| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135084 | A. Building<br>B. Wing | 12/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Oak Creek Rehabilitation Center of Kimberly | 500 Polk Street East<br>Kimberly, ID 83341 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>Based on observation, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with a clean, safe, homelike environment. This was true for all 33 residents who resided in the facility whose equipment and environment were observed. This deficient practice created the potential for harm if: a) residents were embarrassed by and/or felt the disrepair in the facility was unacceptable, disrespectful, undignified, or b) residents were injured due to unsafe areas in the facility. Findings include: The facility's Preventive Maintenance Program policy, revision date December 2025, documented preventive maintenance schedule included daily tasks of: inspecting halls, exits, lighting . On 12/1/25 at 12:00 PM, observed during dining room inspection, directly over tables where residents were eating, was 2 fluorescent lights with large cracks and broken light covers with dead insects on the inside of the light covers.On 12/3/25 at 2:50 PM, the administrator and maintenance director verified the lights needed cleaned and fixed and said they would make sure it got done. |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>Based on observation, interviews and record review, the facility failed to ensure adherence to infection control and prevention practices to provide a safe and sanitary environment when staff did not offer or encourage residents hand hygiene prior to meals, replace resident's soiled equipment, and implement water management control and monitoring measures. This was true for the facility and 1 of 3 residents (Resident #7). These failures placed residents at risk for cross-contamination and infection. Findings include: A. The following was observed during resident meal service in the dining room. 1.On 12/1/25 at 12:40 PM, the lunch meal was served to residents in the dining room. No hand hygiene was offered to the residents prior to eating their food. On 12/1/25 at 1:20 PM, LPN #1 stated residents are usually offered hand hygiene prior to eating but the facility had run out of the hand wipes and no hand hygiene was provided today. 2. On 12/1/25 at 12:40 PM, observed staff picking up the residents' knife utensil to pry the meal plate of food out of the warmer tray and replace the knife on the table for the resident to use during the meal. On 12/1/25 at 1:10 PM, NA #1 stated the plates are hard to get out of the warmer tray, so staff use the knife to pry out the plate and serve to the residents. On 12/3/25 at 10:00 AM, the RNC stated residents should be offered hand hygiene prior to meals and had not been and staff should not be using residents' utensils to remove plates from the warmer trays. B. The following was observed in Resident #7's room. On 12/1/25 at 10:54 AM, observed Resident #7's oxygen tubing and mask on the floor next to her bed. On 12/1/25 at 10:55 AM, LPN #1 stated Resident #7 should be wearing her oxygen mask and went to the resident's bedside and picked up the oxygen mask off the floor and placed it on Resident's #7's face. On 12/3/25 at 10:02 AM, the DON stated the oxygen tubing and mask should have been discarded and replaced and had not been. C. The following was observed during the Infection Control interview and record review. On 12/3/25 at 2:25 PM, the Maintenance Supervisor stated the facility did not have an active water management program in place and the Water Management Plan had not been updated. The Maintenance Supervisor presented a document titled; Water Management Team, not dated and mark throughs on several pages, to the surveyor and stated the prior Infection Preventionist had this document and this is what would have been used. The document contained a table with ?Control' and ?Monitoring' tasks. On 12/4/25 at 3:45 PM, the surveyor requested the water management weekly logs as referenced in the ?Control' and ?Monitoring' portion of the document and the facility could not provide documentation of control measures and monitoring measures for the water management program. On 12/4/25 at 4:10 PM, the RNC stated the Water Management Plan should have been updated and had not been. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, the State Survey Agency's Long-Term Care Reporting Portal, and staff interviews, it was determined the facility failed to ensure residents' rights were protected to be free from abuse. This was true for 1 of 3 residents (Resident #4) reviewed for abuse. This failure placed all residents at risk of ongoing abuse, potential physical, and psychosocial harm. Findings include: Resident #4 was initially admitted to the facility on [DATE] with readmission on [DATE], with multiple diagnoses including, hemiplegia (paralysis of one side of the body) and depression. A facility reported incident investigation, initiated 4/27/25 at 11:00 AM, documented CNA #3 heard CNA #2 verbally abuse Resident #4. CNA #3 immediately reported the incident to the Charge Nurse. The DON was notified, and CNA #2 was suspended pending an investigation. On 12/4/25 at 12:02 PM, during record review the facility grievances dated 5/28/25 to 9/27/25 revealed no abuse/neglect issues. On 12/4/25 at 12:32 PM, Resident Council Minutes dated June 2025 to November 2025 were reviewed. One abuse concern in June 2025 was documented with follow up by the facility administration. No other documented abuse/neglect issues. On 12/4/25 at 12:45 PM, the facility timecards for 4/1/25 to 12/4/25 were reviewed and confirmed CNA #2's last worked shift was 4/27/25 from 6:00 AM to 1:45 PM. The facility took the following actions: -Resident #4 was interviewed about his care. -Staff interviews were conducted and confirmed CNA #2 had made verbally abusive statements to Resident #4.- Terminated CNA #2 from employment on 5/1/25, and submitted findings to the State's Long-Term Care Reporting Portal.- Confirmed all employees received abuse/neglect training. Scheduled additional refresher course for all staff to take place on 5/13/25.- Behavior Care Training for all facility staff conducted on 6/3/25.These findings represent past non-compliance with this regulatory requirement. There was sufficient evidence the facility corrected the non-compliance as of 6/3/25, and there have been no further occurrences reported. At the time of this survey the facility was in substantial compliance and therefore does not require a plan of correction. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, policy review, and record review, the facility failed to ensure a copy of the residents' discharge or transfer notices were sent to the Office of the State Long Term Care (LTC) Ombudsman. This was true for 1 of 1 Residents (Resident #2) reviewed for Ombudsman notification. This failed practice had the potential to affect all residents by; 1) denying residents the added protection from being inappropriately discharged ; 2) providing the residents with access to an advocate who can inform them of their options and rights; and 3) ensuring the Office of the State LTC Ombudsman was aware of facility practices and activities related to transfers and discharges. Findings include:Review of the facility's Discharge and Transfer policy, revision date 4/17/2025, documented a copy of the notice [of discharge] is sent to the Office of the State Long-Term Care (LTC) Ombudsman after discharge.Appendix PP states the following:S483.15(c)(3) Notice of Transfer or Discharge and Ombudsman NotificationWhen a facility transfers or discharges a resident . the facility must provide notice of discharge to the resident and resident representative along with a copy of the notice to the Office of the State LTC Ombudsman at least 30 days prior to the discharge or as soon as possible. The copy of the notice to the ombudsman must be sent at the same time notice is provided to the resident and resident representative .The facility must maintain evidence that the notice was sent to the Ombudsman.Resident #2 was admitted to the facility on [DATE], with multiple diagnoses including atrial fibrillation (irregular heart rhythm) and urinary tract infection.On 12/3/25 at 4:07 PM, during record review Resident #2's medical record contained a physician order dated 11/28/25 for a planned discharge from the facility to home with home health services and continued physical therapy and occupational therapy. Resident #2's record included a nursing progress note dated 11/28/25, related to Resident #2's discharge to home. On 12/4/25 at 11:18 AM, the CRN stated the facility could not provide documentation indicating Resident #2's Notice of Discharge had been sent to the State LTC Ombudsman and should have been. On 12/4/25 at 11:20 AM, the Administrator presented the surveyor with 3 email notifications to the Ombudsman dated March 2025, May 2025, and July 2025, and stated there were no other documented notices to the State LTC Ombudsman. |

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| F 0646<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Notify the appropriate authorities when residents with MD or ID services has a significant change in condition.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the State Operations Manual - Appendix PP, facility policy, record review, and staff interview, it was determined the facility failed to make a referral to the state mental health authority for a possible new PASRR level II evaluation when residents were diagnosed with a new serious mental disorder. This was true for 1 of 1 resident (Resident #6), whose PASRR records were reviewed. This deficient practice had the potential for negative outcomes if the resident was not assessed, treated, and monitored appropriately. Findings include:The facility's Resident Assessments PASRR Screening Coordination policy, dated April 2025, documented:- The facility would notify the state designated agency when a resident with a mental disorder experiences a significant change in status.- Refer to the appropriate state designated authority any resident with newly evident or possible serious mental disorder, intellectual disability, or related condition.Resident #6 was initially admitted to the facility on [DATE], with multiple diagnoses including epilepsy (a brain disorder causing unprovoked seizures), anxiety disorder, and bipolar disorder (a mental health condition causing extreme mood swings).Resident #6's medical record documented a PASRR level II evaluation, dated 9/30/10, from the state of Nevada.Resident #6's PASRR level II documented she had a diagnosis of bipolar disorder, mild mental retardation, epilepsy, and hyperglycemia.Resident #6's medical history and physical notes dated 5/18/15, documented she had a history of asthma, schizophrenia (a severe mental disorder which may have features of paranoia, delusions, or hallucinations), and seizures.Resident #6's Schizophrenia Diagnosis Accuracy Verification Worksheet, dated 2/13/23, documented a diagnosis of paranoid schizophrenia.Resident #6's care plan problem, date initiated 1/28/19, documented she is being treated with psycho active medication for a diagnosis of paranoid schizophrenia and epilepsy.Resident #6's medical record did not document a level II evaluation to include her diagnosis of paranoid schizophrenia.On 12/3/25 at 2:50 PM, the administrator and regional nurse consultant stated the facility had not notified the state mental health authority requesting an updated PASRR level II evaluation when Resident #6 was diagnosed with paranoid schizophrenia, and they should have. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to follow physician orders of delivering specific medications when residents did not have BM within 72 hours for 2 of 8 residents (#5 and #21) whose 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:A. Resident #5 was admitted to the facility initially on 5/5/22 with readmission on [DATE], with multiple diagnoses including depression and anxiety.Resident #5's physician orders for bowel care management were documented as: Day 3 no BM: Administer Miralax 17 grams PO in fluid of choice during medication pass as needed for constipation. Start date 7/8/25 Day 4 no BM: if no BM by 4am, give Dulcolax suppository, as needed for constipation. Start date 7/8/25 Day 5 no BM: If no BM by 2 pm, notify provider for additional instruction. Start date 7/8/25 Resident #5 had a documented bowel movement on 11/4/25 at 1:28 AM and not again until 11/10/25 at 12:17 AM, over 142 hours with no documented bowel movement.No documentation of Resident #5 receiving the physician ordered medications for constipation management on day 4. No notification to provider on day 5 as ordered, if resident had not had a BM. On 12/5/25 at 10:25 AM, the DON stated the nurse had not documented bowel medication interventions on the medication administration record as ordered by the provider for Resident #5 and should have. B. Resident #21 was admitted to the facility on [DATE], with multiple diagnoses including hemiplegia (paralysis on one side of the body) and respiratory failure. Resident #21's physician orders for bowel care management were documented as: Day 3 no BM: Administer Miralax 17 grams PO in fluid of choice during medication pass as needed for constipation. Start date 7/7/25 Day 4 no BM: if no BM by 4am, give Dulcolax suppository, as needed for constipation. Start date 7/7/25 Day 5 no BM no BM: If no BM by 2 pm, notify provider for additional instruction. Start date 7/7/25 Resident #21 had a documented bowel movement on 11/5/25 at 2:49 PM and not again until 11/12/25 at 5:59 PM, over 168 hours with no documented bowel movement.No documentation of Resident #21 receiving the physician ordered medications for constipation management during 11/5/25 to 11/12/25. Resident #21 had a documented bowel movement on 11/12/25 at 2:49 PM and not again until 11/24/25 at 4:27 PM, over 264 hours with no documented bowel movement.No documentation of Resident #21 receiving the physician ordered medications for constipation management during 11/12/25 to 11/24/25. On 12/5/25 at 10:25 AM, the DON stated the nurse had not documented bowel medication interventions on the medication administration record as ordered by the provider for Resident #21 and should have. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure resident received oxygen as prescribed by the provider. This was true for 1 of 3 residents (Resident #7) reviewed for respiratory care. This failure created the potential for respiratory difficulties or impaired breathing. Findings include: Resident #7 was initially admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including respiratory failure and depression. Resident #7's medical record included physician orders for oxygen 2 liters per minute via nasal cannula at HS and PRN. Notify provider if O2 sat% < 90%. Order start date of 1/18/25. On 12/1/25 at 10:50 AM, observed Resident #7 sitting in bed with oxygen administered at 4L/min via mask. On 12/1/25 at 10:55 AM, LPN #1 stated she was unsure of Resident #7's ordered oxygen rate but knew resident was to have oxygen on while in bed and at night. On 12/2/25 at 1:10 PM, observed Resident #7 sitting in bed with oxygen at 3L/min via mask. On 12/2/25 at 1:14 PM, CNA #1 stated she was unsure what Resident #7's oxygen ordered rate was but knew Resident #7 was to receive oxygen while in bed. On 12/2/25 at 1:25 PM, the RNC stated Resident #7's oxygen rate should have been at 2L/min via nasal cannula as ordered and had not been. |

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| F 0728<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.<br><br>Based on review of the State Operations Manual, Appendix PP, staffing schedules, and staff interviews, it was determined the facility failed to a) ensure full-time nurse aides working less than 4 months are enrolled in a State approved nurse aide training and competency evaluation program (NATCEP) and b) ensure full-time nurse aides working in the facility more than 4 months have successfully completed a NATCEP. This was true for 10 of 13 nurse aides whose personnel files were reviewed. This failure had the potential to result in negative outcomes for the 33 residents living in the facility. Findings include:On 12/5/25,13 Nurse Aide (NAs) files were reviewed with the following results:- NA #1 was hired on 1/6/25. Has not successfully completed a NATCEP.- NA #2 was hired on 1/10/25. Has not successfully completed a NATCEP.- NA #3 was hired on 6/18/25. Has not successfully completed a NATCEP.- NA #4 was hired on 9/30/25. Has not enrolled in a NATCEP.- NA #5 was hired on 10/1/25. Has not enrolled in a NATCEP. - NA #6 was hired on 10/13/25. Has not enrolled in a NATCEP. - NA #7 was hired on 10/21/25. Has not enrolled in a NATCEP. - NA #8 was hired on 11/11/25. Has not enrolled in a NATCEP. - NA #9 was hired on 11/11/25. Has not enrolled in a NATCEP. - NA #10 was hired on 11/13/25. Has not enrolled in a NATCEP. On 12/5/25 at 11:29 AM, the RNC stated NA #1, NA #2, and NA #3, had not completed the NATCEP course and NA #4, NA #5, NA #6, NA #7, NA #8, NA #9, and NA #10 had not enrolled in a NATCEP yet. |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Post nurse staffing information every day.<br><br>Based on review of the State Operations Manual, Appendix PP, observation, and staff interview, it was determined the facility failed to ensure the daily nurse staffing information was accurately posted for each shift. 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 current staffing levels. Findings include:On 12/3/25, the daily postings of licensed and unlicensed nurse staffing were reviewed between 4/1/25 - 11/30/25. There were no adjustments to the posted staffing when the scheduled hours did not match the actual hours worked.On 12/3/25 at 9:45 AM, the RNC and DON stated the facility does not make adjustments to the daily postings with actual hours worked, they only adjust the time on the daily assignment sheets. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>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 in the facility. Findings include:On 12/1/25 at 10:45 AM, during the 100 & 200 Hall medication cart audit, observed the narcotic accountability sheets, dated 11/5/25 to 12/1/25, with 2 licensed nurse signatures not documented on 11/25/25 and 11/26/25. On 12/1/25 at 10:47 AM, LPN #3 stated two nurses should have signed the narcotic accountability sheet when they accepted the medication cart or released the medication cart. On 12/3/25 at 9:40 AM, during the Dining room & 300 Hall medication cart audit, observed the narcotic accountability sheets, dated 11/26/25 to 12/3/25, with 1 licensed nurse signature not documented on 12/2/25. On 12/3/25 at 9:42 AM, LPN #2 stated the two nurses should have signed the narcotic accountability sheet when they accepted the medication cart or released the medication cart. On 12/3/25 at 10:05 AM, the DON stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**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 residents were free from significant medication errors when 1 of 2 residents (Resident #6) did not receive her Invega injection (antipsychotic medication) as ordered by the physician. This failure had the potential to cause harm if the resident's psychiatric behaviors increased due to not receiving her medications timely. Findings include:Resident #6 was initially admitted to the facility on [DATE], with multiple diagnoses including epilepsy (a brain disorder causing unprovoked seizures), anxiety disorder, and bipolar disorder (a mental health condition causing extreme mood swings). Schizophrenia was added to her diagnosis on 5/18/15.Resident #6's physician order start date 2/24/24, documented the following: Invega Sustenna Intramuscular Suspension Prefilled Syringe 234 MG/1.5ML (Paliperidone Palmitate) Inject 1 dose intramuscularly one time a day every 28 day(s) for paranoid schizophrenia.On 10/4/25, Resident #6's Medication Administration Record (MAR) documented see progress notes.On 10/4/25, Resident #6's order administration notes documented Invega sustenna IM not available at this time. Nurse called pharmacy, and it will be delivered by tonight.On 10/5/25, Resident #6's nurse's note documented she received the Invega sustenna injection but was not documented on the MAR.On 11/1/25, Resident #6's MAR documented see progress notes.On 11/1/25, Resident #6's order administration notes documented not available at facility. Nurse call pharmacy to order Invega IM, not received.On 11/3/25, Resident #6's MAR documented on she received her Invega injection (29 days after previous injection).On 12/1/25, Resident #6's MAR documented on see progress notes.On 12/1/25, Resident #6's order administration notes documented do not have the shot. Will have day shift call the pharmacy.On 12/2/25, Resident #6's nurse notes documented the Invega shot did not come tonight as well from pharmacy. Day shift nurse said she did not call on it today. I will again ask the day shift nurse to follow up on this so we can get her the shot as soon as possible.On 12/3/25 at 6:51 AM, Resident #6's medical record documented the Invega injection has not arrived from pharmacy. The pharmacy was contacted and stated there are no refills left on the prescription. Provider was notified to request updated prescription and late administration.On 12/3/25, Resident #6's MAR documented the Invega injection arrived and was administered (30 days after previous injection).On 12/3/25 at 9:45 AM, the RNC and DON stated the nurse should have documented on the MAR when the Invega injection was given on 10/5/25. The RNC verified Resident #6 received her Invega injections late in November and December due to the pharmacy not sending them to the facility. She also stated the physician should have been notified of the medications not being given on time and was not until she notified him. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135084 | A. Building<br>B. Wing | 12/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Oak Creek Rehabilitation Center of Kimberly | 500 Polk Street East<br>Kimberly, ID 83341 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observations, record review and staff interviews it was determined the facility failed to ensure medications were properly stored, not expired, and biologicals were labeled when opened. This was true for the facility. This failure created the potential for residents to receive expired medications with decreased efficacy, use of expired biologicals, and the potential for theft and/or diversion. Findings include: The EvenCare ProView users Guide documented the testing solutions should be dated when bottle opened and discarded after 3 months of use or at time of printed expiration date. The State Operations Manual, Appendix PP, updated 8/8/24, Schedule II-V medications must be maintained in separately locked, permanently affixed compartments.A.The following was observed during the medication cart audits. On 12/3/25 at 10:52 AM, the dining room/300 Hall medication cart was audited with LPN #2 present. Observed the following: - one bottle of Vitamin D with an expiration date of 3/20/25- one bottle of Aspirin 81mg containing round yellow tablets and round orange tablets On 12/3/25 at 10:53 AM, LPN #2 stated, two bottles of aspirin had been combined and should not have been. On 12/4/25 at 9:15 AM, the RNC stated the expired medications should have been removed from the medication cart and had not been. B. The following was observed for biologicals.On 12/4/25 at 9:10 AM, observed one set of glucose test solutions (Lot #4ARZA14 / #4AR3A12) with no opened date. LPN #3 stated the test solutions should have been dated when opened and had not been. On 12/4/25 at 9:13 AM, observed LPN #3 date each test solution with 12/4/25 after surveyor had inquired about dating the bottle after opening. On 12/4/25 at 915 AM, observed Testing Logs dated from 5/11/25 to 11/30/25, with documentation of glucose testing solutions (Lot #4ARZA14 / #4AR3A12) had been opened on 7/5/25 and continued to be used through 11/30/25 for weekly glucometer machine testing.On 12/4/25 at 9:45 AM, the DON stated the glucose test solutions should have been removed from the cart and had not been. C. The following was observed for controlled medications. On 12/4/25 at 8:52 AM, observed in the 300 Hall medication refrigerator 2 bottles of lorazepam concentrated solution (Schedule IV controlled medication) stored in a removable metal black box on the medication refrigerator shelf. On 12/4/25 at 9:00 AM, the RNC stated the controlled medications should have been in an affixed box in the medication refrigerator and were not. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and review of the Idaho Food Code, the facility failed to ensure food was appropriately stored, distributed, and labeled. 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, 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 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.<br><br>On 12/1/25 at 10:10 AM, during the initial observation of the kitchen, the following was observed with cook #1 present.<br><br>Reach-in refrigerator:<br><br>- uncovered, undated container of shaved parmesan cheese.<br><br>- open bag of shredded cheddar cheese with no opened or use by date.<br><br>- open bag of Swiss cheese with no opened or use by date.<br><br>- a can of dairy whipped topping with no cap and no open or use by date.<br><br>Storage room:<br><br>- an open bag of hotdog buns with no open or use by date.<br><br>- an open bag of hamburger buns with no open or use by date.<br><br>On 12/1/25 at 10:30 AM, the cook removed the uncovered and the undated items and stated the items should have been covered and dated but were not.<br><br>On 12/4/25 at 8:25 AM, during a second observation of the kitchen the following was observed with the FSM present:<br><br>Reach-in refrigerator:<br><br>- Cooked shredded turkey in Ziplock bag dated 11/26/25 and a use by date of 2/1/26. The FSM stated the turkey should have been discarded after the use by date, but was not.<br><br>- A container with approximately 10 egg salad half sandwiches in a Ziplock bags with smeared, unreadable writing on the bags. The FSM stated the sandwiches were made that morning, but the dates were not readable and should have been.<br><br>- A pan of pureed corn covered in plastic wrap with must use tonight written on it. It did not have a<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | date made or use by date. The FSM stated the pureed corn was made the day before and should have been used the day it was made.<br><br>- A carton of potato salad with an expiration date of 12/2/25. FSM removed from refrigerator and stated it should have been discarded.<br><br>- A container of yogurt with an expiration by date of 10/20/25. FSM removed from refrigerator and stated it should have been discarded.<br><br>In storage room:<br><br>- A chest freezer had an open bag of corn inside an open box. Corn was not sealed and had no open or use by dates. The FSM removed the corn from the freezer and stated it should have been put into a sealed container and dated but was not.<br><br>Dish room:<br><br>- The dish machine log was filled out 2 days in advance with wash temperatures, the rinse temperatures, and the PPM.<br><br>On 5/4/25 at 8:40 AM, the FSM stated the dish machine log should not have been filled out in advance and had been.<br><br>The facility's Foods Brought by Family/Visitors/Personal Refrigerators policy dated, Revised May 2024, documented For perishable foods, containers will be labeled with the resident's name, and the use by date.The nursing staff will discard perishable foods on or before the use by date.<br><br>On 12/4/25 at 11:40 AM, observed in the resident refrigerator:<br><br>- - One 2-pack Jello pudding cups with an expiration date of 11/6/25<br><br>- - One 4-pack Jello pudding cups with an expiration date of 11/22/25On 12/4/25 at 11:45 AM, LPN #2 stated the pudding cups should have been discarded and had not been. On 12/4/25 at 11:47 AM, observed the resident refrigerator with dark brown dried material, approximately 12 inches in length, on floor of refrigerator under crisper drawers, each refrigerator shelf front had dark brown splattered spills, and shelves with dried dark material.<br><br>On 12/4/25 at 12:29 AM, LPN #2 stated the refrigerator should have been cleaned and had not been. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>Based on observation, interview and record review the facility failed to provide a safe, clean and comfortable environment for residents in 2 of 2 shower rooms (200 hall and 300 hall). This failure had the potential to put residents at risk for a diminished quality of life. Findings included:On 12/3/25 at 1:17 PM, observed the shower room on the 200 hall, the following was noted: 10-inch x 5-inch x1.25-inch jagged shaped hole in floor by shower stall with the area of the flooring peeling off the surface of the floor and not cleanable. 4 holes in middle of shower room floor; 3 of the holes measured 2-inch circle, and 1 hole measured 4-inch jagged circular shape with each of the four areas of the flooring peeling off the surface of the floor and not cleanable. The floor had soiled and darkened matter in the gaps and crevices. On 12/3/25 at 1:37 PM, observed the shower room on the 300 hall, the following was noted: The left shower stall was filled with equipment; lift, large bucket, and chair. A 16-inch x7-inch x 2-inch jagged hole in flooring by entry of the left shower stall with the area of the flooring peeling off of the surface of the floor and not cleanable. The deepest portion of the open area filled with dark looking matter. A 12-inch x 2 inch ?T' shaped hole in the floor near base of the right shower stall with the flooring peeling off of the surface of the floor and not cleanable. The deepest portion of the open area filled with dark looking matter. The right shower stall circular drain had soft brown stool looking material caught in 3 of the drain screen holes The large, jetted tub had a side panel removed and was not functioning A salon chair and workstation placed at the end of the shower room On 12/3/25 at 1:47 PM, the Maintenance Supervisor acknowledged the shower rooms on the 200 and 300 halls needed repairs and a work plan had been submitted but not yet approved for the needed repairs. On 12/3/25 at 1:57 PM, the DON stated the shower rooms on the 200 and 300 halls needed to be cleaned and repaired. |