

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER Countryside Care & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 Eighth Street Rupert, ID 83350	

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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, State Operations Manual Appendix PP-Guidance to Surveyors for Long Term Care Facilities, and staff interview, it was determined the facility failed to ensure residents and their representatives received assistance to exercise their right to formulate an Advance Directive. This was true for 1 of 12 Residents (Resident #3) whose records were reviewed for Advance Directive. This deficient practice created the potential for harm or adverse outcomes if residents' wishes were not followed or documented regarding their advance care planning. Findings include:According to Appendix PP: DEFINITIONS S483.10(c)(6), (c)(8), (g)(12) Physician Orders for Life -Sustaining Treatment (POLST).a POLST form is not an advance directive. S483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives), (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative If the resident does not have an advance directive, facility staff must inform the resident or resident representative of their right to establish one as set forth in the laws of the State and provide assistance if the resident wishes to execute one or more directive(s). Facility staff must document in the resident's medical record these discussions and any advance directive(s) that the resident executes. Resident #3 was admitted to the facility on [DATE], with diagnoses including anoxic brain damage (brain injury caused by lack of oxygen) and quadriplegia (inability to voluntarily move upper and lower body).On 9/9/25 at 10:02 AM, Resident #3's medical record contained a POST and a Letter of Guardianship document. Resident #3's medical record contained no documentation of Advance Directive and no documentation that the facility had offered to assist the resident guardian with formulating an Advance Directive.On 9/10/25 at 8:35 AM, the DON stated Resident #3 had not created an Advance Directive prior to admission, and Resident #3's guardian had not completed an Advance Directive document either. On 9/10/25 at 11:27 AM, the Administrator stated Resident #3's record did not have documentation the Advance Directive information had been offered to Resident #3's guardian.</p>

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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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to provide the Advance Beneficiary Notice (CMS-10055 form) for 1 of 3 residents (Resident #1) whose medical records were reviewed for beneficiary protection notification. This deficient practice had the potential to cause financial harm or distress for residents when they were not informed of their potential liability for payment when their Medicare Part A benefits ended. Findings include:Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including stroke and hypertension.The facility had not provided an Advance Beneficiary Notice document to Resident #1 when he was discharged from Medicare Part A Skilled Nursing on 6/9/25 and admitted to the facility long term care unit on 6/10/25.On 9/9/25 at 2:30 PM, the Administrator stated Resident #1 should have received an Advance Beneficiary Notice document upon discharge and readmitted to the long-term care unit and had not been.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility standing orders, record review and staff interview, it was determined the facility failed to follow facility bowel care standing order of delivering specific medications when residents do not have BM within 24, 48, and 72 hours for 4 of 7 Residents (#1, #18, #24, and #26) who records were reviewed for bowel and bladder care. This failed practice created the potential for residents to experience discomfort when medications were not administered according to the physician's order. Findings include: The Countryside Care & Rehab Standing Orders for bowel protocol dated 1/14/25, documented: - (step 1) No BM X 24 hours: Prune Juice in AM. - (step 2) 48 hours no BM: Prune Juice in AM, no result, give Prune Juice in PM, - (step 3) No BM by day 3: Give Prune Juice in 30ml MOM. - (step 4) Day 4 no BM: Give Bisacodyl, supp or Fleets enema. - (step 5) Day 5 no BM: Complete assessment and notify PCP.a. Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including stroke and hypertension. Resident #1's medical record for bowel care documented no bowel movement from 8/15/25 to 8/19/25 with step 1, step 2, step 4, and step 5 being missed.b. Resident #18 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including polyosteoarthritis (a condition where multiple joints in the body develop osteoarthritis, a form of degenerative joint disease) and respiratory failure with hypoxia (a condition in which the lungs are unable to adequately exchange oxygen and carbon dioxide, leading to low levels of oxygen (hypoxia) in the blood). Resident #18's medical record for bowel care documented no bowel movement from 8/12/25 to 8/16/25 with step 1 being missed. Resident #18's medical record for bowel care documented no bowel movement from 8/27/25 to 9/6/25 with step 2 and step 5 being missed.c. Resident #24 was admitted to the facility on [DATE], with multiple diagnoses including epileptic seizures (brief episodes of abnormal brain activity that can cause involuntary movements, altered consciousness, and other symptoms) and hypertension. Resident #24's medical record for bowel care documented no bowel movement from 8/14/25 to 8/18/25 with step 4 being missed.d. Resident #26 was initially admitted to the facility on [DATE], and was readmitted on [DATE] with multiple diagnoses including chronic kidney disease and chronic obstructive pulmonary disease (a group of lung diseases that cause airflow obstruction and breathing problems). Resident #26's medical record for bowel care documented no bowel movement from 9/1/25 to 9/6/25 with step 1, step 2, and step 3 being missed or given a day late. On 9/9/25 at 3:15 PM, the DON stated the nursing staff had missed some of the bowel protocol steps with these four residents and should not have.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, record review, and interviews, it was determined the facility failed to provide respiratory services as ordered by the physician. This was true for 4 of 5 residents (#4, #13, #19, and #26) whose records were reviewed for respiratory services. This failure created the potential for residents to experience respiratory related infections, increased fatigue, and low oxygen levels. Findings include: The facility's Oxygen Administration policy undated documented change oxygen tubing and mask/cannula monthly and as needed if it becomes soiled or contaminated. a. Resident #4 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including dementia and anxiety disorder. The facility oxygen audit for the month of August dated 8/25/25, documented Resident #4's oxygen tubing was last changed 7/2/25 and it should also have been replaced on 8/3/25 but was not. b. Resident #13 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including hypertensive heart and chronic kidney disease. Resident #13's physician oxygen order dated 5/19/25, documented to change oxygen tubing first Sunday of each month. On 9/8/25 at 9:45 AM, observed Resident #13's oxygen tubing was last changed on 8/3/25 and should have been changed on 9/7/25 but was not. Resident #13's TAR documented the oxygen tubing was changed on 9/8/25 at 12:29 PM, after the surveyor brought this issue to the attention of the DON. c. Resident #19 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including paroxysmal atrial fibrillation (a type of heart rhythm disorder where the upper chambers of the heart (atria) beat irregularly for a short period of time) and chronic kidney disease. Resident #19's physician order related to oxygen tubing change dated 4/2/25, documented night shift to change oxygen tubing on the 1st of each month. On 9/8/25 at 11:22 AM, observed Resident #19's oxygen tubing was last changed on 8/3/25 and should have been replaced on 9/1/25 but was not. d. Resident #26 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including chronic kidney disease and chronic obstructive pulmonary disease (a group of lung diseases that cause airflow obstruction and breathing problems). Resident #26's physician order related to oxygen tubing change dated 5/19/25, documented night shift to change oxygen tubing on the 1st of each month. On 9/8/25 at 9:50 AM, observed Resident #26's oxygen tubing had yellowed and was last changed on 8/3/25 and should have been replaced on 9/1/25 but was not. On 9/8/25 at 11:30 AM, the DON stated resident oxygen tubing should be changed on the first Sunday of each month and had not been.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, observation, and staff interview, it was determined the facility failed to ensure that prior to the placement of bed rails, alternatives to bed rails were attempted and how the alternatives failed to meet the resident's assessed needs. This was true for 4 of 6 residents (#6, #7, #8, and #32) reviewed for bed rails. This failure created the potential for harm due to the risk for injury, entrapment and/or death. Findings include: The facility's policy, Proper Use of Bed Rails, revised 2024, stated it was the policy of the facility that the resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs.if no appropriate alternatives are identified, the medical record should include evidence of the following; purpose for which the bed rail was intended and evidence that alternatives were tried and were not successful.a. Resident #6 was admitted to the facility on [DATE], with multiple diagnoses including hemiparesis (weakness or inability to move on one side of the body) and diabetes.On 9/8/25 at 10:02 AM, Resident #6's bed was observed with bilateral upper side rails. Resident #6's medical record did not have documentation of the evaluation of the alternatives attempted or documentation of the purpose of the intended use of the side rails.b. Resident #7 was admitted to the facility on [DATE], with multiple diagnoses including encephalopathy (condition that causes brain dysfunction) and respiratory failure.On 9/8/25 at 11:02 AM, Resident #7's bed was observed with bilateral upper side rails. Resident #7's medical record did not have documentation of the evaluation of the alternatives attempted or documentation of the purpose of the intended use of the side rails.c. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including heart failure and diabetes.On 9/8/25 at 10:32 AM, Resident #8's bed was observed with bilateral upper side rails. Resident #8's medical record did not have documentation of the evaluation of the alternatives attempted or documentation of the purpose of the intended use of the side rails. d. Resident #32 was admitted to the facility on [DATE], with multiple diagnoses including osteomyelitis (infection in a bone) and atherosclerosis (thickening of the arteries).On 9/8/25 at 2:37 PM, Resident #32's bed was observed with bilateral upper side rails. Resident #32's medical record did not have documentation of the evaluation of the alternatives attempted or documentation of the purpose of the intended use of the side rails. On 9/9/25 at 2:52 PM, the DON stated documentation of the evaluation of alternatives attempted or the intended purpose of the use of side rails should be documented in the resident's medical record and had not been. On 9/9/25 at 2:53 PM, the Administrator stated bed rails are used primarily for mobility but there should be documentation of the evaluation of alternatives attempted or the intended purpose of the use of side rails in the resident's medical record and had not been.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on record 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 cart 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: On 9/9/25 at 11:16 AM, during the medication cart audit, observed the narcotic accountability sheets, dated 2/1/25 to 9/9/25, with 3 licensed nurse signatures not documented. On 9/9/25 at 11:20 AM, LPN #1 stated two nurses should have signed the narcotic accountability sheet when they accepted the medication cart or released the medication cart. On 9/9/25 at 12:07 PM, the Administrator stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, policy review, and review of the Idaho Food Code, the facility failed to ensure staff wore beard nets in the kitchen and appropriately stored, distributed, and labeled foods. This deficient practice had the potential to affect all residents who received meals prepared in the facility's kitchen. This placed residents at risk for potential contamination and use of spoiled foods, and adverse health outcomes including food-borne illnesses. Findings include: The Idaho Food Code, revised February 2021, documented, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking . refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. The Idaho Food Code, revised February 2021, 2-402.11 listed under hair restraints documented, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens. The facility Food and Nutrition Services Policy and Procedures undated documented, Minidoka Memorial Hospital Food and Nutrition Services will follow the current edition of the [NAME] Policy and Procedure Manual, Chapter 4 Handwashing procedures of when to wash hands; after touching bare human body parts except for clean hands; and Chapter 4 Personal Hygiene - when around exposed foods, beards must be restrained using beard covers. On 9/8/25 at 9:15 AM, observed a contractor male cook touch his face and hair with his gloved hands and then pick up an open container of food without removing gloves and washing his hands. Additionally, observed the contractor main cook who had a beard, was not wearing a beard cover or net as required. On 9/8/25 at 9:16 AM, the contractor food service manager stated she was not aware the male cook needed to wear a beard net or cover. On 9/8/25 at 9:20 AM, observed the following in the dry food storage room. - [NAME] cracker crumbs were in a new container that had not been labeled with an expired or use by date. - Chocolate chips were stored in a new container that had not been labeled with an expired or use by date. On 9/8/25 at 9:30 AM, observed in the walk-in freezer an opened package of egg rolls that had not been labeled with an opened date and not labeled with an expired or use by date. On 9/8/25 at 9:35 AM, the contractor food service manager stated the food items in the walk-in refrigerator and freezer should have been labeled and dated correctly and were not.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>Based on observation, interview, Department of Health and Welfare - Idaho Administrative rules, and U.S. Food and Drug Administration 2022 Food Code review, the facility failed to ensure garbage cans were properly closed with lids to minimize attracting pests and rodents into the kitchen. This deficient practice had the potential to affect all residents and staff in the facility. This placed residents and staff at risk of potential food contamination from bugs and rodents that may enter the kitchen due to the open garbage containers. Findings include: Department of Health and Welfare - Idaho Administrative Rules 16.03.02. Environmental Sanitation 108. Garbage and Refuse 03a. All containers used for storage of garbage and refuse shall be constructed of durable, nonabsorbent material and shall not leak or absorb liquids. Containers shall be provided with tight-fitting lids unless stored in vermin-proof rooms or enclosures, or in a waste refrigerator. U.S. Food and Drug Administration 2022 Food Code, 5-501.113 Covering Receptacles. Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered: (A) Inside the FOOD ESTABLISHMENT if the receptacles and units: (1) Contain FOOD residue and are not in continuous use; or (2) After they are filled. On 9/8/25 at 9:23 AM, observed in the food prep area, a 55-gallon garbage can half full not being used at the time without a lid. On 9/8/25 at 9:30 AM, the contractor food service manager stated the lid was on the ground under the table if they needed to close it but she was not aware the lid needed to be on when the trash can was not being actively filled. On 9/10/25 at 8:20 AM, observed two 55-gallon garbage cans without lids in the kitchen food prep areas. The contractor food service worker stated she was not aware the lids were needed.</p>