STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Transitional Care Center	1001 South Hilton Street Boise, ID 83705

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 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** 3. Resident #27 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including schizoaffective disorder, bipolar type (a mental health condition characterized by bouts of hypomania [stated of heightened or irritable mood and unusually increased energy or activity that is similar to but less intense than mania] or mania and sometimes depression). Resident #27's record documented a PASRR Level II, dated 1/19/23, was completed. An annual MDS assessment, section A1500, dated 7/17/24, documented, No Resident #27 did not have a completed PASRR Level II. On 3/4/25 at 1:20 PM, the MDS Coordinator stated Resident #27's MDS was coded No on his annual MDS section A1500 because his PASRR Level II documented, no further evaluation was required. 4. Resident #8 was initially admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including bipolar disorder (a chronic mental condition characterized by extreme shifts in mood, energy, and behavior), depression, and problems with communication due to difficulties of thinking clearly. The annual MDS assessment, section A1500, dated 9/20/24, documented Resident #8 did not have a PASRR Level II. A PASRR Level II, dated 9/19/24, was completed for Resident #8, and provided to the facility. On 3/5/25 at 2:00 PM, the MDS Coordinator stated, she did not code the MDS assessment a PASRR Level II had been completed for Resident #8. At 3:27 PM, the Social Worker confirmed a PASRR Level II had been completed for Resident #8, and the MDS Coordinator should have coded the MDS assessment appropriately. Based on review of the Resident Assessment Instrument (RAI) Manual, record review, and staff interview, it was determined the facility failed to ensure residents' Minimum Data Set (MDS) Assessments included correct assessment information. This was true for 4 of 16 residents (#1, #8, #25, and #27) 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: (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Transitional Care Center	1001 South Hilton Street Boise, ID 83705

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The RAI, revised 10/1/2024, documents section A1500, PASRR (Preadmission Screening and Resident Review), was to be coded yes when a PASRR Level II screening determines a resident has a serious mental illness and/or mental retardation, or related condition. 1. Resident #1 was admitted to the facility on [DATE], with a diagnosis of bipolar disorder (a major mental mood disorder), depression, anxiety opioid dependence, and tobacco use. Resident #1's PASRR Level II dated 6/6/23, and PASRR Level II dated 8/23/24, documented she had a diagnosis of bipolar disorder, depression, anxiety, opioid dependence and tobacco dependence. Resident #1's annual MDS assessment, dated 3/11/24, and significant change MDS dated [DATE], documented under A1500 in section A, No for the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? However, there were two PASRR Level II's found in her electronic medical record dated 6/6/23, and 8/23/24. On 3/5/25 at 3:30 PM the MDS Coordinator stated Resident #1's MDS assessments were coded that the resident did not receive a PASRR Level II screening because she believed the form HW0090 Abbreviated Level II PASRR screening form was not considered a true level 2 screening. 2. Resident #25 was admitted to the facility on [DATE], with a diagnosis of major depressive disorder, severe with psychotic symptoms, paranoid schizophrenia (mental disorder involving chronic or recurrent psychosis), and anxiety. Resident #25's admission MDS assessment, dated 2/4/25, documented under A1500 in section A, No for the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? However, there was a PASRR Level II found in her electronic medical record dated 1/29/25, which documented she had a diagnosis of schizophrenia (a diagnosis categorized as a major mental illness). On 3/5/25 at 3:35 PM the MDS Coordinator stated Resident #25's MDS assessments were coded that the resident did not receive a PASRR Level II screening because she believed the form HW0090 Abbreviated Level II PASRR screening form was not considered a true PASRR Level II screening.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Transitional Care Center	1001 South Hilton Street Boise, ID 83705

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interview, it was determined the facility failed to ensure professional standards of practice were followed for 1 of 2 residents (Resident #12) reviewed for bowel and bladder incontinence. This failed practice created the potential for Resident #12 to experience bowel obstruction when her medications were not administered according to the physician's order. Findings include: Resident #12 was admitted to the facility on [DATE], with multiple diagnoses including congestive heart failure and chronic respiratory failure with hypoxia (low levels of oxygen in the body tissues). A physician's order, documented Resident #12 was to receive the following medications: - Colace capsule 100 mg (milligrams), one capsule by mouth every 12 hours as needed for constipation, ordered 2/24/25. -Milk of Magnesia (MOM) Suspension 400 mg/5 ml (milliliter), give 30 ml by mouth every 24 hours as needed for bowel care if no bowel movement for 3 days, ordered 7/1/24. - Dulcolax suppository 10 mg, insert one suppository rectally every 24 hours as needed for bowel care if no results from MOM, ordered 7/1/24. - Fleet Enema 7-19 gm/118 ml, insert one application rectally every 24 hours as needed for bowel care if no results from Dulcolax, ordered 7/1/24. Resident #12's Bowel Movement Records, dated 2/5/25 through 3/6/25, documented she did not have a bowel movement from: - 2/15/25 through 2/19/25 (5 days). - 2/25/25 through 2/27/25 (3 days). There was no documentation in Resident #12's record that she was administered MOM suspension when she did not have a bowel movement for 3 days. On 3/3/25 at 1:06 PM, Resident #12 stated she was experiencing constipation. On 3/5/25 at 12:06 PM, the DON reviewed Resident #12's record and stated Resident #12 should have been given MOM suspension when she did not have a bowel movement for 3 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Transitional Care Center	1001 South Hilton Street Boise, ID 83705

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, policy and record review, it was determined the facility failed to ensure that prior to placement of bed rails, residents were thoroughly assessed for the risk of entrapment. This was true for 1 of 1 resident (Resident #115) reviewed for bed rails. This deficient practice created the potential for harm from entrapment or injury related to use of bed rails. The facility's Bed Rails policy and procedure, revised 12/2023 documented the following: - The facility would attempt to use appropriate alternatives prior to installing a side or bed rail. - If it was determined that these alternatives failed to meet the resident's assessed needs, the interdisciplinary team would assess the resident for risk of entrapment. - The risks and benefits regarding the use of bed rails would be considered for each resident. - The facility would obtain an informed consent form from the resident, or if applicable, the resident representative for the use of bed rails prior to installation or use. On 3/3/25 at 3:36 PM and 3/6/25 at 9:00 AM, Resident #115 was observed in his bed in his room with two mobility bars in an upright position. Resident #115's record did not include documentation that he was assessed for the use of the mobility bars. On 3/6/25 at 10:15 AM, the DON stated Resident #115 was not assessed for the use of his mobility bars. The DON stated Resident #115 should have been assessed prior to installation of his mobility bars.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Transitional Care Center	1001 South Hilton Street Boise, ID 83705

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility's policy and procedure, review of Incidents and Accidents (I&As) 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 (#116 and #117) reviewed for medication errors. The facility's Six Rights of Medication Administration, revised May 2024, documented the following in order to ensure safety and accuracy of medication administration. - Right resident - Right time - Right medication - Right dose - Right route - Right documentation The facility's Medication Errors and Adverse Reactions policy and procedure, revised January 2025 documented resident's condition must be monitored for 72 hours or as may be directed and detailed account of the incident must be recorded on an incident report. Clinically relevant information about follow-up of the resident should be recorded in the chart including: - The kind of medication error or adverse reaction. - The date and time the physician was contacted. - The physician orders. The policy also stated resident's condition and response to treatment must be recorded during the monitoring period. 1. Resident #116 was admitted to the facility on [DATE], with multiple diagnoses including diabetes. Resident #116's physician's orders included the following: - Insulin Lispro (rapid acting insulin) solution 100 unit/ml (milliliter), inject 18 units subcutaneously with meals for diabetes, ordered 4/4/24. - Insulin Glargine (long acting insulin) solution 100 unit/ml, inject 33 units subcutaneously two times a day for diabetes, ordered 4/14/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Transitional Care Center	1001 South Hilton Street Boise, ID 83705

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Glucose gel 40%, 15 mg orally as needed for blood sugar below 70. Recheck blood sugar in 15 minutes and notify the physician. If blood sugar remains below 70 may repeat for a total of three doses. If blood glucose is below 70 after glucose gel, provide snack/meal and recheck in one hour, ordered 4/1/24. An I&A report, dated 5/10/24 at 7:05 AM, documented Resident #116 was administered 33 units of Novolog (a rapid acting insulin) instead of Lantus. Immediate action taken documented Resident #116 was given glucose gel and OJ (orange juice) x2 along with peanut butter and cottage cheese, and her blood glucose was taken every 15 - 30 minutes for four hours. The I&A report documented Resident #116's blood glucose became stable. The report documented Resident #116's initial blood glucose was 171 and ending blood glucose was 152. Resident's representative and physician were notified of the medication error. The I&A report did not include documentation of how and why the medication error occurred, and what Resident #116's signs and symptoms were before she was given glucose gel and OJ x2 along with peanut butter and cottage cheese. Resident #116's record did not include documentation her blood glucose was monitored every 15 - 30 minutes, as stated on the I&A. On 3/6/25 at 12:19 PM, the DON together with UM #1, stated LPN #1 was training MAC #1(Medication Assistant Certified) on how to prepare the insulin injection. When asked why Resident #116 was given glucose gel and OJ x2 along with peanut butter and cottage cheese, the DON stated, I would say it was a nursing judgment not wanting her blood glucose to drop. When asked about what it meant, Resident #116's blood glucose became stable as stated in the I&A, the DON stated Resident #116 was placed on alert charting for 72-hours and she did not show signs and symptoms of hypoglycemia. When asked about documentation of blood glucose monitoring every 15-30 minutes, the DON stated it was monitored but it was not documented, and it should have been documented. The DON stated LPN #1 was provided education regarding medication administration. Documentation of education provided to LPN #1 was requested from the DON. A nurse practitioner progress note, dated 6/3/24 at 4:45 PM, documented Resident #116 had . with one episode of low blood sugar several weeks ago that she is fearful of repeating. The nurse practitioner's assessment and plan documented, Hypoglycemia, unspecified: Patient had an episode of hypoglycemia due to missed meal after administering short-acting insuli[n] several weeks ago, plan to adjust only long acting insulin at this time. Documentation of LPN #1's education regarding medication administration after this incident was not received prior to the exit conference on 3/7/25. 2. Resident #117 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including diabetes and schizophrenia (a diagnosis categorized as a major mental illness). An I&A report, dated 10/26/24 at 6:50 PM, documented Resident #117 received a medication error. The provider was notified and ordered to put Resident #117 on alert charting and to hold her scheduled Seroquel (antipsychotic medication) for possible side effects with incorrect medications. Resident #117 denied any signs and symptoms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Transitional Care Center	1001 South Hilton Street Boise, ID 83705

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The I&A report did not include documentation how and why the medication error occurred, and what medication was administered to Resident #117 which resulted in a medication error. On 3/6/25 at 11:56 AM, the DON together with UM #1, stated LPN #1 self-reported the medication error. When asked what medication was administered to Resident #117, the DON stated it was oxycodone (narcotic pain medication) 5 mg. The DON stated LPN #1 was preparing Resident #117's medication when another resident requested her pain medication. The DON stated LPN #1 discovered the medication error during reconciliation of narcotic medication. The DON provided documentation LPN #1 was educated of the six rights of medication administration, and random medication audits were conducted by the nurse manager.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Transitional Care Center	1001 South Hilton Street Boise, ID 83705

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 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. Based on observation and staff interview, it was determined the facility failed to ensure the cleaning and sanitation of kitchen cookware. This deficiency had the potential to affect the 64 residents who consumed food prepared by the facility. This placed residents at risk for potential foodborne illnesses and adverse health outcomes due to contaminated food services equipment. Findings include: The Food Drug Administration (FDA) Code Section 4-602.12 Cooking and Baking Equipment documented: Food-contact surfaces of cooking equipment must be cleaned to prevent encrustations that may impede heat transfer necessary to adequately cook food. Encrusted equipment may also serve as an insect attractant when not in use. On 3/6/25 at 3:34 PM, baking sheets and frying pans were observed with the Certified Dietary Manager (CDM) and Registered Dietitian to have a crusted black residue. They stated the cookware was cleaned and sanitized using appropriate food service methods; however, it was not cleaned thoroughly as the CDM was able to scratch off the crusted black residue with her fingernail.