STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on observation and staff interview, it was determined the facility failed to ensure resident's right to privacy was maintained during cares. This was true for 1 of 1 resident (Resident #6) observed during cares. This deficient practice placed Resident #6 to experience embarrassment and psychosocial distress if her body was exposed to others unnecessarily. Findings include: The SOM Appendix PP, dated 4/25/25, documented each resident has the right to privacy and confidentiality for all aspects of care and services. A nursing home resident has the right to personal privacy or not only his or her own physical body, but of his or her personal space, including accommodations and personal care. Resident #6 was admitted to the facility on [DATE], with multiple diagnoses including Huntington's disease (a neurological disorder that affects a person's movements, thinking ability, and mental health, with symptoms often including chorea, which are rapid, involuntary movements of the limbs and face). On 5/28/25 at 2:08 PM, LPN #2 provided wound care to Resident #6's bottom. Resident #6 was in bed with her shorts down to her knees exposing her periarea as she moved from lying on her back to her side. The window blind was open as LPN #2 continued to complete Resident #6's wound care. On 5/28/25 at 2:16 PM, LPN #2 stated I should have closed the blinds before performing her wound care.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48402 Based on record review, staff interview, and review of the RAI manual, it was determined the facility failed to ensure MDS assessments were completed and reported timely. This was true for 7 of 9 residents (Resident #1, # 6, #9, #11, #12 #13, #120) reviewed for encoding and transmitting resident assessments. This failure created the potential for harm and inaccuracy of assessments when residents were not assessed timely to identify their needs. Findings include: The RAI manual, dated October 2024, version 1.19.1, documented the ARD must be within 92 daysafter the ARD of the previous OBRA assessment (Quarterly, Admission, SCSA, SCQA, or Annual assessment + 92 days). 1. Resident #9 was admitted to the facility on [DATE], with multiple diagnosis including malnutrition, seizures, and history of falling. Resident #9's Admission MDS assessment dated [DATE], was transmitted to CMS database, but her Quarterly MDS assessment documented an ARD of 1/13/26, it was 31 days overdue. 2. Resident #11 was admitted to the facility on [DATE], with multiple diagnoses including bipolar disorder, anxiety, and major depressive disorder. Resident #11's Quarterly MDS assessment dated [DATE], was transmitted to CMS database, but her Annual MDS assessment with ARD of 4/17/25 was not completed, it was 28 days overdue. 3. Resident #12 was admitted to the facility on [DATE], with multiple diagnoses including constipation, muscle weakness, and diabetes mellitus. Resident #12's Annual MDS assessment dated [DATE], was transmitted to CMS database, but his Quarterly MDS assessment with ARD of 3/24/25 was not completed, it was 52 days late. 4. Resident #120 was admitted to the facility on [DATE], with multiple diagnoses including, seizures, swelling of the brain and brain abscess. Resident #120's Admission MDS assessment with ARD of 5/1/14 was not completed, it was 21 days overdue. On 5/29/25 at 11:58 AM, the DON stated, we are not reporting the assessments to CMS, we have no excuse, we are behind. 36193 5. Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including dementia and hypertension. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #1's Quarterly MDS assessment, dated 1/20/25 was transmitted to the CMS database. but her Quarterly MDS assessment with ARD of 4/22/25 was not transmitted, it was 23 days overdue. 6. Resident #6 was admitted to the facility on [DATE], with multiple diagnoses including Huntington's disease (a neurological disorder that affects a person's movements, thinking ability, and mental health, with symptoms often including chorea, which are rapid, involuntary movements of the limbs and face). Resident #6's Quarterly MDS assessment, dated 1/23/25 was transmitted to CMS database, but her Quarterly MDS assessment with ARD of 4/25/25 was not completed, it was 20 days overdue. 7. Resident #13 was admitted to the facility on [DATE], with multiple diagnoses including dementia. Resident #13's Annual MDS assessment dated [DATE] was transmitted to CMS data base, but her Quarterly MDS assessment with ARD of 5/18/25 was not completed, it was 11 days overdue. On 5/29/25 at 11:58 AM, the DON stated, we are not reporting the assessments to CMS, we have no excuse, we are behind.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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** 48402 Based on record review and staff interview, it was determined the facility failed to ensure residents' assessments accurately reflect their status. This was true 4 of 12 residents (#2, #11, #16, and #17) whose bedrails were assesed as a restraint. This created the risk for harm when residents' were not accurately assessed. Findings include: 1. Resident #17 was admitted to the facility on [DATE], with a diagnosis of adult failure to thrive (a decline in overall health and functional abilities). Resident #17's Quarterly MDS assessment dated [DATE], documented he used his bed rails daily under section P- Restraints Resident #17's care plan dated 8/19/24, documented his bed rails were used for mobility. It also documented that he has been informed of the risk of using side rails. A bed rail assessment dated [DATE], documented the bed rails would be used for improved independence. 2. Resident #11 was admitted to the facility on [DATE], with multiple diagnoses including bipolar disorder, anxiety, and major depressive disorder. Resident #11's care plan dated 7/18/24, documented she may have her bed rails up or down as desired. Her care plan also stated she would be evaluated quarterly and if she obtained an injury related to the bed rails they may have to be removed. A Quarterly MDS assessment dated [DATE], documented she used her bed rail daily under section P- Restraints A Side Rail assessment dated [DATE], documented the bed rail was not used for mobility or independence. It also documented Resident #11 was not able to use the bed control. On 5/29/25 at 11:58 AM, The DON and LSW stated, the MDS was coded incorrectly as Resident #9, #11, and #17 do not use bed rails as a restraint. 3. Resident #2 was admitted to the facility on [DATE], with multiple diagnoses including dementia,urinary tract infection and chronic pain. Resident #2's Quarterly MDS assessment dated [DATE], documented she use a bed rail daily under section P - Restraints. Resident #2's Initial Side Rail assessment dated [DATE], documented she used the side rail to improve her mobility and independence, and she is able to use the bed controls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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	Resident #2's care plan, initiated 9/4/24 documented she was using two side rails in bed for mobility. The care plan also documented Resident #2 and her POA were aware of the dangers of using a side rail and they have signed a consent. On 5/29/25 at 9:44 AM, the DON stated Resident #2 uses the side rail as a mobility aid and it was not restraining her movement in bed. The DON stated Resident #2 was coded as using a restraint in her MDS because she used the side rail daily and she did not want to falsify her record by documenting she was not using a side rail. 4. Resident #16 was admitted to they facility on 10/1/24, with multiple diagnoses including Alzheimer's disease and apraxia (a disorder of the brain and nervous system in which a person is unable to perform tasks or movements when asked) following stroke. Resident #16's Initial Side Rail assessment dated [DATE], documented he used the side rail to improve his mobility and independence, and he is able to use the bed controls. Resident #16's care plan, initiated 2/2/24, documented he used one side rail for his repositioning. On 5/29/25 at 9:44 AM, the DON stated Resident #16 uses the side rail as a mobility aid and it was not restraining Resident #16 movement in bed. The DON stated Resident #16's was coded as using a restraint in his MDS because he used the side rail daily and she did not want to falsify his record by documenting he was not using the side rail. 36193

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure person-centered comprehensive care plans were developed and implemented to address residents' needs. This was true for 6 of 12 residents (#1, #2, #9, #11, #15, and #120) whose care plans were reviewed. This failure created the potential for harm should residents receive inappropriate or inadequate care. Findings include: The facility's Care Plans policy, dated 1/1/24 documented the care plan for each resident at the facility would be individualized according to each resident's needs or wants as much as possible. 1. Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including dementia and hypertension. Resident #1 physician's order documented the following: - Risperidone (antipsychotic) 0.5 mg by mouth two times a day, ordered 1/24/25 - lorazepam (antianxiety) 0.5 mg by mouth at bedtime related to anxiety disorder, ordered 1/17/25. - Monitor and document her behavior: . yelling and 2. restlessness and to provide interventions such as: a. activities b. puzzles and word searches. Resident #1's care plan revised 7/31/24, documented she had behavior issues of loud rumination (repeating the same thing over and over) related to her dementia. Sometimes this disrupts group activities such as meals and games. Resident #1's care plan goal was to document her behavior daily on behavior monitor. Resident #1's April and May 2025 Behavior monitor documented she was being monitored for the following behaviors: paranoia, hallucination, delusion, verbal aggression, repetitive anxious statements, agitation, and getting up without assistance. These behaviors were not documented in Resident #1's care plan. On 5/28/25 at 3:01 PM, the LSW stated Resident #1 was being monitored for paranoia, hallucination, delusions, and verbal aggression. When asked if these behavior were in the care plan, LSW then reviewed Resident #1's care plan and stated No. The LSW stated Resident #1's behaviors that was being monitored were not in the care plan and it should be in the care plan. 2. Resident #2 was admitted to the facility on [DATE], with multiple diagnoses including dementia, urinary tract infection and chronic pain. A care plan initiated on 11/2/23, documented Resident #2 was taking an antidepressant and directed staff to encourage her to read, go outside, knit or join in group activities when she shows signs of increased sadness. The care plan also directed staff to monitor her for adverse side effects and report if suspected. The care plan did not identify what side effects the staff should monitor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #2's April and May 2025 Behavior monitor documented she was being monitored for the following behaviors: increased sadness, sleeping a lot and overeating. These behaviors were not documented in her care plan. On 5/28/25 at 2:25 PM, LSW stated Resident #2's behavior of sleeping a lot and overeating were not documented in the care plan. The LSW also stated the care plan should document what side effects the staff should monitor. 3. Resident #15 was admitted to the facility on [DATE], with multiple diagnoses including aphasia ((an impairment of language due to brain injury, affecting the production or comprehension of speech and the ability to read or write) following a stroke. A care plan initiated on 5/2/24, documented Resident #15 was on psychotropic medication for her anxiety and depression. Resident #15's symptoms documented the following anger and talking slow or low and I stop talking. The care plan did not indicate Resident #15 was to be monitored for adverse side effects of her psychotropic medication. Resident #15's April and May 2025 Behavior monitor documented she was being monitored for the following behaviors: snappy, short tempered, forgot she was given her medications, and air hunger anxiety. These behaviors were not documented in her care plan. On 5/28/25 at 2:55 PM, the LSW stated Resident #15's behaviors of being snappy and short tempered and having air hunger were not documented in her care plan and it should be in her care plan. The LSW also stated Resident #15's care plan did not document she was to be monitored for adverse side effects of her psychotropic medication. 48402 4. Resident #11 was admitted to the facility on [DATE], with multiple diagnoses including bipolar disorder, anxiety, and major depressive disorder. Resident #11's care plan dated 7/18/24, did not identify she had bipolar, anxiety or depression. On 5/29/25 at 9:19 AM, the LSW stated Resident #11's care plan did not include documentation of interventions or mood and behavior triggers. The LSW also stated Resident #11 was a trauma survivor, but her care plan does not document triggers. 5. Resident #120 was admitted to the facility on [DATE], with multiple diagnoses including brain abscess, swelling of the brain, and seizures. A fall assessment dated [DATE], documented Resident #120 was identified a moderate risk for falls. Resident #120's record documented he had a history of falls at home. An incident report dated 5/11/25, documented Resident #120 had a witnessed fall while trying to get his glasses from the floor. Resident #120's care plan did not include documentation of fall preventions or interventions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/29/25 at 1:39 PM, the DON stated the care plan should have reflected the risk for falls and should have been revised on 5/11/25 after his last fall. 6. Resident #9 was admitted to the facility on [DATE], with multiple diagnoses including protein-calorie malnutrition, malignant neoplasm, and history of falls. An Admission MDS assessment dated [DATE], documented Resident #9 had bed rails used daily. Resident #9's care plan did not include documentation indicating she used bed rails. On 5/29/25 at 9:46 AM: The LSW stated, Resident #9's care plan did not include the bedrails she used daily however, it should have.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents' care plans were revised and updated as needed. This was true for 1 of 12 residents (Resident #16) whose care plan was reviewed. This created the potential for Resident #16 to experience harm if cares and services were not provided appropriately due to inaccurate information in his care plan. Findings include: Resident #16 was admitted to the facility on [DATE], with multiple diagnoses including Alzheimer's disease and apraxia (a disorder of the brain and nervous system in which a person is unable to perform tasks or movements when asked) following stroke. The facility's Care Plans policy, dated 1/1/24 documented residents' care plans will be reviewed quarterly, annually, and with change of status to ensure that they are current for the residents' care. An I&A report documented the following: - On 3/15/25 at 4:10 PM, Resident #16 had an unwitnessed fall with no injury. The I&A documented he continued to get out of his bed, and it was recommended for Resident #16 that he may need an alarm placed on for safety. - On 3/20/25 at 4:30 PM, Resident #16 had an unwitnessed fall with no injury. The I&A documented his tab alarm was on. Review of Resident #16's care plan did not document he had a tab alarm. On 5/29/25 at 9:13 AM, the DON reviewed Resident #16's care plan and stated she did not find the tab alarm on his care plan, only just leave the call button within reach was in his care plan. The DON stated Resident #16's care plan should have been updated to include the tab alarm in his care plan when it was placed after his fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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** 36193 Based on record review, and staff and resident interview, it was determined the facility failed to ensure professional standards of care were followed for 1 of 12 residents (Resident #69) reviewed for quality of care. Resident #69's physician's order was to restrict his fluid intake to 1,500 ml was not followed. This deficient practice had the potential to adversely affect or harm Resident #69 when his fluid intake was not restricted or monitored. Findings include: Resident #69 was admitted to the facility on [DATE], with multiple diagnoses including Syndrome of Inappropriate Secretion of Antidiuretic Hormone (a condition in which the body retain too much water and commonly leads to hyponatremia which is low levels of sodium in the blood). A physician's order, dated 12/9/23, documented Resident #69 was on 1,500 ml of fluid restriction. A care plan initiated on 11/26/24, documented Resident #69 was on fluid restriction of 1,500 ml, on which the kitchen would supply 1,200 ml and leaves him with 300 ml of other fluids. On 5/28/25 at 11:43 AM, Resident #69 stated he was on fluid restriction. When asked how much water was he allowed to have, Resident #69 did not answer. Review of Resident #69's 5/17/25 - 5/29/25 total fluid intake documented he has taken more than 1,500 ml of fluid on the following dates: - 5/17/25 = 1,780 ml - 5/18/25 = 1,560 ml - 5/19/25 = 1,840 ml - 5/20/25 = 1,800 ml - 5/21/25 = 1,530 ml - 5/22/25 = 2,220 ml - 5/24/25 = 1,620 ml - 5/25/25 = 1,740 ml - 5/26/25 = 1.740 ml - 5/27/25 = 1,770 ml - 5/28/25 = 1,510 ml - 5/29/25 = 1,320 ml (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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	On 5/30/25 at 11:31 AM, the DON stated Resident #69 was on 1,500 ml of fluid restriction. The DON reviewed Resident #69's fluid intake record and stated Resident #69 was difficult to control on his fluid intake. She stated we should have monitored him more closely to ensure he is only taking his required fluid requirement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48402 Based on record review and staff interview it was determined the facility failed to ensure residents were properly assessed for bed rails. This was true for 3 of 9 resident (Resident #1, #9, and #11) whose records were reviewed for bed rails. This failure created the potential for harm when residents were not assessed for entrapment. Findings include: The facility's Side Rail Used/ Restraint Policy, dated 2/15/17, documented all residents requiring side rails, will be given a risks vs. benefits of side rail use form to review and a consent form. Residents will have a side rail use assessment completed quarterly with their MDS reporting and with any changes in their status. 1. Resident #9 was admitted to the facility on [DATE], with multiple diagnoses including malnutrition, breast cancer, and history of falls. On 5/27/26 at 1:56 PM, Resident #9 was observed resting in bed comfortably with the left side of her bed against the wall and a bed rail on the right side. A request for bedrail assessment and risk vs. benefits was requested and not provided. 2. Resident #11 was admitted to the facility on [DATE], with multiple diagnoses including bipolar disorder, major depressive disorder, and muscle weakness. Resident #11's care plan dated 7/18/24, documented she may have her bed rails up or down as desired. Her care plan also stated she would be evaluated quarterly and if she obtained an injury related to the bed rails they may have to be removed. A Side Rail assessment dated [DATE], documented the following: 1. Will side rails be used for mobility? No 2. Will side rails be used for improved independence? No 3. Will resident be able to use the bed controls? No 4. Are side rails in good working order? NA 5. Are side rails installed correctly and safely? 6. Does the resident request the side rails are up when in bed? No 7. Is there any potential or risk for resident to have extremities caught on side rails? NO 8. They have been assessed and are safe to be used with this resident? No (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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	9. If side rails will be used has the resident and family been informed of use such as upper injuries from falls and lim[bs] being caught in rails.- No On 5/29/25 at 5:35 PM, the DON and LSW stated the prior DON had assessed residents for bed rails but did not document the assessments correctly. However, none of the bed rails are currently used as a physical restraint. 36193 3. Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including dementia and hypertension. On 5/28/25 at 10:40 AM, Resident #1 was observed in bed with one side rail in raised position. Resident #1's Side Rails Assessment form, dated 10/10/22, documented the following assessment/questions and next to it was Yes and No column: 1. Will side rails be used to improve mobility? 2. Will side rails be used to improve independence? 3. Will resident be able to use the bed controls? 4. Will the side rails in good working order? 5. Are the side rails installed correctly and safely? 6. Does the resident request the side rails are up when they are in bed? 7. Is there any potential or risk of the resident their extremities caught in the side rails? 8. They have been assessed and are safe to be used with this resident? 9. If side rails will be used, has resident and family been informed of risks of use such as upper injuries from falls and lim[bs] being caught in rails? Assessment/question #1, #2, #3, #4, #5, #6, and #8 had a check mark on the No column and assessment #9 has NA on the Yes column. The facility was unable to provide documentation that Resident #1 was assessed quarterly for her side rail use. On 5/29/25 at 2:15 PM, the DON with the LSW present reviewed Resident #1's Side Rails Assessment. The DON stated she did not know why the assessment was filled out incorrectly. The LSW stated it was not filled out appropriately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review and staff interview, it was determined the facility failed to ensure pharmacist recommendation was addressed by the physician. This was true for 1 of 5 residents (Resident #2) whose medications were reviewed. This failure created the potential for Resident #2 to receive medications that were unnecessary, ineffective, or used in excessive duration. Findings include: Resident #2 was admitted to the facility on [DATE], with multiple diagnoses including dementia, urinary tract infection and chronic pain. A Physician Action Report/Pharmacist Report form, included a section for the pharmacist to write his/her detailed description of irregularity and recommendations and a section for the physician to make a comment regarding the pharmacist recommendation. Resident #2's Physician Action Report/ Pharmacist Report form, dated 4/30/25, documented the Pharmacist wrote Document citalopram dose. The physician's section had the physician signature, but the physician did not indicate the dosage of Resident #2's citalopram. On 5/30/25 at 8:52 AM, the LSW reviewed the Resident #2's Physician Action Report/Pharmacist Report form and stated she did not notice the physician did not write his/her response on the form during their psychotropic medication meeting. The LSW stated she would make sure the physician writes his response on the form on their next meeting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48402 Based on record review and staff interview it was determined the facility failed to ensure residents were properly assessed for anticoagulants. This was true for 1 of 5 residents (Resident #9) whose records were reviewed for unnecessary medications. This failed practice created the potential for harm when Resident #9 was not assessed for bleeding. Findings include: Resident #9 was admitted to the facility on [DATE], with multiple diagnoses including non-surgical wound, history of falls, and right artificial hip joint. A physician's order dated 12/30/24, documented Apixaban (a blood thinner) oral tablet 5 mg give 1 tablet by mouth two times a day for deep [NAME] thrombosis (DVT) prevention. A physician's order dated 12/21/24, documented Aspirin oral tablet 81 mg give 1 tablet by mouth one time a day for DVT prevention. Resident #9's record did not include monitoring for bruising or bleeding. On 5/29/25 at 12:40 PM, the DON stated Resident #9's record did not include monitoring for adverse outcomes or monitors for bruising and bleeding. She also stated the physician assessed Resident #9 once every 60 days, but the licensed nurse does not assess Resident #9 for bleeding on a daily basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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** 48402 Based on review of Incidents and Accidents reports, and staff interview, it was determined the facility failed to ensure residents were free from significant medication errors. This affected 2 of 2 residents (#11 and #14) whose records were reviewed for medication error. This failure placed Resident #11 at risk for hypoglycemic episodes and even death and Resident #14 to experienced uncontrolled pain. Findings include: 1. Resident #11 was admitted to the facility on [DATE], with multiple diagnoses including Diabetes and restless leg syndrome. An I&A report dated 3/2/25, documented Resident #11 was given the incorrect insulin by Med-Tech #1. The incident report also documented the physician was notified and the following order was given: Check blood sugar every 30 minutes for 4 hours. Give soda, candy or juice to keep blood sugar above 150. If blood sugar drops below 80 send to emergency room . The I&A report documented the following blood sugar levels along with the following interventions: - At 9:10 PM her blood sugar was 214 she was given glucose 15 - At 9:40 PM her blood sugar was 231 she was given donuts and A&W root beer - At 10:10 PM her blood sugar was 181 she was given peanut butter creme, 1 oatmeal cream pie, and an A&W root beer. - At 10:40 PM her blood sugar was 153 She was given apple juice. - At 11:10 PM her blood sugar was 236 she was given soda and juice - At 11:40 PM her blood sugar was 202 she was given soda - At 12:10 AM her blood sugar was 156 she was given a soda - At 12:30 AM her blood sugar was 153 no interventions were implemented. The I&A report documented on 3/2/25 at 10:40 PM, Resident #11's stomach became upset. The I&A report documented Med-Tech #1 was educated on verifying the MAR and medication before administration. On review of Med-Tech #1's skills check off. Insulin was not identified as an area of competency. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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	On 5/28/25 at 2:25 PM, the DON stated it was the responsibility of the registered nurse to over see Med-Tech #1. She also stated the medication error should have never happened. However, she did not realize the skills check off did not include insulin therefore Med-Tech #1 should have not been administering insulin to anyone. 2. Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including chronic pain, anxiety, and dementia. A physician order dated 7/1/24, documented Oxycodone-Acetaminophen 5-325 mg (a opioid pain medication) give 1 tablet by mouth every morning and at bedtime related to chronic pain. An I&A report dated 1/1/25, documented Resident #14 was not given her Oxycodone 5-325 mg. The I&A report included documentation that Resident #14 requested to have her medications at a later time, but she never received it. During a narcotic reconciliation it was identified Resident #14 did not get her Oxycodone. The incident report documented Med-Tech #1 was educated on verifying the MAR and the 5 rights of medication administration. On 5/28/25 at 2:30 PM, the DON stated, she had provided education to Med-Tech #1. She also stated she has been using Med-Techs for medication administration to allow for the RN to be able to do some of the administrative work, but she will be using LPN's moving forward to prevent further medication errors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 48402 Based on observation and staff interview, it was determined the facility failed to ensure medications available for residents were removed from the medication cart on expiration date. This was true for 1 of 1 medication carts inspected. This failure created the potential for residents to receive expired medications with decreased efficacy. Findings include: On 5/30/25 at 9:45 AM, a Novolog insulin pen was in the medication cart with the open date of 4/26/25 and expiration date of 5/24/25. On 5/30/25 at 9:47 AM, LPN #3 stated the insulin pen was expired. She also stated she had administered the expired insulin that morning to Resident #11.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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. 36193 Based on staff interview, it was determined the facility failed to ensure there was a qualified dietary manager with required competencies and skills. This deficient practice had the potential to affect all the 20 residents residing in the facility who received food from the kitchen. Findings include: On 5/29/25 at 12:38 PM, the DM stated she started in the facility working as a dietary manager about five weeks ago. She stated she did not have the certification yet, but she registered herself to take the classes to become a certified dietary manager. The DM stated she was being supervised by their Registered Dietitian and is in constant communication with him/her. On 5/29/25 at 2:13 PM, the DON stated the Dietary Manager was not certified, but she is being supervised by their Registered Dietitian. When asked if the facility had a full-time dietitian, the DON stated No. The Registered Dietitian visits the facility at least once a week

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on observation and staff interview, it was determined the facility failed to ensure kitchen staff wear their hair restraints appropriately and discard outdated food items in the kitchen. These deficiencies had the potential to affect the 20 residents residing in the facility who consumed food prepared by the facility. This placed residents at risk for potential contamination of food and adverse health outcomes, including food borne illnesses. Finding include: 1. The FDA Food Code 2022, Section ,d+[DATE].11 Effectiveness. (Hair Restraints) states except as provided in paragraph (B) of this section, 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; and unwrapped single-serve and single-use articles. On [DATE] at 12:10 PM, the Dietary Aide #1 was observed in the kitchen with her hair not completely restrained to cover her bangs and the hair around her face. On [DATE] at 2:24 PM, the Dietary Manager stated Dietary Aide #1 should have worn her hair restraint to completely cover her hair. 2. An initial kitchen inspections was conducted on [DATE] at 10:58 AM, with Dietary Aide #2. The following were observed: - 2 Hershey Syrup with best by date ,d+[DATE] - 1 Hershey Syrup Zero Sugar with best by date ,d+[DATE] - 1 Farmer Brothers Seasoning dated [DATE] - Taco mix - expiry date of [DATE] - Soup Base - undated A second kitchen inspection was conducted on [DATE] at 12:38 PM with Dietary Aide #1. The following were observed: - 1 Hershey Syrup with best by date ,d+[DATE] - 1 Hershey Syrup with best by date ,d+[DATE] - 2 bags of flour tortilla expired on [DATE] - 4 bags of spinach tortilla with best by date [DATE] - 1 bag of corn tortilla expired on [DATE] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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	- 1 bag of corn tortilla expired on [DATE] On [DATE] at 1:00 PM, The Dietary Manager was informed of the above items expiry date and best by date, and stated the food items should not be in the kitchen and should be discarded.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48402 Based on resident interview, and staff interview, it was determined the facility failed to ensure rehabilitative services were provided. This was true for 1 of 1 resident (Resident #14) whose records were reviewed for rehabilitative services. This failure created the potential for poor quality of life and declined ability to perform activities of daily living. Findings Include: Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including age-related osteoporosis and pathological fractures. A physician's order dated March 2025, documented Resident #14 was to be evaluated and treated for a wheelchair. On 5/27/25 at 11:22 AM, Resident #14 stated she has been waiting for physical therapy to get her a wheelchair that fits appropriately but they keep telling her its being ordered. On 5/27/25 at 11:28AM, Resident #14 was observed sitting in her wheelchair. The hand rest of the wheelchair was observed at the same level of Resident #14's chest. Making it difficult to rest her arms on the hand rest of the wheelchair. On 5/29/25 at 9:57 AM, the Physical Therapist #1 stated she got the physician order 3 weeks ago however, a vendor needs to come out and measure Resident #14 for an appropriate wheelchair. She also stated the vendor is not scheduled because they need to have three residents with needs. She stated she had previously informed the facility they can buy Resident #14 a wheelchair if they need it done faster. On 5/29/25 at 1:31PM, the DON stated the facility if not able to purchase equipment for everyone. She also stated Resident #14 had insurance, but physical therapy has been delaying the process. On 5/30/25 at 11:20 AM, the LSW stated the facility has no documentation that Resident #14 was evaluated for a wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 48402 Based on facility document review, and staff interview, it was determined the facility failed to ensure the Quality Assessment and Assurance (QAA) committee took actions to identify and resolve systemic problems. This failure affected 20 of 20 residents residing in the facility. The deficient practice resulted in failure to report resident assessments and comprehensive care planning which had the potential for adverse outcomes when residents' needs were not identified. Findings include: The facility's QAPI plan revised on 1/2/24, directed the QAPI committee to do the following: - Include all departments and employees in the plan. - Maintain a comprehensive, effective system for monitoring and evaluating. - Assure patient care is provided at an optimal level. - Focus on improving systems and processes using a systemic approach. - Increase communication and transparency of corrective action to improve processes and systems facility wide. - Develop criteria for identifying causes with potential risks and correcting the problem. - Protecting financial resources The facility's Long-Term Care performance improvement plan (PIP) documents the following identified concerns: - Medication audits to reduce medication errors - see F760 - Timely completion of Minimum Data Set (MDS) - see F640 - Care plan and Resident Assessment - see F656 and F657 On 5/30/25 at 1:08 PM, the Administrator and the DON stated the QAPI committee conducts a monthly review of audits. The facility utilizes different departments for different perspectives. The DON stated she is not able to provide measurements of improved PIP's. She also stated she bases her achieved percentage on the number of incidents that occurred during the prior month but does not have a way to track the improved performance plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48402 Based on observation and staff interview it was determined the facility failed to ensure appropriate infection control measures were maintained. This was true for 1 of 1 resident (Resident #119) when LPN #3 failed to apply personal protective equipment while administering a nasal medication to Resident #119 who tested positive for methicillin-resistant staphylococcus aureus (MRSA - a bacterial infection). This failed practice created the potential for adverse outcomes including infection due to cross contamination. Findings include: On 5/30/25 at 9:40 AM, during a medication administration observation LPN #3 was observed performing hand hygiene and entering Resident #119's room to administer medication. Resident #119 was on enhanced barrier precautions due to testing positive for MRSA via a nasal swab. LPN #3 applied gloves and administered oral medication. On completion of oral medication LPN #3 then administered his nasal medication. LPN #3 was not observed putting on a mask or gown prior to administration of his nasal medication. On 5/30/25 at 10:07 AM, the DON stated LPN #3 should have applied a mask and gown when administering medication via a nasal swab.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street American Falls, ID 83211

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review and staff interview, it was determined the facility failed to ensure pneumococcal immunizations were offered and administered with the current CDC recommendation. This was true for 1 of 5 residents (Resident #9) reviewed for pneumococcal immunizations. This failure increased Resident #9's risk for contacting pneumonia with potential negative outcome. The CDC website's article titled Pneumococcal Vaccine Recommendation, dated 10/26/24 and accessed on 6/2/25, documented for routine vaccination, administer PCV15, PCV20, or PCV21 for all adults [AGE] years or older. - Who have never received any pneumococcal conjugate vaccine. - Whose previous vaccination history was unknown. If PCV 15 is used, administer a dose of PPSV23 one year later. Their vaccination is complete. If PCV20 or PCV 21 was used, a dose of PPSV 23 is not indicated. Regardless of which vaccine was used (PCV20 or PCV21), their pneumococcal vaccinations are complete. Resident #9, age [AGE] years old was admitted to the facility on [DATE], with multiple diagnoses including cancer of the breast. There was no documentation in Resident #9's record she was offered or received the pneumococcal immunizations. On 5/28/25 at 3:45 PM, the DON together with the IP and LPN #1 stated residents were offered Flu, RSV, COVID and pneumococcal immunization upon admission. LPN #1 stated Resident #9 was offered the pneumococcal immunization on May 22, 2025. When asked why Resident #9 was only offered the pneumococcal immunization on May 22, 2025 when she was admitted in the facility on 12/30/24, the DON stated Resident #9 or her representative did not know what type of pneumococcal immunization she had received in the past. The DON stated they called Resident #9's primary physician and asked for her immunizations record, but the clinic did not have her immunizations record. The DON was unable to provide documentation pneumococcal immunization was offered to Resident #9 upon admission.