to check the following to administer the medication:<br><br>- Right resident<br><br>- Right medication<br><br>- Right dose<br><br>- Right route<br><br>- Right time<br><br>- Right documentation<br><br>- Right reason<br><br>- Right response<br><br>1. Resident #134 was admitted to the facility on [DATE] with multiple diagnoses including aftercare following surgery for stomach cancer and gastrostomy status (an opening in the stomach from the abdominal wall, made surgically for the induction of food.)<br><br>An I&A report, dated 5/7/24 at 3:30 PM documented resident #134's J-tube was clogged. The nursing staff attempted to unclog Resident #134's J-Tube (a thin flexible tube inserted into the small intestine through surgical intervention). unsuccessfully. The provider was notified and an order was received to transfer the resident to the emergency room (ER) for an occlusion of the J-Tube. The I&A report documented the facility received a call from the ER asking them why Resident #134's medications were administered via his J-Tube when the resident was taking medications by mouth prior to admission to the facility. The facility then reviewed the admission orders which documented Resident #134's medications were to be given by mouth. The admission orders also documented "PO STATUS-sips and chips only-water and green tea.<br><br>This medication error resulted in Resident #134 being admitted to the hospital and requiring his J-Tube to be surgically replaced.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 4/3/25 at 11:21 AM, the CNO reviewed the I&A report and confirmed the residents' orders were not clarified resulting in the medication being administered in his J-Tube causing the J-Tube to be clogged. She stated, when there is a question about an order, the provider should be contacted to clarify to avoid errors like this.<br><br>2. Resident #133 was admitted to the facility on [DATE], with multiple diagnoses including rehabilitative therapy for right fibula and tibia (bones of the lower leg) fractures, and [NAME] Lymphoma (a cancer that affects the lymphatic system, a network of glands that are part of the body's immune system).<br><br>A physician's order dated, 10/3/24 documented an order for Fentanyl (an opioid pain medication) transdermal patch 25 mcg(microgram) per hour, apply one patch transdermal every 72 hours for pain. Remove old patch per schedule.<br><br>An I&A report, dated 12/3/24 at 3:00 PM, documented it was discovered that resident #133 was wearing 2 x 25 mcg/hour Fentanyl patches. The physician was notified and ordered the facility to remove the Fentanyl patches, place the Fentanyl order on hold until 12/8/24, and monitor the resident for signs of oversedation.<br><br>On 4/3/25 at 10:51 AM, the CNO reviewed the I&A report and stated the Agency nurse who placed the second patch without removing the first patch did not follow the eight rights of medication administration. The CNO stated, since this incident, the licensed nurses underwent in-service training on 12/3/24 for transdermal patch placement protocol and the facility has changed the procedure for transdermal patches to require documentation on placement and removal.<br><br>These findings represent past non-compliance with this regulatory requirement. The facility did the following:<br><br>-Physician and resident representatives were notified.<br><br>-All nurses were educated on the eight rights of medication administration.<br><br>-All nurses were educated on transdermal patch placement protocol.<br><br>-Facility has changed the procedure for transdermal patches to require documentation on placement and removal.<br><br>-All patient orders with questionable PO status orders will be clarified by a provider prior to admission as of 5/10/24.<br><br>There was sufficient evidence the facility corrected the non-compliance as of 12/3/24 as there were no further medication error reported after this date.<br><br>At the time of the survey, the facility was in substantial compliance and therefore does not require a plan of correction. |

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|---|---|
| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>50981<br><br>Based on observation, record review, resident interview, test tray evaluation, and staff interview, it was determined the facility failed to ensure palatable food was served. This affected 5 of 16 residents (#2, #14, #16, #17, and #127) who were reviewed for dietary concerns. This failed practice created the potential to negatively affect residents' nutritional status and psychosocial well-being. Findings include:<br><br>The facility's Food Preparation policy dated 8/1/23, documented food is prepared by methods that conserve nutritive value, flavor, and appearance.<br><br>The following resident interviews were conducted:<br><br>On 3/31/24 at 4:04 PM, Resident #14 said the food is terrible, as if it came from a box like hamburger helper, no taste, the chicken has no flavor and sometimes food is too salty.<br><br>On 3/31/25 at 4:15 PM, Resident #16 said food is not palatable and his daughter has started taking him home on Sundays to feed him good food.<br><br>On 3/31/25 at 4:29 PM, Resident #2 said the food had bland taste and food that should be hot is sometimes served cold even though she eats in dining room.<br><br>On 4/1/25 at 9:00 AM, Resident #17 said the food tastes good, but it looks terrible. She stated if she were to place it in front of her husband, he would vomit.<br><br>On 4/1/25 at 10:10 AM, Resident #127 said the food tastes good and is well seasoned, but the appearance is lacking and resembles dog poop.<br><br>On 4/2/25 at 12:38 PM, a lunch meal test tray was evaluated by two surveyors, a CNA and the CEO. The main dish of meat and pasta had an inner temperature of 149-degrees Fahrenheit. The toasted French bread had in inner temperature of 108.7-degrees Fahrenheit and was determined to be cold and hard. The broccoli had an inner temperature of 135.3-degrees Fahrenheit and was determined to be mushy, dark muddy green color, and did not taste palatable. The CEO confirmed the broccoli looked mushy and not palatable. The chocolate pie had an inner temperature of 51.0-degrees Fahrenheit and had good flavor but tasted a bit too warm for a cold pie and was melting, and did not look palatable.<br><br>On 12/3/25 at 12:00 PM, the Kitchen Manager stated he did not recall ever getting any grievances regarding food temperatures and palatability. He stated he thought the broccoli had become mushy and unpalatable because he had used frozen instead of fresh and due to the time in the heating table. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135145 | A. Building<br>B. Wing | 04/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cascadia of Lewiston | 2852 Juniper Drive<br>Lewiston, ID 83501 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>50981<br><br>Based on observation, interview, policy review, and review of the Idaho Food Code, the facility failed to appropriately store, label, and serve foods. This deficient practice had the potential to affect all 27 residents who received meals from the facility kitchen served in the dining room and resident rooms. This placed residents at risk for potential contamination and use of spoiled foods, and adverse health outcomes, including food-borne illnesses. Findings include:<br><br>Review of the Idaho Food Code, revised February 2021, stated 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking . refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.<br><br>The facility's Food and Supply Storage policy dated 11/28/17, documented under Policy for Labeling and rotating food supply: 1. For products that are opened and not completely used or prepared at the facility and stored, the product should be labeled as to its contents and use-by dates.<br><br>On 3/31/25 at 2:00 PM, during the initial kitchen tour with cook #1 the following was observed in:<br><br>a. walk-in freezer<br><br>- the inside of the walk-in freezer, the left corner just inside the door was observed with thick layers of ice along the food racks. The boxes stacked along that side of the shelf were observed to have sparkling ice crystals covering the outside and inside of these boxes. Ceiling was observed to have ice buildup in small round cone shapes.<br><br>- a container of jam with a use-by date of 3/8<br><br>- an opened and unlabeled bag of blueberries<br><br>- an opened and unlabeled bag of dinner bread<br><br>- a bag of crinkle cut carrots opened to the air, not sealed correctly and not dated when opened<br><br>- a large bag of tater tots opened to the air, not sealed correctly and not dated when opened<br><br>- a large bag of breaded chicken patties opened to the air, not sealed correctly and not dated when opened<br><br>b. walk-in refrigerator<br><br>- two opened and plastic wrapped stacks of sliced yellow cheese with use by date of 3/27<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | - four small containers of single serve salad dressing with use by date of 3/28<br><br>- a large bag of broccoli opened to the air, not sealed correctly and not dated when opened<br><br>- a large container of mayonnaise opened and undated<br><br>- a large container of ranch dressing opened and undated<br><br>- a container of milk opened and undated<br><br>On 3/31/25 at 2:10 PM, [NAME] #1 stated they sometimes don't write the dates on opened packages when they know they will be used that day.<br><br>On 4/2/25 at 9:30 AM, during a second trip to the kitchen with the Kitchen Manager, a box of opened undated bag of diced potatoes with crystallized freezer burn was observed in the walk in freezer. Kitchen manager confirmed food should be labeled and sealed after opening and the potatoes looked freezer burned. He stated that he believes that the door to this freezer doesn't get closed all the way sometimes resulting in thawing and refreezing of foods located by the door. |