| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135091 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Idaho Falls | 2725 East 17th Street<br>Idaho Falls, ID 83406 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0578<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121<br><br>Based on policy review, record review, and staff interview, it was determined the facility failed to honor residents' Do Not Resuscitate (DNR) and Do Not Intubate (DNI) orders, and to ensure residents and their representatives received assistance to exercise their right to formulate an advanced directive. This was true for 1 of 18 residents (#24) whose records were reviewed for advanced directives. This deficient practice caused actual harm with the potential for more than minimal harm or adverse outcomes if residents' wishes were not followed or documented. Findings include:<br><br>The facility's Cardiopulmonary Resuscitation (CPR) policy, dated [DATE], documented the facility should ensure resident preferences and physician orders related to CPR and other advance directive issues are communicated so that staff know immediately what action to take or not take when an emergency arises.<br><br>1. Resident #24 was admitted to the facility on [DATE], and readmitted [DATE], with multiple diagnoses including C2 level cervical spinal cord lesion (damage to the spinal cord at the level of the second cervical vertebra) and chronic kidney disease.<br><br>Resident #24 nursing note dated [DATE] at 12:05 (late entry), documented nursing staff were assessing Resident #24 for possible choking issue when she was found in her room with agonal respirations. The DON and MD assisted Resident #24 to the floor to continue assessment and initially found but quickly lost her pulse and she was not breathing.<br><br>On [DATE] at 8:45 AM, the facility called a code blue (a medical emergency code that indicates a patient needs immediate medical attention or resuscitation) for Resident #24. Facility staff connected Resident #24 up to an automated external defibrillator (AED) which indicated no shockable rhythm. Facility staff then continued CPR on Resident #24 for 13 minutes until EMS arrived. EMS took over CPR and intubated Resident #24. At no time did any facility staff member check Resident #24 medical record to confirm her code status.<br><br>Resident #24's medical record contained a Physician Orders for Scope of Treatment (POST) in her medical record documenting she was a DNR and DNI.<br><br>Resident #24's care plan, dated [DATE], documented she requested DNR status.<br><br>(continued on next page) |

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: 135091 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/10/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Life Care Center of Idaho Falls | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2725 East 17th Street Idaho Falls, ID 83406 | |

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 0578<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On [DATE] at 8:53 AM, the surveyor reviewed Resident #24's medical record, confirmed she was a DNR, and notified the Executive Director Resident #24 was a DNR.<br><br>A hospital emergency department report, dated [DATE], documented EMS staff were not notified by facility staff of Resident #24's code status until after she was intubated and loaded into the ambulance in route to the hospital.<br><br>A hospital emergency department report, dated [DATE], documented when family arrived at the hospital, they confirmed Resident #24 was a DNR/DNI and should have been allowed to pass naturally.<br><br>A statement submitted by the Medical Director (MD), dated [DATE], documented he was not aware Resident #24's code status was a DNR/DNI until after she was transferred to the hospital.<br><br>On [DATE] at 9:30 AM, the DON stated she was not aware Resident #24's code status was a DNR/DNI until after the resident's care was turned over to EMS.<br><br>Resident #24 expired at the hospital on [DATE] at 12:06 PM. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135091 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Idaho Falls | 2725 East 17th Street<br>Idaho Falls, ID 83406 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121<br><br>Based on review of facility policy, Idaho Administrative Code, and the State Operations Manual, observation, and interviews, it was determined the facility failed to ensure residents were provided with a safe, clean, and homelike environment. This was true for 7 of 48 resident rooms and other areas throughout the facility which were observed. This deficient practice created the potential for diminished quality of life and resident safety. Findings include:<br><br>The facility's Water Temperature Inspection policy dated 1/15/24, documented satisfactory temperature range is maintained per state regulations.<br><br>Idaho Administrative Code 16.03.02 section 120.13.c, documented the temperature of hot water at plumbing fixtures used by residents is between 105 degrees F and 120 degrees F.<br><br>State Operations Manual Appendix PP pg 342, documents water temperature of 124 degrees F will cause a 3rd degree burn to occur within 3 minutes, and water temperatures of 120 degrees F will cause a 3rd degree burn to occur within 5 minutes.<br><br>The following areas were observed for safe and homelike environment:<br><br>On 1/6/25 at 9:35 AM, observed room [ROOM NUMBER]'s sink water temperature was 124 degrees F.<br><br>On 1/6/25 at 11:00 AM, with the maintenance manager, rechecked room [ROOM NUMBER]'s sink water temperature to be about 112 degrees F.<br><br>On 1/6/25 at 12:12 PM, the maintenance manager requested the surveyor recheck room [ROOM NUMBER]'s sink water temperature again and it was found to be 122 degrees F.<br><br>On 1/6/25 at 12:15 PM, the maintenance director stated all resident room sink water temperature should be maintained below 118 degrees F.<br><br>The following areas were observed for clean and homelike environment:<br><br>- On 1/6/25 at 7:26 AM, observed in room [ROOM NUMBER], the front of the drawer on the closet was missing.<br><br>- On 1/6/25 at 7:33 AM, observed in room [ROOM NUMBER]'s shower, the base had a black substance and hair on it.<br><br>- On 1/7/25 at 8:08 AM, observed in room [ROOM NUMBER], the corner of wall by the bathroom, was missing the dry wall.<br><br>- On 1/7/25 at 8:14 AM, observed in room [ROOM NUMBER]'s bathroom, the baseboard was missing from the wall.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/10/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Life Care Center of Idaho Falls | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2725 East 17th Street Idaho Falls, ID 83406 | |

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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - On 1/7/25 at 11:15 AM, observed in room [ROOM NUMBER], multiple light brown splattering on the ceiling, at the room entrance, by the sink.<br><br>- On 1/8/25 at 11:32 AM, observed in the kitchen, dust on the ceiling above the oven and serving table. Also observed the vent by the back door of the kitchen, a gray substance on the vent slats.<br><br>On 1/8/25 at 11:40 AM, the dietary manager stated the ceiling and vents should have been cleaned.<br><br>On 1/8/25 at 1:04 PM, the Maintenance Director stated the staff are to put items that need to be repaired in TELS (electronic maintenance management system), and he should fix the issues as soon as it is received on his phone.<br><br>- On 1/10/25 at 7:23 AM, the light at the end of 200 hall was observed with a gray, fuzzy substance hanging from the light fixture.<br><br>- On 1/10/25 at 7:27 AM, observed on Hall 400, the vent and ceiling tiles around vent had a gray fuzzy substance on them.<br><br>- On 1/10/25 at 7:28 AM, observed on Hall 400, the light outside the activity room had a gray fuzzy substance hanging from the light fixture.<br><br>- On 1/10/25 at 7:29 AM, the activity room vent was observed with a layer of a black substance. The hooks in the ceiling had a gray, fuzzy substance hanging from them.<br><br>On 1/10/25 at 7:40 AM, the Administrator stated the ceiling and vents should have been cleaned.<br><br>49552 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/10/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Idaho Falls | 2725 East 17th Street Idaho Falls, ID 83406 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983<br><br>Based on review of the Resident Assessment Instrument (RAI) Manual, record review, and staff interview, it was determined the facility failed to ensure residents' Minimum Data Set (MDS) Assessments included correct assessment information. This was true for 8 of 18 Residents (#4, #6, #12, #29, #40, #54, #58, and #65) whose records were reviewed for accuracy. This deficient practice had the potential for negative outcomes if residents were not assessed and/or monitored due to inaccurate assessments. Findings include:<br><br>The Resident Assessment Instrument (RAI), revised 10/1/2024, documents section K0520 Nutritional Approaches, was to be checked if a resident receives nutrition from a feeding tube.<br><br>The RAI, revised 10/1/2024, documents section A1500, PASRR (Preadmission Screening and Resident Review), was to be coded yes when a PASRR Level II screening determines a resident has a serious mental illness and/or mental retardation, or related condition.<br><br>1. Resident #4 was admitted to the facility on [DATE], with a diagnosis of Cerebral Palsy (permanent, nonprogressive motor dysfunction due to abnormalities in developing the brain).<br><br>Resident #4's physician order dated 12/31/18, documents she received her nutrition through a feeding tube.<br><br>Resident #4's MDS assessment dated [DATE], documented she did not receive nutrition through a feeding tube.<br><br>On 1/7/25 at 3:41 PM, the MDS Coordinator stated resident #4's MDS assessment dated [DATE], was not coded correctly and should have been marked that she does receives her nutrition through a feeding tube.<br><br>2. Resident #6 was admitted to the facility on [DATE], with a diagnosis of schizophrenia (mental disorder involving chronic or recurrent psychosis).<br><br>Resident #6's PASRR Level II dated 5/31/16, and PASRR Level II dated 1/7/25, documented she had a diagnosis of schizophrenia (a diagnosis catagorized as a major mental illness).<br><br>Resident #6's MDS assessment section A1500, dated 10/14/24, did not document she had a major mental illness.<br><br>On 1/7/25 at 3:41 PM, the MDS Coordinator stated Resident #6's MDS assessment, dated 11/12/24, was not coded correctly and they would do a modification.<br><br>3. Resident #12 was initially admitted to the facility on the 10/14/24, with multiple diagnoses including bipolar disorder (a major mental mood disorder) and PTSD (post-traumatic stress disorder).<br><br>Resident #12's PASRR I dated 10/11/24, documented under section 2.5 A if resident has an MMI (major mental illness) a PASRR II needs to be done. Resident #12 had bipolar checked for her MMI.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/10/2025 |
| --- | --- | --- | --- |
| NAME OF PROVIDER OR SUPPLIER Life Care Center of Idaho Falls | | STREET ADDRESS, CITY, STATE, ZIP CODE 2725 East 17th Street Idaho Falls, ID 83406 | |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #12's care plan dated 10/15/24, documented she had an active diagnosis of bipolar depression.<br><br>Resident #12's Admission MDS assessment, dated 10/15/24, documented in section A, No for the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?<br><br>On 1/8/25 at 3:22 PM, the DON stated Resident #12's MDS assessment should have had Yes checked for a MMI.<br><br>4. Resident #29 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (characterized by damage to the lungs that narrows the airways and makes breathing more difficult), schizoaffective disorder (a chronic mental illness that combines symptoms of schizophrenia and a mood disorder, such as bipolar disorder or depression), and major depressive disorder with severe psychotic symptoms (a serious mental illness that involves depression and psychosis).<br><br>Resident #29's MDS assessment dated [DATE], documented under A1500 No for PASRR II however there was a PASRR II found in her medical paper chart dated 10/25/24.<br><br>On 1/9/25 at 11:10 AM, the DON stated Resident #29's MDS assessment under A1500 PASRR II should have been documented as Yes.<br><br>5. Resident #40 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including hemiplegia and hemiparesis (both conditions that cause weakness or paralysis on one side of the body), dementia with psychotic disturbance/agitation, and depression.<br><br>Resident #40's MDS assessment, dated 8/13/24, documented resident did not have a catheter in place.<br><br>Resident #40's MDS assessment, dated 11/12/24, documented resident had a catheter in place.<br><br>On 1/7/25 at 1:39 PM, Resident #40 confirmed she did not have a catheter in place.<br><br>On 1/7/25 at 3:42 PM, the MDS coordinator confirmed Resident #40 did not have a catheter in place and the MDS assessment was coded in error.<br><br>6. Resident #54 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease, anxiety disorder, and opioid abuse.<br><br>On 1/8/25, Resident #54's MDS assessment dated [DATE], documented under A1500 No for PASRR II however there was a PASRR II found in her medical paper chart dated 12/27/24.<br><br>On 1/9/25 at 11:12 AM, the DON stated Resident #54's MDS assessment under A1500 PASRR II should have been documented as Yes.<br><br>7. Resident #58 was admitted to the facility on [DATE], with a diagnosis of bipolar disease (a severe mental illness causing mania or depression).<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/10/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Idaho Falls | 2725 East 17th Street<br>Idaho Falls, ID 83406 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #58's PASRR Level II, dated 7/31/24, documented he had a diagnosis of bipolar disease.<br><br>Resident #58's MDS assessment section A1500, dated 8/5/24, did not document he had a serious mental illness.<br><br>On 1/7/25 at 3:41 PM, the MDS Coordinator stated Resident #58's MDS assessment, dated 8/5/24, was not coded correctly.<br><br>8. Resident #65 was admitted to the facility on [DATE], with multiple diagnoses including dysphagia (difficulty swallowing) and emphysema (chronic lung condition).<br><br>Resident #65's physician's order, dated 12/13/24, documented his Dobhoff (small flexible nasogastric tube used to deliver nutrition to the stomach) was for enteral feedings only. No medications.<br><br>Resident #65's Admission/Medicare - 5 Day/MDS assessment, dated 12/17/2024, documented, YES under section K0520 for Nutritional Approaches: A. Parenteral/IV feeding. Under B. NO was documented for Feeding tube (e.g., nasogastric, or abdominal tube (PEG).<br><br>On 1/9/25 at 3:05 PM, the MDS coordinator stated Resident #65's MDS assessment should have been marked as B for his Dobhoff.<br><br>49552<br><br>51121 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/10/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Life Care Center of Idaho Falls | | STREET ADDRESS, CITY, STATE, ZIP CODE 2725 East 17th Street Idaho Falls, ID 83406 | |

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 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552<br><br>Based on policy review, record review, and staff interview, it was determined the facility failed to refer residents for further evaluation when residents were diagnosed with a major mental illness. This was true for 4 of 7 residents (#12, #51, #60, and #219) reviewed for Pre-Admission Screening and Resident Review (PASARR) level II evaluations. This deficient practice had the potential to cause harm if resident's specialized services for mental health needs were not evaluated by an appropriate state-designated authority. Finding include:<br><br>The facility's Pre-admission Screening and Resident Review (PASARR) policy revision date 9/26/24, documented a positive Level I screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as PASARR Level II, which must be conducted prior to admission to a nursing facility.<br><br>1. Resident #12 was initially admitted to the facility on the 10/14/24, and readmitted to the facility on [DATE], with multiple diagnoses including bipolar disorder (a major mental mood disorder) and post-traumatic stress disorder (a major mental illness).<br><br>Resident #12's PASARR I dated 10/11/24, documented under section 2.5 A if resident has an MMI (major mental issue) a PASARR II needs to be completed. Resident #12 had Bipolar checked for her MMI.<br><br>Resident #12's medical record did not document a PASARR II had been done.<br><br>On 1/8/25 at 3:22 PM, the DON stated Resident #12 should have had a correct PASARR I which would have triggered a PASARR II to be done.<br><br>2. Resident #51 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and post-traumatic stress disorder (a major mental illness).<br><br>Resident #51's medical record documented on 11/21/24, she had received a new diagnosis of borderline personality disorder (a major mental illness).<br><br>Resident #51's medical record did not document a PASARR Level 2 evaluation had been completed.<br><br>On 1/8/25 at 4:34 PM, the DON stated Resident #51 should have had a PASARR Level II completed on admission and a PASARR Level II completed with her new diagnosis.<br><br>3. Resident #60 was admitted to the facility on [DATE] with a diagnosis of Myasthenia Gravis, anxiety, and PTSD (Post PTSD (Post Traumatic Stress Disorder).<br><br>The States Operations Manual Appendix PP documented if a resident remains in the facility longer than 30 days, the facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID or a related condition to the appropriate state-designated authority for Level II PASRR evaluation and determination.<br><br>Resident #60's PASRR Level I dated 8/23/24, did not document a diagnosis of anxiety or PTSD.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/10/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Life Care Center of Idaho Falls | | STREET ADDRESS, CITY, STATE, ZIP CODE 2725 East 17th Street Idaho Falls, ID 83406 | |

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 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #60's PASRR Level I dated, 8/23/24, documented:<br><br>- Medical diagnosis only-no psychiatric, intellectual disability, or related condition diagnosis.<br><br>- Prior to admission the attending physician certified in writing resident will be admitted for 30 days or less following a medical hospitalization .<br><br>Resident #60's length of stay had exceeded 30 days therefore the facility was required to initiate a new Level I PASARR screening and refer to the state-designated authority for a Level II evaluation.<br><br>On 1/10/25 at 1:04 PM, the Admissions Director stated the facility did not have a Level II PASARR for Resident #60 but he was in the process of getting one completed.<br><br>4. Resident #219 was admitted to the facility on [DATE], with multiple diagnoses including acute and chronic respiratory failure with hypoxia (a medical condition where the body is unable to adequately exchange oxygen in the lungs, leading to a deficiency of oxygen in the blood (hypoxia), which can occur suddenly (acute) or develop over a long period of time (chronic) due to various underlying lung diseases) and schizoaffective disorder, bipolar type (people with this condition experience manic episodes, which are periods of extreme energy, irritability, and sometimes depression).<br><br>Resident #219's medical record had a hospital partially completed PASARR I that identified a Major Mental Illness (MMI) that should have triggered a PASARR II if completed correctly.<br><br>On 1/8/25 at 2:41 PM, the MDS coordinator confirmed Resident #219's PASARR I was not completed properly and should have been submitted to the state for review.<br><br>On 1/9/25 at 11:14 AM, the DON stated Resident #219's PASARR I should have been submitted to the state for review but was not.<br><br>50983<br><br>51121 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135091 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Idaho Falls | 2725 East 17th Street<br>Idaho Falls, ID 83406 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121<br><br>Based on observation, interview, and record review, the facility failed to follow a resident's comprehensive person-centered care plan. This deficient practice had the potential to affect 1 of 18 resident's (Resident #41) health and wellbeing. Findings include:<br><br>Resident #41 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including hemiplegia, hemiparesis, and seizures.<br><br>Resident #41's care plan dated 11/27/24, documented under Bed Mobility: Dependent, Resident #41's bones are fragile, use 2 staff members.<br><br>Resident #41's medical chart listed under tasks, ADL - bed mobility, the following dates documented that one CNA or NA assisted Resident #41 with mobility in her bed;<br><br>- 12/27/24 at 6:25 PM, CNA #1<br><br>- 12/28/24 at 12:09 AM, CNA #2<br><br>- 12/29/24 at 6:51 PM, NA #2<br><br>- 12/30/24 at 11:47 AM, CNA #3<br><br>- 12/31/24 at 1:36 PM, NA #1 and 6:47 PM, CNA #4<br><br>- 1/2/25 at 11:43 PM, CNA#5<br><br>- 1/5/25 at 3:52 PM, CNA #6<br><br>- 1/8/25 at 4:39 PM, CNA #7<br><br>On 1/9/25 at 11:23 AM, the DON stated the CNAs and NAs should have been following Resident #41's care plan by using two staff members to help with bed mobility. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/10/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Life Care Center of Idaho Falls | | STREET ADDRESS, CITY, STATE, ZIP CODE 2725 East 17th Street Idaho Falls, ID 83406 | |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552<br><br>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure residents' care plans were revised to reflect current needs and interventions. This was true for 4 of 18 residents (#12, #23, #59, and #65) whose care plans were reviewed. This placed residents at risk of adverse outcomes if care and services were not provided due to care plans not being revised as residents' needs changed. Findings include:<br><br>The facility's Care Planning-Baseline, Comprehensive, and Routine Updates policy, revision date 11/25/24, documented the facility would monitor the individual's progress and adjusts interventions to their care plan as needed.<br><br>1. Resident #12 was initially admitted to the facility on the 10/14/24, and readmitted to the facility on [DATE], with multiple diagnoses including bipolar disorder (a major mental mood disorder) and post-traumatic stress disorder (a major mental illness).<br><br>Resident #12's care plan, dated 11/22/24, documented she had clostridium difficile (a bacterial inflammation of the colon).<br><br>During an interview with the DON on 1/9/25, at 4:42 PM, the DON stated Resident #12 had not had clostridium difficile for a while and her care plan should have been updated.<br><br>2. Resident #23 was admitted to the facility on [DATE], with multiple diagnoses including heart failure and kidney disease.<br><br>On 1/6/25, at 7:43 AM, a bottle of Biofreeze (a pain relief gel) was observed on Resident #23's bedside table.<br><br>Resident #23's medical record documented a physician's order, dated 1/7/25, for Biofreeze Roll-On External Gel 4% Menthol (topical analgesic) to be applied to affective area topically every 6 hours as needed for pain, and may be kept at bedside.<br><br>Resident #23's care plan dated 12/11/24, did not document self-administration of Biofreeze.<br><br>On 1/8/25, at 9:45 AM, LPN #1 stated residents can self-administer medications if they have had a self-administration assessment completed, an order to self-administer the medication, and it is care planned. LPN #1 stated Resident #23 should have had her Biofreeze care planned.<br><br>3. Resident #59 was admitted to the facility on [DATE], with multiple diagnoses including stroke and benign prostatic hyperplasia (prostate gland enlargement).<br><br>On 1/6/25 at 4:41 PM, Resident #59's record review documented a physician's order for Calmoseptine Ointment 0.44-20.625 % (Menthol-Zinc Oxide). Apply to affected area topically two times a day for excoriation.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/10/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Life Care Center of Idaho Falls | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2725 East 17th Street Idaho Falls, ID 83406 | |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 1/8/25 at 3:52 PM, a record review of Resident #59's care plan did not document excoriation or treatment for excoriation.<br><br>On 1/10/25 at 12:05 PM, LPN #1 stated Resident #59 should have had wounds and treatment orders on his care plan.<br><br>4. Resident #65 was admitted to the facility on [DATE], with multiple diagnoses including dysphagia (difficulty swallowing) and emphysema (chronic lung condition).<br><br>A physician's order, dated 1/6/25, documented Resident #65's Dobhoff (nasogastric tube) was discontinued.<br><br>On 1/9/25, Resident #65's care plan documented he had a Dobhoff for enteral feedings.<br><br>On 1/9/25 at 4:10 PM, the DON stated Resident #65's Dobhoff was discontinued and should have been removed from his care plan. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135091 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Idaho Falls | 2725 East 17th Street<br>Idaho Falls, ID 83406 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552<br><br>Based on observation, record review, policy review and staff interview, it was determined the facility failed to ensure medications were administered according to professional standards of practice. This was true for 1 of 10 residents (Resident #222) observed during medication administration. These failed practices created the potential for residents to experience adverse effects when their medications were not administered according to the physician's order. Findings include:<br><br>The facility's Refusal of Care or Treatment policy, dated 11/28/22, documented if a resident refuses medication or treatment, the facility, will:<br><br>- notify the resident and/or the resident representative of the risks versus benefits of the refusal.<br><br>- explore the reason for the refusal and possible alternatives with the resident and/or resident representative.<br><br>- refer to the Omnicare Resident Medication Rights policy which documented the facility should notify the physician of a resident's refusal of medication/treatment for periods greater than twenty-four hours.<br><br>Resident #222 was admitted to the facility on [DATE], with multiple diagnoses including kidney disease and bladder pain.<br><br>Resident #222's physician order, dated 12/27/24, documented he was to receive a Nicotine Transdermal Patch 14mg, one time a day for tobacco use.<br><br>Review of Resident #222's MAR documented resident had refused the nicotine patch 11 out of 12 times since admission.<br><br>On 1/8/25 at 4:27 PM, record review of Resident #222's medical record did not document that his physician was notified of the medication refusals.<br><br>On 1/8/25 at 3:25 PM, the DON stated after 3 refusal of medication the physician should have been notified. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135091 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Idaho Falls | 2725 East 17th Street<br>Idaho Falls, ID 83406 |

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<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** 49552<br><br>Based on observation, record review, and staff interview, it was determined the facility failed to ensure professional standards of nursing practice were followed for 2 of 12 residents (#12 and #65) reviewed for quality of care. Residents were at risk for adverse outcomes when they did not have physician orders to provide care to meet residents' needs. These failed practices had the potential to adversely affect residents whose care and services were not followed according to accepted standards of practice. Findings include:<br><br>1. Resident #12 was initially admitted to the facility on the 10/14/24, and readmitted to the facility on [DATE], with multiple diagnoses including bipolar disorder (a major mental mood disorder) and post-traumatic stress disorder (a major mental illness).<br><br>On 1/6/25 at 11:58 AM, a wound was observed to Resident #12's left knee.<br><br>On 1/7/25 at 8:10 AM, Resident #12's medical record did not document orders for the wounds on her left knee.<br><br>On 1/8/25 at 10:38 AM, observed with LPN #1 present, 2 large dressings dated 1/7/25, to Resident #12's left knee. LPN #1 removed the dressings and observed 3 linear wounds (approx. 4-5 inches in length) to Resident #12's left knee. The following were observed:<br><br>- the middle wound had approximately 0.5 cm area at the bottom of the wound with yellow drainage.<br><br>- the inner and outer wounds had a small amount of serous sanguineous drainage.<br><br>- LPN #1 cleaned the site with normal saline, applied hydrocortisone and a board dressing.<br><br>On 1/8/25 at 1:58 PM, LPN #1 stated there were no wound care orders in Resident #12's chart and there should have been.<br><br>2. Resident #65 was admitted to the facility on [DATE], with multiple diagnoses including dysphagia (difficulty swallowing) and emphysema (chronic lung condition).<br><br>A progress noted dated 1/5/25 at 8:58 PM, documented Resident #65 had been on oxygen at 2 liters per minute.<br><br>On 1/6/25 at 11:08 AM, observed Resident #65 in his room with an oxygen concentrator set to 2 liters per minute but, he was not wearing his nasal cannula.<br><br>Resident #65's progress note, dated 1/6/25 at 11:50 AM, documented he had a diagnosis of emphysema and he had been on continuous oxygen via nasal cannula.<br><br>On 1/6/25 at 3:28 PM, Resident #65's electronic medical records did not document an order for oxygen.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135091 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Idaho Falls | 2725 East 17th Street<br>Idaho Falls, ID 83406 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/8/25 at 11:17 AM, Resident #65's paper medical records documented Standing Orders for Oxygen: Check oxygen saturations as needed for sign and symptoms of respiratory distress. For oxygen saturations less than 88% titrate supplemental oxygen 1-4 liter per minute via nasal cannula or mask.<br><br>On 1/8/25 at 1:53 PM, LPN #1 stated Resident #65's Standing Orders should have gone into his electronic medical record and the nurses should have been documenting when the standing orders were completed.<br><br>On 1/9/25 at 8:33 AM, LPN #2 stated Resident #65's oxygen is as needed. She also stated Resident #65 does not have orders for the oxygen and should have. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135091 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Idaho Falls | 2725 East 17th Street<br>Idaho Falls, ID 83406 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983<br><br>Based on review of the State Operations Manual, observation, and staff interview, it was determined the facility failed to ensure residents were free from accident hazards for 1 of 18 residents (Resident #30) whose room was observed for environmental safety. This deficient practice had the potential to cause physical harm if a power strip used to plug in a medical device was to overheat and cause a fire. Findings include:<br><br>The State Operations Manual, Appendix PP revised 8/8/24, documented power strips may not be used as a substitute for adequate electrical outlets in a facility and are not designed to be used with medical devices in patient care areas.<br><br>Resident #30 was admitted to the facility on [DATE], with atrial fibrillation (irregular rapid heart rhythm that can lead to blood clots in the heart).<br><br>A physician order dated 10/9/23, documented Resident #30 was to use sequential compression devices (inflatable sleeve to prevent blood clots) to bilateral lower extremities two times a day for lymphedema management.<br><br>On 1/7/25 at 7:57 AM, a power strip was observed to be in Resident #30's room with the compressor for the sequential compression device plugged into it.<br><br>On 1/7/25 at 8:00 AM, Resident #30 confirmed the power strip was used to plug in the compressor for the compression device.<br><br>On 1/8/25 at 1:10 PM the Maintenance Director stated Resident #30 should not have had a medical device plugged into a power strip in her room. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/10/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Life Care Center of Idaho Falls | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2725 East 17th Street Idaho Falls, ID 83406 | |

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 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121<br><br>Based on facility standing order policy, observation, and staff interview, it was determined the facility failed to ensure licensed nurses performed tasks which they had the knowledge, skills, and competencies. This was true for 3 of 4 licensed nurses observed. This had the potential for adverse effects for all residents when the facility's standing orders were not followed. Findings include:<br><br>The facility's Standing Orders, dated 2/15/24, documented for oxygen saturations less than 88%, titrate supplemental oxygen 1-4 liters per minute via nasal cannula or mask.<br><br>Resident #41 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including hemiplegia, hemiparesis, and seizures.<br><br>Resident #41's medical record documented the following SpO2 (peripheral oxygen saturation, is a measurement of the amount of oxygen in your blood) with no documented follow-up to address the low SpO2.<br><br>- 8/8/24 at 4:50 PM, SpO2 was 86% RA, RN #2<br><br>- 8/9/24 at 8:03 AM, SpO2 was 85% RA, RN #3<br><br>- 8/9/24 at 1:04 PM, SpO2 was 86% RA , RN #3<br><br>- 8/10/24 at 10:55 AM, SpO2 was 85% RA, RN #4<br><br>Resident #41's nursing progress notes from 8/7/24 through 8/12/24 had no documentation of low SpO2 interventions by nursing staff.<br><br>On 1/8/25 at 2:51 PM, LPN #1 stated the licensed floor nurses should have been following the facility standing orders policy for Resident #41's low SpO2 findings.<br><br>On 1/10/25 at 11:20 AM, the DON stated nursing staff should have been following the oxygen standing orders for Resident #41's low SpO2 findings.<br><br>On 1/10/25 at 11:45 AM, LPN #1 stated there was no documentation that nursing staff had followed the standing oxygen orders of putting Resident #41 on oxygen or notified the physician the next day. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/10/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Idaho Falls | 2725 East 17th Street<br>Idaho Falls, ID 83406 |

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.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552

Based on observation, policy review, and staff interview, it was determined the facility failed to ensure medications available for residents were stored appropriately. This was true for 2 of 4 residents (#51 and #58), whose rooms were inspected. This failure created the potential for adverse effects if residents self-administered medications inappropriately. Findings include:

The facility's Self Administration of Medications policy, revision date 10/13/21, documented the facility would:

- ensure that each resident who requested to self-administer medication would be assessed by the interdisciplinary team to determine if the resident is safe to self-administer medications.

- after the interdisciplinary team and primary physician review the assessment and determined the resident can safely self-administer, or self-administer and store medications at bedside, a physician's order would be obtained and the care plan for the resident would reflect the self-administration.

- allow bedside medication storage to be permitted only when it does not present a risk to a confused resident who might wander into the room of, or room with, residents who self-administer.

- ensure bedside storage to occur if the storage of medication prevents access by other residents.

1. Resident #51 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and post-traumatic stress disorder (a major mental illness).

On 1/6/25 at 8:16 AM, observed Resident #51 had two medication cups on her bedside table. One medication cup contained 5 different tablets. In another medication cup observed 1 white tablet.

On 1/6/25 at 8:19 AM, Resident #51 stated the nurse left the medication for her to take later.

On 1/9/25 at 7:03 AM, Resident #51's medical record did not document a self-administration assessment had been completed.

On 1/9/25 at 7:04 AM, Resident #51's care plan, dated 10/30/24, did not document self-administration of medications.

On 1/9/25 at 4:38 PM, the DON stated Resident #51 should not have had her medications left on the bedside table.

On 1/10/25 at 11:41 AM, LPN #1 stated medications are not to be left at the resident's bedside unless there is a self-medication assessment completed and then it should be care planned.

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/10/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Life Care Center of Idaho Falls | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2725 East 17th Street Idaho Falls, ID 83406 | |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Resident #58 was admitted to the facility on [DATE], with multiple diagnoses including Paraplegia (inability to move the lower part of your body), malnutrition, and bipolar disease (a severe mental illness causing mania or depression).<br><br>On 8/8/25 at 9:08 AM, the following was observed in Resident #58's room:<br><br>- stoma powder (a powder used to absorb moisture from broken skin around the stoma) on Resident #58's nightstand<br><br>- ostomy/wound supplies on table<br><br>- wound scissors on overbed table<br><br>On 8/8/25 at 9:10 AM, Resident #58 stated the nurses leave it out all the time.<br><br>On 1/08/25 at 10:25 AM, the wound nurse stated the supplies should not have been there.<br><br>50983 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135091 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Idaho Falls | 2725 East 17th Street<br>Idaho Falls, ID 83406 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>50983<br><br>Based on review of the State Operations Manual, interview, and record review, it was determined the facility failed to employ a qualified director of food and nutrition services. This deficient practice had the potential to affect all residents who received meals prepared in the facility's kitchen. Findings include:<br><br>The State Operations Manual Appendix PP, revised 8/8/24, documented the director of food and nutrition services must at a minimum meet one of the following qualifications:<br><br>- be a Certified Dietary Manager; or<br><br>- a Certified Food Service Manager; or<br><br>- has similar national certification for food service management and safety from a national certifying body; or<br><br>- has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or<br><br>- has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023.<br><br>On 1/9/24 at 3:02 PM, the Food Service Director and the Registered Dietician (RD) stated they knew the Food Service Director had not met the regulatory requirements for Certified Dietary Manager or Certified Food Service Manager. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/10/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Idaho Falls | 2725 East 17th Street<br>Idaho Falls, ID 83406 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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** 50983

Based on observation, food code review, and staff interview, it was determined the facility failed to ensure food was stored in a safe and sanitary manner. These deficiencies had the potential to affect all residents 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. Findings include:

The FDA (Food Drug Administration) 2022 Food Code, Section ,d+[DATE].17 documented 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.

During the initial kitchen inspection conducted on [DATE] at 7:00 AM, the following was observed:

Walk-in refrigerator:

- 8 individual yogurts with expired dates of [DATE]

- A sandwich wrapped in cellophane labeled GC and dated [DATE]

- An open bag of salad unlabeled

On [DATE] at 7:20 AM, the Dietary Aide #1 stated the expired yogurts should have been thrown out and she did not know who the sandwich was for or why the salad did not have dates on it.

During a second inspection on [DATE] at 11:15 AM, the following was observed:

Walk-in freezer:

- An opened package of chicken breast with ice crystals, undated, and a binder clip attached to the top of the bag

- A previously opened package of chicken tenders, undated and a binder clip attached to the top of the bag

On [DATE] at 11:25 AM, the Food Service Director stated the chicken breast and chicken tenders should have been dated and not sealed with a binder clip.

On [DATE] at 11:40 AM, observed with the Food Service Director, RD, and [NAME] #1 , multiple ants on the food preparation table, underneath a dish towel and inside a logbook.

On [DATE] at 11:41 AM, the Food Service Director stated the pest control contractor had done his inspection and treatment a couple of weeks ago.

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/10/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Life Care Center of Idaho Falls | | STREET ADDRESS, CITY, STATE, ZIP CODE 2725 East 17th Street Idaho Falls, ID 83406 | |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On [DATE] at 1:05 PM, the Maintenance Director stated the pest control contractor comes to the facility monthly and on an as needed basis.<br><br>On [DATE] at 3:05 PM, the Food Service Director with the Registered Dietician present, stated there should not have been expired foods or an open, undated bag of salad in the walk-in refrigerator. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/10/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Life Care Center of Idaho Falls | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2725 East 17th Street Idaho Falls, ID 83406 | |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>49552<br><br>Based on observation, policy review, and staff interview, it was determined the facility failed to ensure infection control prevention practices were maintained to provide a safe and sanitary environment for 4 of 18 residents (#22, #51, #59, and #222) observed for oxygen and respiratory equipment use, and 2 of 2 residents (#12 and #41) observed for proper cleaning of glucometers. These failures put residents at risk for cross contamination and infection. Findings include:<br><br>1. The facility's Oxygen Administration (Safety, Storage, Maintenance) policy, revision date 10/11/24, documented:<br><br>- oxygen and respiratory supplies are stored in a bag labeled with resident's name when not in use.<br><br>- clean exterior of concentrators weekly.<br><br>- external filter should be checked daily and all dust should be removed. Filters should be washed with soap and water once a week and as needed.<br><br>The following was observed for proper storage of oxygen supplies:<br><br>a) On 1/6/25 at 8:28 AM, observed Resident #51's oxygen concentrator with white substance on the top and white fuzz covering the filter.<br><br>b) On 1/7/24 at 8:17 AM, observed in Resident #22's room, her nebulizer mouthpiece and tubing had been lying on her bedside table, uncovered.<br><br>On 1/9/25 at 4:38 PM, the DON stated oxygen supplies should have been in a bag and hung on the wall when not in use.<br><br>2. The facility's Indwelling Urinary Catheter (Foley) Management policy, revision date 9/10/24, documented the catheter bag was not to rest on the floor.<br><br>The following was observed for catheter bags:<br><br>a) On 01/6/25 at 9:25 AM, Resident #59's catheter bag was observed lying on the floor.<br><br>On 1/6/25 at 9:28 AM, CNA #8 stated Resident #59's catheter bag should not have been on the floor.<br><br>b) On 1/7/25 at 7:36 AM, observed Resident #222's catheter bag lying on the floor.<br><br>On 1/7/25 at 7:40 AM, RN #1 stated Resident #222's catheter bag should not have been on the floor.<br><br>3. The Assure Prism Blood glucose monitoring system manual documented for cleaning of the glucometer:<br><br>- the meter should be cleaned and disinfected after each use on a resident.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/10/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Idaho Falls | 2725 East 17th Street<br>Idaho Falls, ID 83406 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - two disposable towelettes are needed for each cleaning and disinfecting procedure: one towelette for cleaning and a second towelette for disinfecting.<br><br>- with the first towelette, wipe the entire surface of the meter 3 times horizontally and 3 times vertically. Dispose of the used towelette.<br><br>- with the second towelette, wipe the entire surface of the meter 3 times horizontally and 3 times vertically. Dispose of the used towelette.<br><br>- treated surface must remain wet for recommended contact time.<br><br>The following was observed for glucometer cleaning:<br><br>a) On 1/7/25 at 12:18 PM, LPN #3 had used the glucometer to check Resident #12's blood sugar. After LPN #3 had checked Resident #12's blood sugar he cleaned the glucometer with one Sani-Cloth (disinfecting wipe) towelette by wrapping the towelette around the glucometer and rubbing the towelette over the glucometer.<br><br>On 1/7/25 at 12:23 PM, LPN #3 stated he did not know the policy for cleaning the glucometer, but he did know he should clean it with the Sani-cloth.<br><br>b) On 1/9/25 at 11:31 AM, RN #2 had used the glucometer to check Resident #41's blood sugar. After RN #2 had checked Resident #41's blood sugar she cleaned the glucometer with one Sani-Cloth towelette by wrapping the towelette around the glucometer and rubbing the towelette over the glucometer.<br><br>On 1/8/25 at 4:22 PM, the DON stated the nurses should have used the Sani-Cloth towelettes and followed the facility policy when cleaning the glucometers.<br><br>On 1/9/25 at 11:34 AM, RN #2 stated the facility's policy is to clean the glucometer with the Sani-Cloth and the dry time was 2 minutes. She did not know the glucometer needed to remain wet for 2 minutes.<br><br>On 1/10/25 at 9:53 AM, the IP stated the dry time for the Sani-Cloth is 2 minutes, but the manufactures directions stated to not wrap the towelette around the glucometer. She stated the glucometer should have had the cleaning solution on it for 2 minutes, but she was not sure how to do that without wrapping the Sani-cloth around the glucometer. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/10/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Life Care Center of Idaho Falls | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2725 East 17th Street Idaho Falls, ID 83406 | |

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 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>49552<br><br>Based on the review of records and staff interview, it was determined the facility failed to ensure glucometers were calibrated to maintain accuracy of results for 2 of 4 medications carts (Hall 300 and Hall 400) observed.<br><br>The Assure Prism Blood glucose Monitoring System manual documented control solution tests are used to check the meter and the test strips to ensure they are working properly. The control solution test should be done:<br><br>- when using the meter for the first time.<br><br>-whenever a new bottle or box on individually wrapped test strips is opened.<br><br>- if the meter or test strips do not function properly.<br><br>- if the resident's symptoms are inconsistent with the blood glucose test results and you feel that the meter or test strips are not working properly.<br><br>- if the meter is dropped or damaged.<br><br>On 1/8/25 at 2:50 PM, the glucometer solution test logbooks were reviewed and revealed the following:<br><br>- Hall 400 glucometer solution test was not consistently done for the month of December 2024 to January 2025.<br><br>- Hall 300 glucometer solution test was not consistently done for the month of January 2025.<br><br>On 1/8/25 at 2:55 PM, LPN #4 stated the glucometer solution test should have been done daily by the night shift. |