STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135070	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Lake Memorial Skilled Nursing Facility	164 South Fifth Street Montpelier, ID 83254

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **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 informed consent was obtained prior to initiation of psychotropic medications for 1 of 12 residents (Resident #6) reviewed for unnecessary medications. This deficient practice placed residents at risk of receiving medications without knowledge of the reason why medications were prescribed, the expected benefits, and the risks associated with the medications. Findings include:Resident #6 was admitted to the facility on [DATE], with multiple diagnoses including dementia and diabetes. On 1/21/26, a physician order documented Resident #6 was to start Sertaline (an antipsychotic medication) 25 mg one time a day for depression. On 2/18/26 at 3:16 PM, the Licensed Social Worker (LSW) stated there was no psychotropic medication acknowledgement consent for Resident #6's current use of Sertaline. On 2/18/26 at 3:18 PM, the MDS RN stated, Resident #6 should have signed a psychotropic medication acknowledgement consent prior to administration of Sertaline but had not.

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
	135070	A. Building B. Wing	02/19/2026

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, record review, and staff interview, it was determined the facility failed to ensure a resident's call light was within reach for 2 of 12 residents (#30 and #35) reviewed for residents' rights. This deficient practice had the potential to cause harm if the resident could not call for assistance when needed or experienced an adverse medical event that required attention. Findings include: The facility's Call System, Residents policy, no date or revision date, documented each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.Resident #35 was admitted to the facility on [DATE], with multiple diagnoses including atrial fibrillation (rapid irregular heart rate) and high blood pressure. On 2/17/26 at 10:27 AM, observed Resident #35 sitting in her recliner which was placed on the left side of her bed and her call light was lying on the nightstand on the right side of her bed and not within her reach. On 2/17/26 at 10:30 AM, LPN #1 stated Resident #35's call light should be within reach and had not been. Resident #30 was admitted to the facility on [DATE], with multiple diagnoses including end stage renal disease (permanent failure of kidney function), diabetes and repeated falls. On 2/17/26 at 1:25 PM, observed Resident #30 sitting in his recliner which was placed on the right side of his bed, and pinned to the room curtain on the left side of his bed was his call light which was not within his reach. On 2/17/26 at 1:42 PM, LPN #1 stated Resident #30's call light should have been within reach and had not been. On 2/17/26 at 2:52 PM, the Administrator stated resident call lights should be within the resident's reach and had not been.

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	135070	A. Building B. Wing	02/19/2026

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and resident and staff interviews, it was determined the facility failed to ensure residents were provided with a safe and clean, homelike environment that did not pose any safety risks. This was true for 1 of 6 resident room doors (room [ROOM NUMBER]) whose room doors were opened. This deficient practice created the potential for diminished quality of life and psychosocial distress for residents when their room doors do not open correctly or fully to allow entrance or exit of the room. Findings include:Resident #23 was admitted to the facility on [DATE], with multiple diagnoses including paranoid schizophrenia (a chronic mental health condition characterized by intense, irrational paranoia, and auditory hallucinations) and chronic kidney disease.On 2/17/26 at 10:45 AM, when attempting to open resident room [ROOM NUMBER] door, the surveyor observed that the door became jammed when only about halfway open. Resident #23 stated the door has been like that since he was assigned this room.On 2/18/26 at 1:15 PM, the Administrator stated he was unaware room [ROOM NUMBER] door was stuck because maintenance had attempted to repair the stuck door of room [ROOM NUMBER] and the same issue must have occurred again.

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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** Based on observation, interview, and record review, it was determined the facility failed to ensure resident care plans were revised to reflect current needs and interventions. This was true for 2 of 12 residents (Resident #7and Resident #23) whose care plans were reviewed. This placed residents at risk for adverse outcomes if care and services were not provided due to care plans not being revised as residents' needs changed. Findings include.Resident #7 was admitted to the facility on [DATE], with multiple diagnoses including chronic pulmonary edema (long-term condition involving gradual buildup of fluid in the lungs) and open right foot wound. On 2/17/26 at 11:07 AM, during interview of Resident #7 he stated he had fallen multiple times and the most recent had been on 2/16/26 when he slid off his recliner onto the floor and the facility had provided him with a different recliner. On 2/17/26 at 12:35 PM, Resident #7's care plan reviewed, and no documented interventions related to the 2/16/26 fall. No documented interventions related to Resident #7's right adaptive shoe use. On 2/17/26 at 12:37 PM, reviewed Resident #7's medical record and a progress note documented resident had a fall on 2/16/26. On 2/18/26 at 1:50 PM, the MDS RN stated Resident #7's care plan should have been revised when the resident had the recent fall and now requires the use of a spacer with the recliner, and the continued use of the right adaptive shoe and had not been. Resident #23 was admitted to the facility on [DATE], with multiple diagnoses including paranoid schizophrenia (a chronic mental health condition characterized by intense, irrational paranoia, and auditory hallucinations) and chronic kidney disease. On 2/17/26 at 4:36 PM, observed Resident #23's bed very low to the ground. Resident #23 stated it makes it easier for him to get out of bed. On 2/17/26, Resident #23's care plan had not documented that his bed should be in a low position. On 2/18/26 at 1:24 PM, the MDS RN stated Resident #23's low bed position should have been care-planned and had not been.

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	135070	A. Building B. Wing	02/19/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure professional standards of practice were followed for 2 of 12 Residents (#1 and #35) reviewed for bowel and bladder care. This failed practice created the potential for residents to experience discomfort when physicians were not contacted regarding residents not having a BM within the last 72 hours. Findings include:Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including psychosis (a mental health symptom, not a specific illness, characterized by a loss of contact with reality) and dementia. On 2/17/26 at 4:40 PM, Resident #1's medical record documented he had a BM on 1/26/26 at 21:59 and not again until 1/30/26 at 21:53, 96 hours later. Resident #1's physician order dated 10/1/25, documented Docusate 100 mg orally 2 times a day for constipation and his MAR documented it was given two times a day throughout the month of January 2026. On 2/18/26, Resident #1's medical record had no documentation that his physician had been contacted 1/26/26 through 1/30/26, regarding no BM for over 72 hours. On 2/18/26 at 1:25 PM, the MDS RN stated nursing staff for Resident #1 should have contacted the physician after 72 hours without a BM and had not. Resident #35 was admitted to the facility on [DATE], with multiple diagnoses including atrial fibrillation (rapid irregular heart rate) and high blood pressure. On 2/17/26 at 3:40 PM, Resident #35's medical record documented she had a BM on 2/8/26 at 0029 and not again until 2/12/26 at 1505, 87 hours later. Resident #35's medication administration record documented Resident #35 had the following medication orders; -Milk of Magnesia 30 ml prn QD po for constipation -Bisacodyl 10 mg suppository rectally once daily if needed if Milk of Magnesia not effective – constipation -Docusate 100mg orally twice daily as needed – constipation On 2/17/26 at 4:03 PM, during review of Resident #35's medical record no documented administrations of the ordered bowel care medications between 2/8/26 and 2/12/26.

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	135070	A. Building B. Wing	02/19/2026

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Bear Lake Memorial Skilled Nursing Facility	164 South Fifth Street Montpelier, ID 83254

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, facility policy review, record review, and interviews, it was determined the facility failed to provide respiratory services consistent with professional standards of practice. This was true for 3 of 3 residents (#4, #11 and #27) whose SpO2 documentation and respiratory equipment was observed. This failure created the potential for residents' oxygen status and health to be affected and respiratory equipment to malfunction and possibly catch fire. Findings include:The facility CPAP/BiPAP Support Level III policy, undated, documented under steps in the procedure #12, connect supplemental oxygen (Note: Connect oxygen after the CPAP machine has been turned on and disconnect before it has been turned off.) and adjust flow rate as prescribed.Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including transient cerebral ischemic attack (a temporary blockage of blood flow to the brain that causes stroke-like symptoms) and chronic kidney disease.On 2/17/26 at 3:13 PM, Resident #4's medical record documented on 12/3/25, she had an SpO2 of 82% on room air. No nursing interventions related to the low SpO2 were documented in Resident #4's nursing notes.Resident #4's physician oxygen order dated 10/28/24, documented oxygen 1L/NC to 1.5L /NC at night as needed to maintain oxygen saturation above 90%. On 2/18/26 at 4:00 PM, the MDS RN stated Resident #4's low SpO2 level should have been addressed by nursing staff and had not been.Resident #11 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and hallucinations.On 2/17/26 at 1:30 PM, observed Resident #11's oxygen was being bled into her PAP device at 3 lpm and the PAP device was not turned on or in use. On 2/17/26 at 2:45 PM, the MDS RN stated Resident #11's oxygen should have been turned off before turning the PAP device off when she was done using the PAP device but had not been.Resident #27 was admitted to the facility on [DATE], with multiple diagnoses including fracture of lower right leg and diabetes.On 2/17/26 at 11:00 AM, observed Resident #27's oxygen was being bled into her PAP device at 2 lpm and the PAP device was not turned on or in use. On 2/17/26 at 2:50 PM, the MDS RN stated Resident #27's oxygen should have been turned off before turning the PAP device off when she was done using the PAP device but had not been.

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	135070	A. Building B. Wing	02/19/2026

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and staff interviews, it was determined the facility failed to have an RN on duty for at least 8 consecutive hours a day. This was true for 1 of 3 days reviewed for RN coverage. This created the potential for harm if routine and/or emergency nursing services went unmet and had the potential to affect all residents residing at the facility. Findings include:On 2/18/26 at 12:00 PM, during review of monthly scheduled staffing sheets from January 2025 through January 2026 for licensed nursing hours, 4/11/25, was confirmed as having less than 8 consecutive RN hours coverage.On 2/18/26 at 1:31 PM, the Administrator stated on 4/11/25, the facility only had 4.75 hours of RN coverage. On 2/19/26 at 11:37 AM, the DNS stated she could not find any other RN hours worked on 4/11/25 other than the 4.75 hours earlier reported.

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	135070	A. Building B. Wing	02/19/2026

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and staff interview, it was determined the facility failed to ensure nurse staffing information was maintained for 18 months after it had been posted. This failed practice had the potential to affect all residents residing in the facility and their representatives, visitors, and others who wanted to review the facility's staffing levels. Findings include:On 2/17/26 at 9:40 AM, observed the daily nurse staffing documented on a dry erase whiteboard. On 2/17/26 at 4:10 PM, the Administrator provided monthly scheduling staffing sheets for the past 13 months however these did not have the required daily staffing information, for example, the name of the facility, the scheduled vs actual hours worked, and the daily census. On 2/18/26 at 10:10 AM, the Administrator stated the facility had not maintained 18 months of daily staffing sheets due to it being documented on the dry erase whiteboard and should have.On 2/18/26 at 3:35 PM, the MDS RN stated the daily whiteboard information was erased, and new information was added each morning.

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	135070	A. Building B. Wing	02/19/2026

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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 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 2 of 2 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 inthe facility. Findings include:On 2/18/26 at 9:40 AM, observed during the South Hall medication cart audit, the narcotic accountability sheet, dated 2/1/26 to 2/18/26, with 1 licensed nurse signature not documented on 2/2/26, 2/4/26, 2/8/26, and 2/17/26. On 2/18/26 at 9:42 AM, LPN #1 stated two nurses should have signed the narcotic accountability sheet and had not. On 2/18/26 at 9:45 AM, observed during the North Hall medication cart audit, the narcotic accountability sheet, dated 2/1/26 to 2/18/26, with 1 licensed nurse signature not documented on 2/16/26. On 2/18/26 at 9:47 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 2/19/26 at 11:07 AM, the DNS stated two nurses should have signed the narcotic accountability sheet when they accepted the medication cart or released the medication cart and had not.

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	135070	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. Based on observation, interviews, and facility policy review, it was determined the facility failed to ensure medications were secured in a locked medication cart, and of expired medications were removed. This was observed in 2 of 2 medication carts. This failure created the potential for residents to obtain prescribed medications used for other residents, presented the risk for cross-contamination of products, and receive expired medications with decreased efficacy. Findings include:On 2/17/26 at 9:35 AM, observed on entry to the facility, the North Hall medication cart unlocked and unattended as LPN #1 walked away from the medication cart and down the hall to a resident room. No other nursing staff present around the medication cart. The following was observed during the medication cart audits. On 2/18/26 at 9:52 AM, the South Hall medication cart was audited with LPN #1 present. Observed the following: - Two bottles of Milk of Magnesia with a manufacturer printed expiration date of 10/25 on the bottle On 2/18/26 at 9:53 AM, LPN #1 stated, the bottles of Milk of Magnesia should have been discarded and had not been. On 2/18/26 at 9:54 AM, observed white colored fine powder debris along the length of the back edge of medication cart drawer 3. On 2/18/26 at 9:56 AM, LPN #1 stated the medication carts are cleaned monthly and should not have had debris in the drawers. On 2/18/26 at 10:25 AM, the MDS RN stated the expired medications should have been removed from the medication cart and had not been. On 2/17/26 at 12:20 PM, observed the north hall medication cart in the nursing station area, unlocked with no licensed nursing staff present. The surveyor had to wait 10 minutes until a CNA walked past and could request to speak to the MDS RN. On 2/17/26 at 12:35 PM, the MDS RN stated the medication carts are to be locked when not in use and when no nursing staff were present but had not been.

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	135070	A. Building B. Wing	02/19/2026

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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** Based on observation, interview, and review of the Idaho Food Code, the facility failed to appropriately store, distribute, and label foods, and use proper hand hygiene when serving food. 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, stated, 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.On 2/17/26 at 10:00 AM, conducted an initial tour of the kitchen area with FSM with the following issues noted. - Outdated spices (Rotisserie chicken seasoning, garlic salt, Italian seasoning) in the dry food storage area and kitchen cooking area with used by dates 2024 and 2025. - In the kitchen grilling area, a squeeze bottle containing a light-yellow liquid later identified by FSM as cooking oil with no dates on the bottle. - In the walk-in freezer – various bags containing breaded fish, tater tots, and French fries without any use by or opened dates. - In the dry food storage area, two opened bags containing breakfast biscuits without any use by dates, teriyaki sauce with used by date of [DATE], and three boxes of chips that were stored on the ground. - The Walk-in refrigerator temperatures on several dates were greater than 40 degrees F. as follows. [DATE] at 6am [DATE] at 6pm [DATE] at 6am [DATE] at 6pm [DATE] at 6am [DATE] at 6pm [DATE] at 6am [DATE] at 6pm [DATE] at 6am (continued on next page)

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	135070	A. Building B. Wing	02/19/2026

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Bear Lake Memorial Skilled Nursing Facility	164 South Fifth Street Montpelier, ID 83254

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	[DATE] at 6pm [DATE] at 6am [DATE] at 6am The refrigerator temperature log documented the following: temperatures for the refrigerator are 35 to 41 degrees F. Any unit not at the proper temperature must be reported to the supervisor and maintenance at once and perishable foods removed. Please make a note at the bottom of the sheet when it has been reported. On 2/17/26 at 10:25 AM, observed the lack of any notes at the bottom of the refrigerator temperature log to indicate the higher temperatures had been reported. On 2/17/26 at 10:33 AM, the FSM stated the outdated and non-dated food items should have been addressed and were not. Additionally, the higher refrigerator temperatures should have been reported to the maintenance department but had not been. On 2/18/26 at 1:48 PM, the FSM stated after the cook/server rubbed the resident's shoulder, she should have removed her gloves, washed her hands, and put new gloves on before continuing to serve food to residents and did not. On 2/19/26 at 11:17 AM, observed the following issues in the resident snack refrigerator: - Two small containers of food, one with a resident name but neither had any dates labeled on them. On the resident snack refrigerator door, the following document was visible: Resident Fridge; Please label with a name and date all items placed in it. On 2/19/26 at 11:47 AM, the DNS stated all items in the resident refrigerator should be labeled with a date but were not. On 2/17/26 at 12:12 PM, observed during the lunch meal dietary staff placing a piece of chicken fried steak onto the plate, hold the meat on the plate with a gloved hand and take a pizza cutter and cut into bite-size pieces, once the remaining food items were placed on the plate, the dietary staff delivered the plate to the resident seated at the table, rubbed resident's shoulder. The dietary staff returned to plating food items and holding the meat while cutting without having changed gloves or performing hand hygiene. Dietary staff continued serving multiple residents using same technique. .

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	135070	A. Building B. Wing	02/19/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, policy review, and staff interviews, the facility failed to ensure adherence to infection control and prevention practices to provide a safe and sanitary environment when staff did not remove dirty gloves, perform hand hygiene, and redon gloves before continuing to serve residents food. This deficient practice had the potential to contaminate served food items and make residents ill. Findings include:The facility Hand Washing policy, undated, documented dietary staff will wash hands before starting work.and at other times hands have been soiled.Based on staff interview and record review, it was determined the facility failed to ensure current infection control standards of practice were implemented by conducting at least an annual review of ICPC policies and procedures. This placed all residents at risk for contamination or infections. Findings include:On 2/18/26 at 3:16 PM during IP interview ICPC policies observed with no review or revision date. The facility could not provide documentation indicating ICPC policies had been reviewed annually. On 2/18/26 at 3:18 PM, the IP stated the IPCP policies had not been reviewed or revised annually and should have been. The IP stated she did not know how many but there were a lot of them. On 2/19/26 at 11:06 AM, the DNS stated the IPCP policies had not been reviewed annually and should have been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135070	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Lake Memorial Skilled Nursing Facility	164 South Fifth Street Montpelier, ID 83254

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to provide a safe and functional environment. This was true for 1 of 2 medication carts whose sharps containers were overfilled. This failure had the potential for injury and infections. Findings include:On 2/17/26 at 11:02 AM and 2/18/26 at 9:40 AM, observed on the South Hall medication cart, the sharps container filled past the full line and the flip top not freely movable.On 2/18/26 at 9:45 AM, LPN #2 stated the sharps container should have been changed when it was full and had not been.On 2/18/26 at 1:08 PM, the Administrator stated the sharps containers should have been changed when full and had not been.