STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. Building B. Wing	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River's Edge Rehabilitation & Living Center	714 North Butte Avenue Emmett, ID 83617

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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** 36193 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents received information and assistance to exercise their rights to formulate an Advance Directive and this was documented in their record. This was true for 2 of 12 residents (#11 and #30) whose records were reviewed. This failed practice created the potential for harm or adverse outcome if the resident's wishes were not followed or documented regarding their advance care planning. Findings include: The State Operations Manual, Appendix PP, defines an Advance Directive as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. Physician Orders for Life-Sustaining Treatment (or POST) paradigm form is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POST paradigm form is not an advance directive. The facility's Advance Directives and Associated Documentation policy, revised 1/2022, stated a resident's choice about an advance directive would be recognized and respected. The policy stated the facility would inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and at the resident's option to formulate an advance directive, and if an Advance Directive was developed, a copy would be included in the resident's record. This policy was not followed. 1. Resident #11 was admitted to the facility on [DATE], with multiple diagnoses including diabetes, congestive heart failure (a chronic progressive condition affecting the pumping power of the heart muscles) and chronic obstructive pulmonary disease (progressive lung disease characterized by increasing breathlessness). An admission MDS assessment, dated 11/17/23, documented Resident #11 was cognitively intact. Resident #11's record did not include an advance directive or documentation information about an advance directive was provided and discussed with her. (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	2. Resident #30 was admitted to the facility on [DATE], with multiple diagnoses including stroke with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body). Resident #30's MDS assessments, dated 3/23/23, 6/21/23, 9/19/23, and 10/17/23, documented he was severely cognitively impaired. Resident #30's IDT - Care Plan Review, dated 10/26/23, under section 5a. Advance Directives, a check mark was documented on Other Directives, and under 5b Additional Comments, was written DNR (Do Not Resuscitate). Resident #30's record did not include an advance directive or documentation information an advance directive was discussed with his representative. On 12/13/23 at 10:01 AM, the Social Service Designee (SSD) stated she asked about the POA (Power of Attorney) during the care conference with the residents and/or their representative, and when the resident's representative stated I am the POA, I thought that was the AD [advanced directives]. The SSD stated she got confused with the terms POA and Advance Directives. The SSD stated she did not know the difference between the two terms. The SSD stated she thought Honoring Choices (packet of information to assist a person in filling out an advanced directive/living will), POA, and Living Will all meant the same thing. The SSD stated Resident #11 and Resident #30 did not have advance directives.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48172 Based on policy review, record review, and staff interview, it was determined the facility failed to ensure a bed hold notice was provided to residents or their representatives upon transfer to the hospital. This was true of 1 of 1 resident (Resident #49) reviewed for transfer. This deficient practice created the potential for psychosocial distresss if residents were not informed of their right to return to their former bed/room at the facility within a specified time. Findings include: The facility's Bed Hold policy, revised 11/2016, documented it is the policy of this facility to inform the resident, or the resident's representative, in writing, of the right to exercise the bed hold provision of 7 days, upon admission and before transfer to a general acute care hospital. This policy was not followed. Resident #49 was admitted to the facility on [DATE], with multiple diagnoses including fracture of right femur (hip fracture) and Parkinson's disease (a progressive disease of the nervous system that affects movement). A Nursing Home to Hospital Form, dated 10/1/23, documented Resident #49 was transferred to the hospital due to a fall. Resident #49's record did not include documentation a bed hold notice was provided to her or her representative when she was transferred to the hospital. On 12/13/23, at 4:00 PM, the DON stated there was no written bed hold notice given or offered to Resident #49 upon discharge to hospital.

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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 - Few	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** 36193 Based on observation, record review, and staff interview, it was determined the facility failed to develop and implement comprehensive resident-centered care plans. This was true for 3 of 12 residents (#11, #25, and #30) 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 plan. Findings include: The facility's Care Planning policy and procedure, revised 5/2021, documented the facility's IDT team should develop a comprehensive care plan for each resident. This policy was not followed. 1. Resident #11 was admitted to the facility on [DATE], with multiple diagnoses including diabetes, congestive heart failure (a chronic progressive condition affecting the pumping power of the heart muscles) and chronic obstructive pulmonary disease (progressive lung disease characterized by increasing breathlessness). On 12/13/23 at 9:05 AM, 12/12/23 at 10:08 AM, and 12/13/23 at 12:00 PM, a machine connected to a plastic tube was observed on top of Resident #11's bedside table. On 12/12/23 at 10:08 AM, Resident #11 stated it was her BiPap (a bilevel positive airway pressure machine that uses pressure to push air into the lungs) machine and she used it at night. Resident #11's care plan did not include documentation she was using a BiPap machine. On 12/13/23 at 12:00 PM, RN #1 stated she did not see an order for Resident #11 to use a BiPap machine. On 12/13/23 at 12:07 PM, the DON reviewed Resident #11's care plan and stated the BiPap machine was not in the care plan. The DON stated there was no physician order for Resident #11 to use a BiPap machine. The DON stated the nurse on duty should have requested an order for the BiPap machine when it was first observed in Resident #11's room and added it to the care plan. 2. Resident #30 was admitted to the facility on [DATE], with multiple diagnoses including stroke with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body). On 12/11/23 at 2:53 PM and 12/13/23 at 9:29 AM, Resident #30 was observed in bed with Prevalon boots (boots with a cushioned bottom that reduces pressure on the heels to aid in prevention of pressure sores) on his feet. Resident #30's care plan did not include documentation he was using the Prevalon boots. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/13/23 at 11:39 AM, the DON reviewed Resident #30's care plan. The DON stated the Prevalon boots were ordered for Resident #30 on 11/18/22 and should have been in the care plan. 48989 3. The facility's Bowel and Bladder management policy, revised 11/2023, documented residents were to be assessed upon admission for incontinence and a comprehensive care plan would be initiated after residents were evaluated and assessed. This policy was not followed. Resident #25 was admitted to the facility on [DATE], with multiple diagnoses including congestive heart failure (the heart is unable to pump blood efficiently), and dementia. An admission MDS assessment dated [DATE], documented Resident #25 was frequently incontinent of bowel (two or more incontinent episodes in 7 days but at least 1 continent episode), and frequently incontinent of urine (more than 7 episodes of incontinence, but at least 1 continent episode in 7 days). Resident #25's care plan did not include documentation of his bowel and bladder incontinence, interventions, goals, or objectives to manage his incontinence. On 12/13/23, at 3:11 PM, the DON reviewed Resident #25's care plan. The DON stated Resident #25' care plan did not include documentation of his bladder and bowel incontinence. The DON stated Resident #25's care plan should have included his continence/incontinence status, and related goals and interventions on his care plan.

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F 0689 Level of Harm - Minimal harm or potential for 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** 36193 Based on record review, I&A report review, review of the State Agency's Long-Term Care Reporting Portal, and staff interview, it was determined the facility failed to ensure adequate monitoring for residents with a pressure alarm (a device that responds to changes in weight and pressure by emitting an alarm) to their bed. This was true for 1 of 2 residents (Resident #102) whose records were reviewed for falls. Findings include: Resident #102 was admitted to the facility on [DATE], with multiple diagnoses including Lewy body (abnormal deposits of protein in the brain) dementia, disorientation, anxiety and bipolar disorder (A disorder associated with episodes of mood swings ranging from depressive lows to manic highs). A Fall Risk Evaluation report, dated 6/30/23, documented Resident #102 was high risk for falls. She had history of 3 or more falls in the last 3 months. A physician's order, dated 6/30/23, directed staff to place a pressure alarm to Resident #102's bed and wheelchair. Resident #102's at risk for falls care plan, initiated 6/30/23, directed staff to avoid rearranging her furniture, ensure her call light was within her reach and encourage her to use it, provide her with appropriate footwear when she ambulated or was in her wheelchair, keep her pathway free of obstacles, and place a pressure alarm to her bed and wheelchair. An I&A report, dated 7/11/23, documented Resident #102 was found by CNA #1 laying on the floor crying and holding her right arm with swelling to her right elbow. Resident #102 was sent to the hospital to be assessed for a possible fracture. Resident #102's x-ray report, dated 7/11/23, documented Minimally displaced right humeral (upper arm) neck fracture and separate, displaced and angulated spiral fracture in the mid-humeral shaft. The facility's Fall Investigation report, documented Resident #102's pressure alarm to her bed was not sounding. The pressure alarm was found assembled correctly and when it was turned on it was blinking as if alarm was going off but remained silent. The Maintenance Director was notified of the faulty alarm but was unable to fix it. The pressure alarm was then replaced with a functioning alarm. The report documented CNA #1 was interviewed and stated she saw Resident #102's pressure alarm was blinking as it did when alarming, but it was not alarming. The Facility's Fall Investigation report, concluded Resident #102 had an unwitnessed ground level fall. The report documented staff were educated to ensure alarm to her bed and/or wheel chair was functioning appropriately before placing it under her, and that the alarm was working and loud enough for staff to hear. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/14/23 2:15 PM, the DON was asked if Resident #102's pressure alarm was checked prior to putting it on her bed. The DON stated Resident #102's pressure alarm was not checked because there was no specific direction on the physician's order regarding checking Resident #102's alarm. The DON stated she provided education to all staff regarding the need to check alarm function prior to leaving residents unattended and ensure the alarm was working appropriately. The DON stated they were now checking Resident #102's pressure alarm every shift. When asked for the documentation of the education provided to the staff, the DON gave a copy of CNA #1 and RN #1's education, the staff who were on duty when Resident #102 fell . The DON stated she did not have documentation all staff were educated regarding functioning of the pressure alarm.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review and staff interview, it was determined the facility failed to ensure the facility's arbitration agreement was explained and understood by residents and/or their representatives. This was true for 1 of 3 residents (Resident #30) whose arbitration agreements were reviewed. This failure had the potential to cause significant psychological distress to residents and/or their representatives by not clearly knowing their rights. Findings include: 1. Resident #30 was admitted to the facility on [DATE], with multiple diagnoses including stroke with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body). An admission MDS assessment, dated 3/30/22, documented Resident #30 was severely cognitively impaired. An Agreement to Arbitrate Disputes (Optional for Resident and Facility) form, dated 3/24/22, documented Resident #30 signed the agreement. Acknowledged by verbal was written on top of his signature. The Agreement did not include documentation how Resident #30 verbalized he understood the agreement. There was no documentation his representative was present and understood the agreement. On 12/13/23 at 2:48 PM, the Medical Record personnel stated she asked the resident and/or their representatives to read the agreement or she would read it to them if they asked her. The Medical Record personnel stated she would ask the resident's representative to sign the agreement if the resident was cognitively impaired. The Medical Record Personnel reviewed Resident #30's arbitration agreement and stated she was not the one who asked Resident #30 to sign the arbitration agreement form.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review, review of Center for Disease Control (CDC) guidance the facility follows for pneumococcal vaccination, and staff interview, it was determined the facility failed to ensure residents were offered or received the recommended pneumococcal vaccines. This was true for 1 of 5 residents (Resident #9) reviewed for immunizations. This failure created the potential for harm should residents contract Pneumococcal pneumonia and experience illness from pneumonia. Findings include: On 12/13/23 at 11:01 AM, the Infection Preventionist (IP) stated the facility follows the CDC guidelines as their policy for pneumococcal immunizations. The CDC's website accessed on 12/18/23, included an article titled Pneumococcal Vaccination: Summary of Who and When to Vaccinate, last reviewed on 9/23/23, documented the current recommendations for pneumococcal vaccinations for all adults [AGE] years of age or older as follows: - When no previous pneumococcal vaccine was received, give 1 dose of PCV (pneumococcal conjugate vaccine) 15 or PCV20. If PCV15 was used, this should be followed by a dose of PPSV (pneumococcal polysaccharide vaccine) 23 at least one year later. The vaccines are then complete. If PCV20 was used, a dose of PPSV23 is not indicated. The vaccines are then complete. - When only PPSV23 was received, give 1 dose of PCV15 or PCV20 at least one year after the most recent PPSV23 vaccination. Regardless of if PCV15 or PCV20 was given, an additional dose of PPSV23 is not recommended. Their vaccines are then complete. - When only PCV13 was received, give PCV20 or PPSV23 at least one year after the PCV13. Regardless of vaccine used, their vaccines are then complete. Resident #9 who was over 65, was admitted to the facility on [DATE], with multiple diagnoses including dementia, arthritis, and muscle weakness. A Pneumococcal Informed Consent, dated 2/7/13, documented Resident #9 declined to receive the pneumococcal vaccine. Resident #9's Immunization record documented she received the PCV13 vaccine on 4/14/15. There was no documentation in Resident #9's record she was offered the PCV20 or PVC23 one year later, per the CDC guidance the facility follows for pneumococcal vaccines for residents aged 65 and over. On 12/13/23 at 11:01 AM, the IP stated she offered the pneumococcal vaccines to all their new admissions. When asked if Resident #9 received her pneumococcal vaccines, the IP stated she was unable to find documentation Resident #9 received the vaccine. The surveyor stated Resident #9 was over [AGE] years old and the CDC recommended the pneumococcal vaccine for all adults [AGE] years or older. The IP stated she started working as an IP in January 2023 and was still working on the pneumococcal vaccinations for their long-term care residents.