STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135091	A. Building B. Wing	03/19/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, record review, and policy review it was determined the facility failed to assess whether residents had the ability to self-administer their medications for 1 of 1 residents (Resident #63) reviewed for self-administration of medications. This failure created the potential for adverse effects if medications were self-administered inappropriately by the resident. Findings include: The facility's Self-Administration of Medication policy, reviewed 9/15/25, documented the facility will ensure that each resident who requests to self-administer medications is assessed by the interdisciplinary team (IDT) to determine if the resident is safe to self-administer medications. Procedure 4. The interdisciplinary assessment will be completed in the electronic medication record, and results reviewed with the resident and/or responsible party .Resident #63 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including multiple myeloma (cancer of the bone marrow's plasma cells) and diabetes. On 3/17/26 at 3:07 PM, observed Resident #63 sitting in his room placing drops in his eyes. On 3/17/26 at 3:16 PM, observed a bottle of Refresh Tears sitting on Resident #63's bedside table. On 3/17/26 at 3:27 PM, Resident #63's medical record reviewed with no documentation of a physician order for Refresh Tears, and no IDT self-administration assessment. On 3/17/26 at 3:52 PM, the DON stated Resident #63 should not have had the Refresh Tears at his bedside and had not been assessed by IDT for self-administration of medications.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and staff interview, it was determined the facility failed to ensure a resident and their representative received assistance to exercise their right to formulate an advance directive. This was true for 4 of 24 residents (#4, #33, #42, and #67) whose records were reviewed for advance directives. This deficient practice created the potential for harm or adverse outcomes if the residents' wishes were not followed or documented regarding their advance care planning. Findings include:The facility's Advance Directives policy, last reviewed 12/1/25, documented All residents or their responsible parties receive materials concerning their rights under applicable laws to make decisions regarding their medical care including.the formation of advance directives upon admission.Resident #42 was admitted to the facility on [DATE], with multiple diagnoses including Polyneuropathy (a condition involving damage to multiple peripheral nerves) and diabetes. Resident #42's medical record had not included an advance directive for healthcare or information on his right to formulate an advance directive. On 3/17/26 at 1:10 PM, the Social Services Director stated, there is no Durable Power of Attorney for Healthcare for Resident #42, only the Power of Attorney for Financial Affairs. Resident #67 was admitted to the facility on [DATE], with multiple diagnoses including fracture left femur (thigh bone) and dementia. Resident #67's medical record had not included an advance directive for healthcare or documentation she was provided with information on her right to formulate an advance directive. On 3/17/26 at 4:48 PM, the Social Services Director stated, there is no Durable Power of Attorney for Healthcare for Resident #67, only the General Power of Attorney. On 3/17/26 at 4:49 PM, the DON stated Resident #42 and Resident #67 had a financial DPOA but did not have an advance directive for healthcare and was not offered to formulate one. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including Hemiplegia and Hemiparesis affecting the left dominant side following a cerebral infarction (stroke). Resident #4's medical record had not included an advance directive for healthcare or information on his right to formulate an advance directive. Resident #33 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including cancer, hypertension, and spinal stenosis in the lumbar region (the narrowing of the spinal canal causing pain, numbness, and leg weakness). Resident #33's medical record had not included an advance directive for healthcare or documentation she was provided with information on her right to formulate an advance directive. On 3/17/26 at 3:20 PM, the DON stated Resident #4 and Resident #33 had a financial DPOA but did not have an advance directive for healthcare and was not offered to formulate one.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of facility policy, it was determined the facility failed to ensure residents were provided with a safe, clean, and homelike environment. This was true for 1 of 18 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 including infection and cross-contamination. Findings include: The facility's Daily Room Cleaning policy, revised date 10/28/25, documented Procedure 4. Daily cleaning of resident bathrooms b. Clean the toilet bowl daily. The facility's Housekeeping Services - Cleaning Resident Shower Room policy, issued date 10/28/25, documented Procedure: Cleaning Resident Shower Room - Routine Cleaning (Daily) 1.b. Housekeeping should clean resident shower/bath area twice daily.The following areas were observed for clean and homelike environment: On 3/16/26 at 4:32 PM, observed in Resident room [ROOM NUMBER]:Toilet with thick black ring of debris above bowl water line and under rim of toilet, room sink heavily stained with brown residue On 3/18/26 observed: a. Hall 3 - shower with blackened thick debris on floors and tiles, toilet with black/brown debris line around water line and rusty brown discoloration in toilet bowl. Black debris around wall and floor line. Floor under sink with rusty brown area between tiles and wall. b. Hall 4 - shower with blackened thick debris on floors and tiles, toilet with black/brown debris at water line and under toilet rim, toilet seat with discoloration, rusty brown and black ring around entire toilet base, caulking missing at floor and wall line, black debris at floor and wall line and up the tiled wall for 2 tile height. On 3/19/26 at 9:38 AM, the Maintenance Director stated, the Hall 3 and Hall 4 showers do not look like they have been cleaned and should have been. On 3/19/26 at 1:16 PM, the Housekeeping Manager stated, the CNAs clean the shower (wipe down) between each resident shower and housekeeping looks at each shower room at the end of the day to see that the shower room is clean. The shower rooms should have been cleaned but had not been.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review and staff interview, it was determined the facility failed to ensure a written notice of transfer and bed hold policy was provided to residents or their representatives when residents were transferred to the hospital. This was true for 2 of 2 residents (#7 and #33) reviewed for hospital transfers. This deficient practice created the potential for psychosocial distress if residents and their representatives were not made aware of or able to exercise their rights related to transfers from the facility. Findings include:The facility's Discharge Process and Bed Holds policy, reviewed 12/1/25, documented:- under Notice before transfer, Before a facility transfers or discharges a resident, the facility must - (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. - under Notice of bed-hold policy and return, Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies: (i) the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility. Resident #7 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including stage IV pressure ulcers, diabetes, and spinal cord injury.Resident #7's medical record documented he was transferred from the facility and admitted to the hospital on [DATE] and again on 3/14/26. Resident #7's medical record had not documented he was provided with a Notice of Transfer or Bed Hold Policy prior to being transferred to the hospital on 1/6/26 or 3/14/26.Resident #33 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including cancer, hypertension, and spinal stenosis in the lumbar region (the narrowing of the spinal canal causing pain, numbness, and leg weakness).Resident #33's medical record documented she was transferred from the facility and admitted to the hospital on [DATE]. Resident #33's medical record had not documented she was provided with a Notice of Transfer or Bed Hold Policy prior to being transferred to the hospital on [DATE].On 3/18/26 at 1:40 PM, the DON stated they do not have the Notice of Transfer or Bed Hold documentation for Resident #7 or Resident #33.

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, it was determined the facility failed to maintain a person-centered comprehensive care plan for residents. This was true for 1 of 19 residents (Resident #24) whose record were reviewed for comprehensive care plans. This created the potential for harm when staff were not informed of person-centered care and treatment interventions. Findings include: The facility's Area of Focus: Care Planning - Baseline, Comprehensive, and Routine Updates policy, review date 12/4/25, documented.develop and implement a comprehensive person-centered care plan for each resident.Selecting interventions / planning care - identify and implement interventions and treatments to address the individual's physical, functional, and psychosocial needs, concerns, problems, and risks.the comprehensive care plan must be updated with each MDS assessment and periodically.Resident #24 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including Hypertensive heart and chronic kidney disease and diabetes. On 3/17/26 at 11:06 AM, Resident #24's care plan documented last care plan review completed 12/21/25, Endocrine: Diabetes Mellitus, Interventions including High Risk Medications: Insulin per MD order, date initiated: 12/15/25. On 3/17/26 at 11:08 AM, Resident #24's medical record had not included a physician's order for insulin. On 3/17/26 at 2:58 PM, the DON stated Resident #24 had not had an order for insulin during her stay at the facility and the insulin intervention should not have been documented on Resident #24's care plan and had been.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview it was determined the facility failed to follow physician orders of delivering specific medications when residents do not have bowel movement within 72 hours for 1 of 22 residents (Resident #13) 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:The facility's Bowel Protocol policy, reviewed date 9/15/25, documented Procedure 2. The facility in coordination with the resident's attending practitioner will implement standing orders to address a lack of bowel movement.Resident #13 was admitted to the facility on [DATE], with multiple diagnoses including Hypertensive heart and chronic kidney disease and respiratory failure.Resident #13's medication administration record documented the following medication orders; Senna Tablet 8.6 mg - give 3 tablets by mouth as needed for constipation - no BM in 72 hours. Order date 1/22/26.Bisacodyl EC Tablet Delayed Release 5 mg - give 3 tablet by mouth as needed for constipation - No BM in 96 hours. Order date 1/22/26.Bisacodyl Suppository 10 mg - insert 1 suppository rectally as needed for constipation - if no BM by 10:00 following day after oral Bisacodyl. If no BM after 2 hours of suppository, give Fleet enema. Order date 1/22/26.Fleet Enema 7-19 Gm/118 ml (Sodium Phosphates) - insert 1 dose rectally as needed for constipation - if no result 2 hours after suppository, if no BM within 2 hours of enema, call MD for further instructions. Order date 1/22/26.On 3/18/26 at 2:01 PM, Resident #13's medical record documented she had a BM on 2/21/26 at 03:56 and not again until 2/26/26 at 22:39, over 120 hours later with no bowel management medications documented as being administered between 2/24/26 and 2/26/26.On 3/18/26 at 2:07 PM, Resident #13's medical record had no documentation in nursing progress notes that her physician had been contacted 2/25/26 through 2/26/26, regarding no BM for over 96 hours.On 3/18/26 at 2:20 PM, the Executive Director stated nursing staff for Resident #13 should have contacted the physician after 96 hours without a BM and had not.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the State Operations Manual - Appendix PP, review of the State Agency's Long-Term Care Reporting Portal, record review, the facility's I&A reports, policy review, and staff interview, the facility failed to ensure residents were free from accident hazards for 2 of 3 residents (#4 and #65) whose a) fall was not documented timely, and b) whose rooms were observed for environmental safety. This failure increased the potential for avoidable accidents to go unnoticed. Findings include:The State Operations Manual, Appendix PP revised 7/23/25, documented extension cords should not be used to take the place of adequate wiring in a facility.extension cords should be connected to only one device to prevent overloading of the circuit. The facility's Incident and Reportable Event Management policy, reviewed 12/3/25, documented the following:-The facility must ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.- The facility to the best of its ability strives to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:Identifying hazard(s) and risk(s)Evaluating and analyzing hazard(s) and risk(s)Implementing interventions to reduce hazard(s) and risk(s)Monitoring for effectiveness and modifying interventions when necessaryResident #65 was admitted to the facility on [DATE], with multiple diagnoses including, respiratory failure and diabetes.On 3/17/26 at 1:37 PM, observed an extension cord in Resident #65's room with the bed electrical cord, wheelchair electrical cord, and cellphone electrical cord plugged into it.On 3/17/26 at 1:40 PM, Resident #65 stated she had bought the extension cord at Walmart and she used it to plug in the bed, wheelchair, and her cellphone.On 3/17/26 at 1:50 PM, the Maintenance Director stated Resident #65 should not have had medical devices plugged into an extension cord in her room. On 3/17/26 at 2:03 PM, the Executive Director stated he was unaware Resident #65 had an extension cord in her room, and the medical devices should not have been plugged into it. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including Hemiplegia and Hemiparesis affecting the left dominant side following a cerebral infarction (stroke). On 11/24/25 at 12:15 PM, the Certified Occupational Therapy Assistant documented that Resident #4 was seated in wheelchair upon arrival and was agreeable to therapy however expressed left shoulder pain due to a fall earlier in the day. On 11/25/25 at 5:29 PM, the Physical Therapist documented that Resident #4 reported his left shoulder was hurting after an incident falling out of his wheelchair yesterday. On 11/28/25 at 2:09 PM, the Certified Occupational Therapy Assistant documented Resident #4 stated his left shoulder was in pain due to a fall a week ago and was not able to use ULE (upper left extremity). Nurse was notified that Resident #4 would like to meet with the doctor about left shoulder pain. Responded well to interventions however was limited due to left shoulder pain. On 12/1/25, a physician visit progress note documented Resident #4 stated that he has been having some increased left shoulder pain since he had a fall that he heard a small pop with. Physician documented we will start with an x-ray 2 view to further evaluate. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/1/25, a physician's verbal order documented an x-ray to left shoulder one time only for pain following trauma for 1 day. The physician verbal order was confirmed by RN #4. Resident #4's x-ray report dated 12/1/25, documented the following: Osteoporosis Mild to moderate shoulder osteoarthritis is visualized The distal clavicular irregularity is visualized, likely an acute fracture On 12/11/25, a physician's progress note documented the x-ray to the left shoulder on 12/1/25 was inconclusive and he will order a CT scan. On 12/31/25, a physician order documented a DEXA scan (an x-ray to measure bone mineral density and assess fracture risk) for Resident #4 to screen for Osteoporosis. From 1/12/26 – 1/15/26, the facility investigated the fall that Resident #4 had on 11/24/25 with the following results: On 1/13/26, a statement provided by the facility transportation driver documented that on 11/24/25 at 8:30 AM, Resident #4 fell out of his wheelchair and landed on the grass. On 1/13/26 a statement provided by LPN #3 documented the following events that happened on 11/24/25: - Resident #4 had a fall out of his wheelchair in front of the facility. - LPN #3 assessed Resident #4 for pain and ability to move extremities. - LPN #3 and the transportation driver assisted resident back into his wheelchair with a gait belt. - Resident #4 refused further assessment and wanted to go to scheduled appointment. On 1/13/26, the facility investigation documented LPN #3 directed LPN #1 to enter Resident #4's fall into the Risk Management system. On 1/13/26, the facility investigation documented LPN #1 acknowledged she was asked to enter Resident #4's fall on 11/24/25 into the Risk Management system but forgot. On 1/14/26, Resident #4's DEXA scan documented a diagnosis of Osteoporosis. On 3/18/26 at 1:48 PM, the ED stated he did not start the investigation until 1/13/26 because he did not know about Resident #4's fall on 11/24/25. During his investigation is when he found out LPN #3 had directed LPN #1 to document Resident #4's fall in the Risk Management system but LPN #1 forgot. The ED stated LPN #3 should have documented the fall but did not.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, facility policy, record review, and interviews, it was determined the facility failed to provide respiratory services as ordered by the physician. This was true for 1 of 4 residents (Resident #39) whose records were reviewed for respiratory services. This failure created the potential for residents to experience increased fatigue and low oxygen levels. Findings include:The facility's Oxygen Administration policy dated 3/3/26, documented oxygen orders should include the specific liter flow required by the resident.Resident #39 was admitted to the facility on [DATE], with multiple diagnoses including stroke and chronic respiratory failure with hypoxia (a long-term condition where the lungs cannot adequately transfer oxygen into the blood). Resident #39's physician's oxygen ordered dated 11/12/23, documented oxygen 1 liter/NC continuously.Resident #39's care plan dated 7/21/22, documented provide supplemental oxygen, settings per MD order. Resident #39's MAR documented oxygen was administered at 1 lpm on 3/16/26, day and night shift and 3/17/26, day shift. On 3/16/26 at 1:29 PM, observed Resident #39 lying in her bed with her oxygen cannula in her nose and the oxygen concentrator was set at 2 lpm. Resident #39 stated she is on 2 lpm of oxygen.On 3/17/26 at 9:04 AM, observed Resident #39's oxygen concentrator was set at 2.5 lpm. On 3/17/26 at 9:08 AM, RN #1 stated Resident #39's oxygen should be set at 1 lpm and had not been. On 3/18/26 at 9:28 AM, the DON stated Resident #39's oxygen concentrator liter flow setting should be checked often or at least every shift by nursing staff and had not been.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, observation, and staff interview, it was determined the facility failed to ensure that prior to the placement of bed rails, alternatives to bed rails were attempted and how the alternatives failed to meet the resident's assessed needs. This was true for 1 of 4 residents (Resident #72) reviewed for bed rails. This failure created the potential for harm due to the risk for injury, entrapment and/or death. Findings include:The facility's Bed Rails - Safe and Effective Use of Bed Rails policy, reviewed date 9/3/25, documented.Procedure 1. Residents will be assessed upon admission, readmission, or upon initiation utilizing the Evaluation for Use of Bed Rails Assessment. 3. If a bed rail will be utilized, the risks and benefits of bed rail(s) usage will be reviewed with the resident and/or resident representative, and consent will be obtained prior to installation of the bed rails or as soon as practically possible. Resident #72 was admitted to the facility on [DATE], with multiple diagnoses including hypothyroidism (a condition when the thyroid gland does not make enough thyroid hormone) and dementia.On 3/16/26, 3/17/26, and 3/18/26, observed Resident #72 with bilateral upper side rails on her bed and in the up position.On 3/18/26 at 10:20 AM, Resident #72's medical record did not have documentation of the evaluation of the alternatives attempted or documentation of the purpose of the intended use of the side rails or documented discussion of risks and benefits with a signed consent for use of bed rails.On 3/19/26 at 2:02 PM, the DON stated Resident #72 had not been assessed for the use of bed rails. The DON confirmed Resident #72's medical record had not contained documentation of the evaluation of alternatives attempted or the intended purpose of the use of side rails, a physician order for bed rails, or a consent for use of bed rails and should have.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, State Operation Manual, Appendix PP, and staff interview, it was determined the facility failed to ensure nurse staffing information was accurate and posted daily 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 staffing levels. Findings include:The State Operation Manual, Appendix PP revised on 8/8/24, documented S483.35(g) Nurse Staffing Information. S483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.On 3/17/26 at 12:31 PM, observed the daily staffing sheet for 1/20/26 was missing CNA number of staff present and hours worked.On 3/17/26 at 12:45 PM, observed the daily staffing sheet for 2/15/25 was missing RN hours worked for day, evening, and night shift.On 3/18/26 at 9:30 AM, the Executive Director stated the CNA and RN worked hours and staff present data should have been documented on the daily staffing sheets for 1/20/26 and 2/15/25 and had not been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135091	A. Building B. Wing	03/19/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review, staff interview, and policy review 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: The facility's Inventory Control of Controlled Substances policy, revision date 08/01/24, documented.1. Procedure 1.1 Facility should ensure the incoming and outgoing nurses count all Schedule II controlled substances and other medications with a risk of abuse or diversion at the change of each shift.and document the results on a Controlled Substance Count Verification/Shift Change Sheet. 2. Facility should ensure facility staff count all Schedule III-IV controlled substances in accordance with facility policy and applicable law. On 3/18/26 at 8:17 AM, observed during the Hall 2 medication cart audit, the Narcotic Card Item Count sheets, dated 1/1/26 to 1/15/26, 2/1/26 to 2/15/26, and 3/1/26 to 3/15/26, with 1 licensed nurse signature not documented on 1/1/26, 2/3/26, 2/10/26, 2/11/26, and 3/10/26. On 3/18/26 at 8:19 AM, LPN #1 stated two nurses should have signed the Narcotic Card Item Count sheet and had not. On 3/18/26 at 8:50 AM, observed during the Hall 4 medication cart audit, the Narcotic Card Item Count sheet, dated 3/11/26 to 3/21/26, with 1 licensed nurse signature not documented on 3/12/26. On 3/18/26 at 8:55 AM, LPN #2 stated two nurses should have signed the Narcotic Card Item Count sheet when they accepted the medication cart or released the medication cart. On 3/18/26 at 10:16 AM, the DON stated two nurses should have signed the Narcotic Card Item Count sheet when they accepted the medication cart or released the medication cart and had not.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on policy review, record review, and staff interview, it was determined the facility failed to ensure residents were assessed appropriately for adequate indications for the use of opioid pain medications. This was true for 1 of 4 residents (Resident #74) reviewed for unnecessary medications. This failure created the potential for residents to experience adverse consequences or increased risk of death. Findings include:The facility's Pain Management policy dated 12/2/25, documented the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.Assess pain every shift and record on eMAR. Always indicate which pain scale was used and document the type of pain the resident is experiencing. Resident #74's physician order for medication for mild pain documented Acetaminophen Tablet 325 MG, give 2 tablets by mouth every 8 hours as needed for mild acute pain for 30 Days, not to exceed 3000 mg/day.Resident #74 received acetaminophen on March 8th at 0837 for a pain level of 4 but no documented administration of acetaminophen from March 9th, 2026, through March 16, 2026.Resident #74's physician order for medication for moderate to severe pain documented Percocet Oral Tablet 5-325 MG (Oxycodone w/ Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for moderate to severe acute pain related to OTHER ACUTE OSTEOMYELITIS, LEFT ANKLE AND FOOT (M86.172) for 30 Days -Order Date 03/12/2026 1550 On 3/17/26 at 12:39 PM, Resident #74's medical record documented Percocet was given on the following dates and times related to pain level. - March 13, 2026, 0707 pain level 3 - March 15, 2026, 0621 pain level 3 - March 16, 2026, 0625 pain level 3 On 3/17/26 at 12:58 PM, the DON stated the physicians have moved from the pain intensity number scale because some residents might report a pain level of 3 when it really is a 6 or 7.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, policy review, and manufacturer manual it was determined the facility failed to ensure biologicals were labeled when opened, and medications were properly stored in a locked compartment. This was true for the facility. These deficient practices created the potential for use of expired biologicals, and undetected access to medications by unauthorized personnel. Findings include: The facility's Storage and Expiration Dating of Medications and Biologicals policy, revision date [DATE], documented Procedure 11. Once any medication or biological package is opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates. The Assure Prism Blood Glucose Monitoring System Quality Assurance / Quality Control (QA/QC) Reference Manual documented, .when you first open a control solution bottle, record the discard date (date opened plus 3 months) in the space provided on the label. The facility's General Dose Preparation and Medication Administration policy, revision date [DATE], documented Procedure 7. Facility should ensure that medication carts are always locked when out of sight or unattended. 1. The following was observed for biologicals.On [DATE] at 1:25 PM, one set of Assure Prism glucose test solutions (CSYF24BN and CSYM26AM) were not dated when opened or had an expiration date written on the label. On [DATE] at 1:28 PM, RN #2 stated she did not know how long the test solutions had been opened and used. On [DATE] at 11:41 AM, review of the Blood Glucose testing logs from 10/25 to 3/26, blood glucose test solutions (CSYF24BN and CSYM26AM) were documented on the log as being opened and used for testing during 11/25, 12/25, 1/26, 2/26, and 3/26. On [DATE] at 11:53 AM, the IP stated the blood glucose test solutions should be dated when opened and were only to be used for 3 months. 2. The following was observed for unlocked medication cart. On [DATE] at 1:21 PM, observed Hall 2 medication cart had been left unlocked and unattended by the medication nurse. On [DATE] at 1:24 PM, observed RN #3 pushing a Hoyer lift down Hall 2 towards the medication room. On [DATE] at 1:25 PM, RN #3 stated the medication cart should have been locked when left unattended. On [DATE] at 1:37 PM, the DON stated the medication cart should have been locked when not attended by the nurse and had not been.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and staff interviews, it was determined the facility failed to ensure infection control and prevention practices were maintained for residents' Durable Medical Equipment (DME). This was true for 1 of 1 resident (Resident #71) reviewed during environmental observations. This failure had the potential to impact residents by placing them at risk for cross contamination and infection. Findings include:The facility's Infection Prevention and Control Program (IPCP) and Plan revised 6/2/25, documented under Implementing Strategies to Achieve the Goals.4. Methods to reduce the risks associated with procedures, medical equipment, and medical devices, including the following:a. Appropriate storage, cleaning, disinfection, and/or disposal of supplies and equipmentResident #71 was admitted to the facility on [DATE], with multiple diagnoses including atrial fibrillation, heart failure, and hypertension.On 3/16/26 at approximately 8:45 AM, observed Resident #71 operating her power wheelchair towards her room in the 200 Hall.On 3/16/26 at 9:24 AM, observed the following in the shower room on the 200 Hall:- Out Of Order sign on the outside of the door- A thick dirty black ring around inside toilet bowl- A dirty, brown substance on the floor and walls- Used paper towels on the back of the toilet and on the sink- Resident #71's power wheelchair with an open box of cereal in the bag attached to the back of the wheelchair and a Hoyer lift sling in the seat- A resident lounge shower chairOn 3/16/26 at 2:30 PM, observed a Hoyer lift stored in the shower room that was Out of Order on the 200 Hall.On 3/19/26 at 9:50 AM, observed a bariatric shower chair stored in the shower room that was Out of Order on the 200 Hall.On 3/19/26 at 10:30 AM, the Infection Preventionist stated staff should not be storing resident equipment in the Out of Order shower room on Hall 200.