STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135007	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bingham Memorial Skilled Nursing & Rehabilitation	98 Poplar Street Blackfoot, ID 83221

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, staff interview, and policy review, it was determined the facility failed to ensure resident's privacy was protected for 1 of 1 medication carts reviewed for privacy and confidentiality. This deficient practice placed residents at risk of embarrassment and loss of control over their personal information. Findings include:In the facility's admission packet the Health Information Privacy Act Amendment and Actives form, undated, documented all health care professionals, employees, staff, personnel, and volunteers who are authorized to enter information into medical charts and who share information with each other for treatment, payment, and office operations must abide by HIPAA Rules. 1. On 11/17/25 at 8:00 AM, observed hall-300 medication cart outside the dining room with the computer open to resident information. No staff were present.On 11/17/25 at 8:03 AM, LPN #1 stated she should have locked her computer when she went into the dining room.2. On 11/17/25 at 8:25 AM, observed on hall 300, the 300-hall medication cart with the computer on top of it with the screen open to resident #28's information and the cart was unlocked.On 11/17/25 at 8:33 AM, LPN #1 stated she should have shut down her computer and locked her cart before going to give the resident his medications.

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Appendix PP of the State Operations Manual, record review, and staff interview, it was determined the facility failed to refer residents for further evaluation when residents were diagnosed with a major mental illness, intellectual disability, or a related condition. This was true for 1 of 3 residents (Resident #4) reviewed for PASARR level II evaluations. This deficient practice had the potential to cause harm if an appropriate state-designated authority did not evaluate a resident's mental health needs. Findings include: Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including schizophrenia, bipolar, anxiety, and PTSD, each classified as a serious mental illness.On 10/10/25, Resident #4's PASRR level I screening documented she did not have a serious mental illness.On 10/11/25, Resident #4's history and physical documented she had a diagnosis of schizophrenia, bipolar, anxiety, and PTSD.On 10/16/25, Resident #4's MDS assessment documented she had a diagnosis of schizophrenia, bipolar, anxiety, and PTSD. On 10/24/25, Resident #4's psychiatric physician note documented she had a diagnosis of schizophrenia, bipolar, anxiety, and PTSD. On 11/18/25, the administrator and social worker stated they had not updated the PASRR level I with the newly identified mental health diagnoses or contact the state mental health authority for further evaluation of Resident #4, and they should have.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and staff interview it was determined the facility failed to include necessary healthcare information for 2 of 4 residents (#1 and #2) on resident's baseline care plans. This failure created the potential for resident specific needs to go unrecognized due to lack of information for caregivers. Findings include:The facility's Baseline Care Plan policy dated 10/2/25, documented [NAME] Memorial Skilled Nursing and Rehab will develop and implement a baseline care plan for each resident that includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.1. Resident #1 was admitted on [DATE] and readmitted on [DATE], with multiple diagnoses including stage 3 pressure ulcer to the coccyx, MRSA (a type of bacteria that is resistant to several antibiotics), and neurogenic bladder (a condition caused by damage to the nerves controlling the bladder).Resident #1's hospital Discharge summary dated [DATE], documented suprabupic remains in place due to incontinence of urine and importance in maintaining wound cleanliness.Resident #1's baseline care plan dated 10/28/25, did not document she had a suprabupic catheter.On 11/19/2025 at 10:20 AM, the DON stated Resident #1's suprabupic catheter should have been documented on her baseline care plan, but was not.2. Resident #2 was admitted on [DATE], with multiple diagnoses including aftercare following joint replacement surgery, chronic kidney disease, and overactive bladder.Resident #2's hospital discharge instructions dated 10/21/25, documented she had a suprapubic catheter.Resident #2's Licensed Nurse assessment dated [DATE], documented she had a suprapubic catheter.Resident #2's baseline care plan dated 10/22/25, did not document she had a catheter.Resident #2's admission MDS dated [DATE], documented she has an suprapubic catheter.Resident #2's care plan meeting summary dated 11/5/25, documented she has suprapubic catheter.On 11/19/25 at 10:21 AM, the DON stated Resident #2's suprapubic catheter should have been documented on her baseline care plan, but was not.

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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** Based on record review and staff interview it was determined the facility failed to ensure care plans were comprehensive and individualized for 1 of 2 residents (Resident #1) whose comprehensive care plans were reviewed. This placed residents at risk for adverse outcomes if care and services were not provided due to care plans being incomplete and not person-centered. Findings include:Resident #1 was admitted on [DATE] and readmitted on [DATE], with multiple diagnoses including stage 3 pressure ulcer to the coccyx, MRSA (a type of bacteria that is resistant to several antibiotics), and neurogenic bladder (a condition caused by damage to the nerves controlling the bladder).Resident #1's admission MDS dated [DATE], documented she had a suprapubic catheter.Resident #1's comprehensive care plan interventions documented CATHETER: I have (SPECIFY Size) (SPECIFY Type of Catheter). Position catheter bag and tubing below the level of the bladder and away from entrance room door. Resident #1's comprehensive care plan was not person-centered and did not specify the size or type of catheter.On 11/19/25 at 10:20 AM, the DON stated Resident #1's comprehensive care plan interventions should have been personalized to include type and size of catheter, but was not.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, record review, and staff interview, it was determined the facility failed to ensure professional standards of nursing practice were followed for 3 of 4 residents (#5, #11, and #28) reviewed for quality of care. Residents were at risk for adverse outcomes when they did not have Physician orders for medications that residents received or Physician orders did not document all the required elements to prevent adverse drug reactions. These failed practices had the potential to adversely affect residents whose care and services were not followed according to accepted standards of practice. Findings include: 1. Resident #5 was admitted to the facility on the 11/13/25, with multiple diagnoses including aftercare following surgery on the digestive system and dislocation of the left hip. On 11/17/25 at 8:12 AM, observed LPN #1 administer Optase eye drops, 2 drops in both eyes, to Resident #5. On 11/17/25 at 10:47 AM, record review of Resident #5's medical record did not document an order for Optase eye drops. On 11/17/25 at 12:58 PM, LPN #1 stated there were no orders for the Optase eye drops in Resident #5's medical record and there should have been. 2. Resident #11 was admitted to the facility on [DATE], with multiple diagnoses including sepsis (a life threatening medical emergency where the body's extreme response to an infection damages its own tissues and organs) and vascular dementia.Resident #11's Physician order dated 10/31/25, documented Invanz (antibiotic) Injection Solution. Reconstituted 1 gram. Use 1 gram intravenously at bedtime for appendicitis with abscess. Her Physician's order did not document the flow rate of the Invanz. 11/17/25 at 2:50 PM, the DON stated the flow rate of an IV medication should have been on Resident #11's Physicians orders. 3. Resident #28 was admitted to the facility on [DATE], with multiple diagnoses including aftercare following surgical amputation and acute osteomyelitis (bone infection) of the left foot and ankle. Resident #28's Physicians order dated 11/14/25, documented Daptomycin-Sodium Chloride Intravenous Solution (an antibiotic) 1000-0.9 MG/100ML. Use 1000 mg intravenously in the afternoon for osteomyelitis.Resident #28's Physician's order dated 11/14/25, documented Meropenem Intravenous Solution (an antibiotic). Use 1 gram intravenously every 8 hours for Osteomyelitis.On 11/17/25 at 8:15 AM, observed LPN #1 entered Resident #28's room and flushed his IV with 10mls of sodium chloride. LPN #1 hung a bag of Meropenem Intravenous Solution (an IV medication). When LPN #1 turned the IV pump on, the pump was set to administer the medication at 150 MLs per hour. LPN #1 reprogramed the IV pump to administer the Meropenem Intravenous Solution at 100 MLs per hour and began the administration of the medication to Resident #28. On 11/17/25 at 10:01 AM, a record review of Resident #28's medical record did not document an order for Sodium Chloride flush and his Meropenem order did not document a flow rate.On 11/19/25 at 10:42 AM, the DON stated there should have been IV flush orders in Resident #28's medical record and his Meropenem order should have had the flow rate documented.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review, policy review, and staff interview, it was determined the facility failed to ensure controlled medications were tracked and kept secure from potential theft and/or diversion. This was true for 1 of 1 medication carts reviewed. This failure created the potential for undetected misuse and/or diversion of controlled medications and had the potential to affect all residents who received controlled medication in the facility. Findings include: The facility's Medication Administration policy revision date 9/25/25, documented if medication is a controlled substance and packed in a medication card or bottle, sign the narcotic book. Count every incoming and outgoing shift to evaluate any discrepancy.On 11/19/25 at 10:17 AM, the following was observed during the hall 300-medication cart audit:- the narcotic accountability record, dated 11/1/25 to 11/19/25, had 16 licensed nurse signatures not document. - the narcotic count sheet for Resident #1's Butrans transdermal 7.5mg patch documented 10 patches available. Observed 2 patches in the narcotic box. After reviewing medication with the DON, it was noted that only 4 patches were delivered, and 2 patches had not been signed out on the narcotic count sheet.On 11/19/25 at 10:21 AM, the MDS coordinator stated the nurses should have signed the medication cart narcotic accept/release sheet when they accepted the medication cart or released the medication cart. He also stated he was not sure why Resident #1's narcotic count sheet for Butrans Transdermal patch documented 10 patches available when there were only 4 patches delivered, and he said there were only 2 patches in the narcotic box, and he was not sure where the other 2 patches were but he would check into it. On 11/19/25 at 10:46 AM, the DON stated Resident #1's missing Butrans Transdermal patch was signed out on the MAR but had not been signed out on her narcotic count sheet and should have been.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and staff interview, it was determined the facility failed to ensure medications available for residents were stored appropriately, this was true for 1 of 2 nurses observed for medication pass and 1 of 1 medication carts audited for labeling and storage of medication. This failure created the potential for residents to have missed doses of medication and created the potential for harm to a resident if they were to obtain medications which were left unattended and unsecured by staff. Findings include:1.On 11/17/25 at 8 AM, the 300-hall medication cart was observed outside the dining room, by the front door of the facility, unlocked. On top of the medication cart was the medication cart keys. No staff were present.On 11/17/25 at 8:03 AM LPN #1 stated the medication cart should have been locked and she should not have left the key to the medication cart on the cart.2. On 11/17/25 at 8:17 AM, observed the 300-hall medication cart outside room # 316, unlocked.On 11/17/25 at 8:20 AM, LPN #1 stated she should have locked the medication cart when she went into the resident's room.3. On 11/17/25 at 9:46 AM, observed on Resident #11's bedside table a bottle of Allergy relief nasal spray. Resident #11 was unable to demonstrate the proper use of the medication.On 11/17/25 at 3:05 PM, the DON stated Resident #11 was not able to administer her own medications and the nasal spray should not have been in her room.4. On 11/17/25 at 9:55 AM, observed in room Resident #28's room a 12 ml Heparin 5500 units syringe on the nightstand by the door.On 11/17/25 at 10:00 AM, RN #1 stated medications were not to be left in the resident's room and heparin was medication and should not have been in Resident #28's room.5. On 11/17/25 at 10:04 AM, observed on the floor, in the 300-hall a peach-colored pill (Flexeril).On 11/17/25 at 10:10 AM, LPN #1 stated the pill should not have been on the floor.6. On 11/19/25 at 8:05 AM, the 300-Hall medication cart was audited with the MDS coordinator present. Observed on the bottom of the second drawer 1 oval shaped white tablet (Lasix 20 mg).On 11/19/25 at 8:09 AM, the MDS Coordinator stated he did not know what the white tablet was but it should not have been loose in the medication cart.On 11/19/25 at 10:42 AM, the DON stated the medication cart should have been locked when the nurse was not present and medication are not to be left in the resident's room.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, document reviews, and staff interview, it was determined the facility failed to ensure infection control prevention practices were maintained to provide a safe and sanitary environment. These failures had the potential to impact all residents in the facility by placing them at risk for cross contamination and infection. Findings include:The Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens regulations 1910.1030, updated 10/19/21, states, Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure and Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets or on countertops or benchtops where blood or other potentially infectious materials are present.The CDC Long-term Care Facilities Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions (EBP) in Nursing Homes, dated 6/28/24, documented indwelling medical devices and wounds are risk factors for colonization with a MDRO. Once colonized, these residents can serve as sources of transmission within the facility. The expansion of EBP for all residents with wounds or indwelling medical devices is intended to protect these high-risk individuals both from acquisition and from serving as a source of transmission if they have already become colonized.Enhanced Barrier Precautions are recommended for residents with indwelling medical devices or wounds, who do not otherwise meet the criteria for Contact Precautions, even if they have no history of MDRO colonization or infection and regardless of whether others in the facility are known to have MDRO colonization. This is because devices and wounds are risk factors that place these residents at higher risk for carrying or acquiring a MDRO and many residents colonized with a MDRO are asymptomatic or not presently known to be colonized.The facility's Hand Hygiene policy, revision date 8/20/25, documented the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.The follow was observed for infection control:1. On 11/17/25 at 8AM, observed the 300-hall medication cart outside the dining room by the front door of the facility with a can of Coke and a Styrofoam cup with a liquid substance in it on top of the cart.On 11/17/25 at 8:03 AM, LPN #1 stated the personal drinks should not have been on top of the medication cart.2. Resident #11 was admitted to the facility on [DATE], with multiple diagnoses including sepsis and vascular dementia.Resident #11's Physician order dated 10/31/25, documented Invanz (antibiotic) Injection Solution. Reconstituted 1 gram. Use 1 gram intravenously at bedtime for appendicitis with abscess.Resident # 11's Physician's order dated 11/6/25, documented EBP every shift for IV-line use. Every day and night shift to reduce transmission of multi resistant organism.On 11/17/25 at 9:46 AM, observed Resident #11 sitting in her room. She had a PICC line in her left arm. There was no EBP signage present to notify staff of isolation precautions. There were no PPE supplies available near Resident #11's room for staff to donn prior to entering her room as required per EBP protocol.3. Resident #28 was admitted to the facility on [DATE], with multiple diagnoses including aftercare following surgical amputation and acute osteomyelitis (bone infection) of the left foot and ankle.Residents #28's Physicians order dated 11/13/25, documented EBP every shift for: PICC Line. Every day and night shift for reduce transmission of Multi resistant organism. Patient has single lumen PICC to left upper arm.Resident #28's Physicians order dated 11/14/25, documented Daptomycin-Sodium Chloride Intravenous Solution (an antibiotic) 1000-0.9 MG/100ML. Use 1000 mg intravenously in the afternoon for osteomyelitis.Resident #28's Physician's order dated 11/14/25, documented Meropenem Intravenous Solution (an antibiotic). Use 1 gram intravenously every 8 hours for Osteomyelitis.Resident #28's Physician's order dated 11/17/25, documented left knee wound: cleanse gently with Normal saline, ensure skin remains intact. Pat dry. Apply AMD Telfa non-adherent dressing then secure with foam dressing. May apply ABD dressing on top of left knee when wrapping left lower extremity with kerlix and ACE wrap for extra protection from Knee immobilizer. Change dressing 2x/wk. every night, shift every Mon, Thu.On 11/17/25 at 8:15 AM, LPN #1 entered Resident #28's room and administer IV medication. LPN did not donn a gown prior to administering IV medication. There was no EBP signage present to notify staff of isolation precautions. There were no PPE supplies available near Resident #28's room for staff to donn prior to entering her room as required per EBP protocol.On 11/17/25 at 9:32 AM, LPN #1 stated residents with wounds and IV should have been placed on EBP isolation and should have had PPE outside their rooms.4. Resident #30 was admitted to the facility on [DATE], with multiple diagnoses including COPD (a group of lung diseases that block airflow and make it difficult to

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review and interviews, it was determined the facility failed to ensure all call light buttons or pads were easily accessible to residents. This was true for 2 of 19 residents (#14 and #15) whose rooms were observed for call light device locations. This failure had the potential for harm if residents were not able to summon staff for assistance. Findings include:The facility's Call Lights: Accessibility and Timely Response policy revision date 3/1/2025, documented staff will ensure the call light is within reach of each resident and secured, as needed.1. Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including malnutrition and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath).Resident #14's annual MDS dated [DATE], documented was cognitively intact. Resident #14's care plan documented he was able to consistently use his call light.On 11/17/25 at 8:53 AM, Resident #14's call light device was observed draped over the head of the bed, between the bed and the wall, not accessible to him.2. Resident #15 was admitted to the facility on [DATE], with multiple diagnoses including spinal stenosis (the narrowing of the spinal canal) and weakness.Resident #15's quarterly MDS dated [DATE], documented was cognitively intact.Resident #15's care plan documented he was able to consistently use his call light.On 11/17/25 at 8:59 AM, Resident #15's call light device was observed draped over the head of the bed, between the bed and the wall, not accessible to him.On 11/17/25 at 9:09 AM, RN #1 stated the residents should have had their call lights within reach.