STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135127	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Sandpoint	1125 North Division Avenue Sandpoint, ID 83864

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25490 Based on policy review, observation, record review, and resident and staff interview, it was determined the facility failed to ensure a resident was assessed for safety to self-administer an over-the-counter supplement medication. This was true for 1 of 1 resident (Resident # 32) reviewed for self-administration of medications. This failure created the potential for adverse outcomes if Resident #2 received too much or too little of the medication. Findings include: The facility's policy titled Self-administration of Medications, revised 8/29/23 stated .Each resident has the right to self-administer medications after the Interdisciplinary Team has assessed the resident and determined the resident can safely complete the task .If a resident expresses a desire to self-administer medications the DON, Interdisciplinary Team and resident physician must be notified before allowing the resident to self-administer the medication .This request will be documented in the Interdisciplinary Notes of the resident's medical record .A physician's order .allowing .self- administration of medications will not be honored until the Interdisciplinary Team has assessed the resident for the ability to administer the medication (s) safely .Medications will be administered by the licensed nurse or certified medication aide until the Interdisciplinary Team determines the resident can safely store and /or self-administer medication (s) in a safe manner . Resident #32 was admitted to the facility on [DATE], with multiple diagnoses including diabetes, paroxysmal atrial fibrillation (a type of irregular heartbeat), chronic kidney disease, heart failure, and muscle weakness. A quarterly MDS assessment, dated 5/15/24, documented Resident 32 was cognitively intact. During an interview and observation on 7/8/24 at 10:49 AM with Resident #32 in her room, an observation was made of a 4-ounce brown bottle that was approximately 90 percent used and labeled Chanca [NAME] on the resident's bedside table. Resident #32 was asked what was in the bottle and she stated, I have cancer and my doctors are trying something new to treat my pain. The resident continued to share that she uses the supplement daily. During an observation on 7/9/24 at 10:55 AM the Chanca [NAME] supplement remained on the bedside table as observed on 7/8/24. (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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	135127	A. Building B. Wing	07/11/2024

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Healthline website, updated 3/24/23, accessed on 7/24/24, and located at https://www.healthline.com/nutrition/chanca-[NAME], states, As a supplement, chanca [NAME] is reported to help with a variety of conditions related to the digestive system, liver, and kidneys. Supposedly, it contains phytochemicals or plant compounds that can increase urine flow, kill harmful bacteria and viruses, and relieve inflammation. Resident #32's physician orders, dated 7/2024 did not include an order for Resident #32's self-administration of Chanca [NAME]. Resident 32's MAR, dated 7/2024 did not include an order for self-administration of Chanca [NAME]. Resident #32's comprehensive care plan, did not include a plan for Resident #32 to self-administer the Chanca [NAME]. Resident #32's record did not include a self-administration for medication administration assessment. During an interview on 7/9/24 at 2:04 PM, CNA #3 stated she was not aware of residents in the facility who self-administered medications, nor did she know of any over-the-counter medications on a resident's bedside table. During an interview and observation on 7/9/24 at 2:15 PM, LPN #1 stated she was not aware of residents who had been assessed to self-administer medications. LPN #1 then observed and removed the bottle of Chanca [NAME] in Resident #32's room and locked it in the medication storage room. LPN #1 continued to share the facility was not aware Resident #32 was using an over-the-counter supplement. During an interview on 7/9/24 at 2:22 PM, the Administrator stated residents had the right to self-administer medication after they were assessed by a nurse, the Interdisciplinary Team, and a physician. She stated once the resident was assessed and found safe, then the resident would be allowed to self-administer the medication. The Administrator stated she expected all residents were assessed and if there were over-the-counter medications located in the residents' rooms her staff immediately removed the over-the-counter medication until the resident was assessed and the over-the-counter medication was determined to have no negative drug interactions with the resident's current medication regimen.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, record review, and staff interview, the facility failed to ensure residents' Minimum Data Set (MDS) had correct assessment information. This was true for 1 of 17 residents (Resident #24) reviewed for accuracy of MDS assessments. This deficiency created the potential for residents to not have their care needs met due to inaccurate assessments. Findings include: Resident #24 was admitted to the facility on [DATE], with multiple diagnoses including diabetes, Chronic Obstructive Pulmonary Disease (COPD - a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe), hearing loss, and hemiplegia and paraplegia (weakness and paralysis on one side of the body) following a stroke. Quarterly MDS assessments, dated 3/11/24 and 6/10/24, documented Resident #24 had adequate hearing and clear speech. Resident #24's care plan, initiation date 2/15/23, included a focus for a communication problem related to Resident #24's chronic hearing impairment from a childhood illness. During an observation and interview on 7/8/24, Resident #24 was unable to hear when her name was called and a touch to her shoulder caught her attention. When spoken to, Resident #24 pointed to a white board to write on to be asked questions. When the Resident #24 attempted to speak, the words were garbled sounds and no complete words. During an interview on 7/10/24 at 12:56 PM, the MDS Coordinator reviewed the quarterly MDS assessments dated 3/11/24 and 6/10/24 and stated the information was incorrect. She stated Resident #24 was not able to hear, and speech was unrecognizable. During an interview on 7/10/24 at 12:46 PM, the DON stated the quarterly MDS assessments dated 3/11/24 and 6/10/24 were not correctly coded as Resident #24 was deaf and typed on a tablet, used sign language, or a white board to let her needs be known.

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	135127	A. Building B. Wing	07/11/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07246 Based on observation, policy review, record review, and resident and staff interview, the facility failed to ensure a resident was provided toileting assistant and incontinence care. This was true for 1 of 1resident (Resident #44) reviewed for activities of daily living. This failure had the potential to lead to urinary tract infections, skin rashes, skin infections, pressure sores or increased incontinence. Findings include: The facility's policy titled Activities of Daily Living (ADLs), revised 2/12/24, stated, Residents will receive assistance as needed to complete activities of daily living (ADLs).A resident who is unable to carry out activities of daily living receives the necessary services to maintain .grooming and personal .hygiene. Resident #44 was admitted to the facility on [DATE], with multiple diagnoses including Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), scoliosis (curvature of the spine), muscle weakness, and abnormality of gate and mobility, and segmental and somatic disfunction (impaired or altered functions of related components of the body framework) of lower extremity. A quarterly MDS, dated [DATE], documented Resident #44 was independent with toileting hygiene and in need of supervision or touching assistance for shower/bathing and she was cognitively intact. Resident #44's care plan, with a revision date of 5/23/23, documented Resident #44 had an ADL self-care performance deficit related to Parkinson's disease, Scoliosis, Radiculopathy (injury or damage to nerve roots in the area where they leave the spine), Lumbosacral (tailbone) region. The interventions for toileting documented Resident #44 needed the assistance of one person for toileting. During an interview on 7/8/24 at 12:12 PM, Resident #44 stated on one occasion during the evening it took staff one and half hours to respond to her call light and assist her to the bathroom. Resident #44 further stated that she was assisted to the bathroom after her son called the nurse's station and informed the nursing staff his mother needed assistance to the toilet. Resident #44 further stated during the wait time she had a urine incontinent episode. When asked how she knew it took 1.5 hours, Resident #44 pointed to a clock that was hanging on the wall directly in front of her bed. During an interview on 7/10/24 at 12:11PM with CNA #5, stated she had just started her shift on 6/19/24. At approximately 6:10am, when she answered a telephone call from the son of Resident #44 who stated his mother had her call light on and was lying wet in bed and had not been assisted. CNA #5 further stated Resident #44 was flustered when she went to assist her. During a follow up interview with Resident #44 on 7/11/24 at 3:43 PM regarding the 1.5-hour call light response, Resident #44 stated she was angry and felt disgusted and ashamed.

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	135127	A. Building B. Wing	07/11/2024

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure there was an ongoing activity program designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. This was true for 1 of 3 residents (Resident #41) reviewed for activities. This failure created the potential for harm if residents experienced boredom and lacked meaningful activities throughout the day. Findings include: The facility's policy titled, Care of the Cognitively Impaired (Dementia Care), reviewed 8/22/23, stated, The facility will provide dementia treatment and services . Utilizing individualized, non-pharmacological approaches to care (e.g., purposeful and meaningful activities). Meaningful activities are those that address the resident's customary routines, interests, preferences, and choices to enhance the resident's wellbeing. The facility's policy titled, Person Centered Care Plan, reviewed 8/26/23, stated, The facility will develop a person-centered care plan that addresses the goals, preferences, needs and strengths of the resident, including those identified in the comprehensive resident assessment, to assist the resident to attain or maintain his or her highest practicable well-being and prevent avoidable decline. Resident #41 was admitted on [DATE], with multiple diagnoses including Alzheimer's Disease, dementia, and cognitive communication deficit. An admission MDS assessment, dated 5/10/23, documented in section D the questions for mood assessment including little interest or pleasure in doing things, was not assessed for Resident #41. A significant change MDS with ARD of 01/25/24, documented in section D the questions for mood assessment including little interest or pleasure in doing things, was answered no. A quarterly MDS assessment, dated 4/26/24, documented Resident #41 was severely cognitively impaired. An Admission Activities assessment, with a completion date of 10/6/23, 5 months after Resident #41 was admitted , documented Resident #41 preferred the nickname Deedle. Activity interests included pets/animals, arts and crafts with current small group interests were very important, and board games in small groups were very important, to name a few. Resident #41's record did not include documentation of his preferred nickname or participation in activities. Resident #41's care plan did not include documentation or interventions for a nursing focus about her participation in activities. During an interview on 7/10/23 at 12:58 PM, the MDS Coordinator confirmed there was not a care plan for activities for Resident #41 and there should be a care plan focus specific to activities for a resident with dementia. During an interview on 7/10/24 at 12:32 PM, the DON confirmed Resident #41 should have had a care plan focus for activities. (continued on next page)

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	135127	A. Building B. Wing	07/11/2024

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/24 at 12:22 PM, the DON verified the admission assessment was completed five months after admission and should have been completed during the initial admission process.

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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** 39540 Based on observation, record review, review of a facility risk management report, and resident staff interview, it was determined the facility failed to ensure a resident's care plan was followed to prevent accidents. This was true for 1 of 4 residents (Resident #24) reviewed for accidents. This resulted in the potential for more than minimal harm to Resident #24 when she was transfered and sustained increased pain to her left knee due to lack of adequate supervision during a transfer. Findings include: Resident #24 was admitted to the facility on [DATE], with multiple diagnoses including hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following a stroke, pain in left knee, and chronic pain syndrome. A quarterly MDS assessment, dated 10/21/23, documented Resident #24 required two person staff assistance for transfers. A quarterly MDS assessment, dated 6/10/24, documented Resident #24 was cognitively intact. Resident #24's care plan for activities of daily living, documented Resident #24 had an ADL self-care performance deficit related to activity intolerance, fatigue, limited mobility, chronic pain and acute stroke. Interventions included two-person assistance for transfers using a Hoyer mechanical lift at all times (initiated 2/15/23 and Revised 3/14/2024). The history of the interventions for transfer included a two-person moderate assist for transfers to stand-pivot bed or wheelchair. May need Hoyer lift if tired or more weak than usual (revised 3/10/23). Review of the facility risk management incidents included a transfer injury incident with Resident 24 on 10/23/23. The investigation documented Resident #24's daughter reported to this LN that resident had an injury in her Left (L) knee that was most likely caused by a transfer the night before. Resident c/o [complained of] intense pain in L knee and knee was swollen with a hard lump on knee cap. A physician order, dated 8/24/23, directed staff to administer tramadol HCl oral tablet (opioid pain medication) 50 mg. The order stated to administer one tablet by mouth to Resident #24 every eight hours as needed for pain. Resident #24's MAR for October 2023 documented she received tramadol for pain as needed between 10/1/23 to 10/22/23, once for a pain level of 5 out of 10 (0 being no pain and 10 the worst pain). Beginning 10/23/23 to 10/28/23, after the incident, the tramadol was being administered for pain every day, sometimes twice a day, for pain levels of 4, 5, 6, and 7 out of 10. A physician order, dated 10/28/23, directed staff to administer an additional tramadol HCl Oral Tablet 50 mg to be administered to resident #24 for one tablet by mouth three times a day for pain, scheduled, not as needed. Resident #24's MAR for October 2023 and November 2023, documented tramadol was administered to Resident #24 three times a day, scheduled, beginning 10/28/23. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/10/24 at 9:45 AM, Resident #32, who was the roommate with Resident #24 at the time of the incident (and Resident #24's sister) explained the CNA was transferring Resident #24 using a pivot method, by one CNA, and it appeared Resident #24's left foot (affected side from the stroke) was stuck to the floor and with the pivot, hit the metal side of the bed with the left knee. Resident #32 stated the action loosened a screw in Resident #24's knee/leg and after the injury Resident #24 required frequent pain medication. During an interview on 7/10/24 at 9:56 AM, [NAME] #1, who knew sign language, assisted in an interview with Resident #24. Resident #24 explained (using sign language) when the incident happened in October that injured her knee, it hurt pretty bad and had trouble sleeping. There are pins in the knee and the pain level is about seven out of 10. The left knee hurts now and is stiff to move. During an interview on 7/10/24 at 2:10 PM, CNA #4 recounted what occurred with Resident #24 in October 2023. CNA #4 stated she was transferring Resident #24 by herself into her bed using the pivot method from Resident #24's wheelchair to the bed. CNA #4 did not know where her partner was (to assist her) when the transfer occurred. After laying Resident #24 down in bed to perform incontinent care and upon returning to the wheelchair, Resident #24 expressed her knee was hurting. CNA #4 knew she was to transfer Resident #24 using two people and did not during this transfer that resulted in the injury to Resident #24's left knee. The ADON was present during the interview with CNA #4. The ADON confirmed CNA #4 was no longer scheduled to work with Resident #24. During an interview on 7/10/24 at 9:07 AM, the DON verbalized the injury occurred, not a significant injury, it was soft tissue and Resident #24 was referred to orthopedic physician and was sent for x-ray of the left knee. No fracture was identified. There was injury, not significant and if anything was tissue that was painful to the resident. The DON confirmed the resident was a two person assist for transfer and the transfer that resulted in injury to Resident #24's left knee occurred when Resident #24 was assisted by one CNA when there should have been two. The DON confirmed the care plan for Resident #24 documented a two person assist for transfers and that the care plan was not followed.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599 Based on observation, policy review, record review, and resident and staff interview, the facility failed to ensure a resident's food preference was accommodated. This was true for 1 of 2 residents (Resident #21) reviewed for dietary preferences. This deficient practice created the potential for harm if residents experienced dissatisfaction, hunger and/or weight loss from not having meal preferences accommodated. Findings include: The facility's policy titled Food Procurement, Diets, Menus, and Production, dated 12/2021, stated, Residents' preferences are followed to the extent possible in order to promote food acceptance; facility will provide as available, food to accommodates resident allergies, intolerances, and preferences. Resident #21 was admitted to the facility on [DATE], with multiple diagnoses, including aftercare following surgery for a shoulder joint prosthesis. An admission MDS assessment, dated 6/24/24, documented Resident #21 was cognitively intact. During an interview on 7/8/24 at 11:11 AM, Resident #21 said I don't eat meat or carrots, and I'm tired of eating scrambled eggs for dinner because that's all they give me. Resident #21 stated, yesterday they served a pile of roast beef and when I said I don't eat meat, they said, you can have scrambled eggs. A Food and Beverage Preference assessment, dated 6/21/24, the RN documented Resident #21's special food requests as no meat, no OJ (orange juice), no carrots. The facility's menu for lunch on 7/8/24 was sliced ham, baked sweet potato wedges, cut green beans, cornbread muffin, and frosted cake. During the dining room observation on 7/8/24 at 12:02 PM, Resident #21 was served mixed vegetables, including carrots, sweet potatoes, cornbread, and a piece of cake. Resident #21 said she did not receive a substitute for the ham and no one offered her a substitute. Both the green beans and the mixed vegetables were observed on other residents' plates. The facility's menu for dinner on 7/8/24 was herb baked chicken, rosemary red potatoes, parslied cauliflower, dinner roll, and fresh fruit. During the dining room observation on 7/8/24 at 5:37 PM, Resident #21 was served a tuna salad sandwich and fruit cup. Resident #21 was not served the rosemary red potatoes, parslied cauliflower, or dinner roll, nor was she asked if she wanted the other food items. When asked about her meal, Resident #21 stated, I guess this is the best they can do. During an interview on 7/9/24 at 11:30 AM, [NAME] #1 said she did not know why Resident #21 was served carrots at lunch because her diet card notes no carrots. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 7/10/24 at 1:51 PM, the RD said she was not aware of Resident 21's preference for not eating meat. The RD stated, No one told me about Resident #21 not eating meat. Either the DM or nursing asks about food preferences, then it's put on the diet card. The RD was asked if she provided the dietary staff with protein options for residents who did not eat meat. The RD said, no, they have cottage cheese, yogurt, eggs, and sometimes they buy that fake meat. As a former vegetarian, I guess I could have told them of options. A Dietician Assessment, dated 7/1/24, did not identify the protein needs of Resident #21 who did not eat meat. During an interview on 7/10/24 at 3:10 PM, [NAME] #2 stated, I was the cook on 7/8/24 and 7/9/24. I'll have to say I probably overlooked Resident #21's diet card. We have options for non-meat like yogurt, one lady likes cottage cheese, a cheese sandwich is not a lot of protein, I guess eggs. I don't know why no one asked her what she wants. Her caregiver (private) told me she eats meat, no cheese, and no carrots. [NAME] #2 confirmed Resident #21's diet card read no meat, no cheese, no carrots. In an interview on 7/10/24 at 3:15 PM, the DM stated, The cooks previously worked in restaurants. I need to educate them about the various options for non-meat and/or vegetarian meals. I did not know that the private caregiver had spoken to [NAME] #2. The resident can speak for herself. The DM stated, we need to have better communication between everyone. During an interview on 7/11/24 at 8:40 AM, the Administrator said, I agree with the lack of communication regarding Resident #21's food choices and proteins not always being provided.

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 11599 Based on record review, facility job description review, and staff interview, it was determined the facility failed to ensure there was a qualified dietary manager. This failed practice created the potential to negatively affect all residents in the facility who ate food which was prepared in the facility's kitchen. Findings include: The facility's Food Service Director - Certified Dietary Manager Job Description, dated 5/1716, stated the Education, Experience, and Licensure/Certifications as: must have completed a CDM or State-approved course in food services; must have a current certification as a Certified Dietary Manager in applicable state; must maintain an active certification in good standing throughout employment; must have one year experience in post-acute food service; and must have a minimum two years' supervisory experience. During an interview on 7/9/24 at 11:22 AM, DM stated she completed the coursework for certification but had not scheduled a time to take the test. During an interview on 7/9/24 at 2:40 PM, the Administrator stated the DM moved from the position of cook to the manager of the facility's dietary services on 5/10/23. During a a telephone interview on 7/10/24 at 1:51 PM, the RD, who was employed on a weekly basis prior to survey, said she was helping out with assessments until the new dietician started. The RD said she was in the facility once a week to complete assessments and follow-up on recommendations and/or questions regarding resident diets. The RD stated she checked the kitchen once a month. In an interview on 7/11/24 at 8:40 AM, the Administrator confirmed the DM's lack of certification, for over a year (5/10/23). The Administrator stated, Yes, you're right, she is not certified, I'm going to sit down with her today to schedule the test. In an interview on 7/11/24 at 9:44 AM, the DM stated, I know I had a Serve Safe certificate, but I can't find it. When asked if her certificate could be located online, the DM stated, the online says I have to take the test again. Review of the DM's personnel file did not include documentation of a Serve Safe certificate.