STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135092	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Rock Health and Rehabilitation of Cascadia	840 East Elva Street Idaho Falls, ID 83401

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interviews it was determined the facility failed to ensure pertinent health information was provided to the receiving health facility for 5 of 9 residents (Resident #1, #3, #7, #11, and #28) reviewed for transfers. This deficient practice had the potential to result in adverse outcomes if the residents were not treated in a timely manner due to a lack of information provided upon transfer. Findings include:Resident #1 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including Progressive Supranuclear Ophthalmoplegia (Steele-Richardson-Olszewski syndrome) (a rare brain disorder causing progressive damage to balance, eye movement, and mobility) and pulmonary embolism (a blockage in a lung artery). An eINTERACT Transfer Form Version 5.0 dated 12/7/25, documented Resident #1 was discharged to the hospital for pain on right side of head after a fall. Resident #1's medical record had not included documentation that the required pertinent medical information including care plan goals and advance directive information was provided to the receiving hospital for his 12/7/25 discharge. An eINTERACT Transfer Form Version 5.0 dated 12/20/25, documented Resident #1 was discharged to the hospital for bruising to back of head after a fall. Resident #1's medical record had not included documentation that the required pertinent medical information including care plan goals and advance directive information was provided to the receiving hospital for his 12/20/25 discharge. An eINTERACT Transfer Form Version 5.0 dated 2/17/26, documented Resident #1 was discharged to the hospital for evaluation after falling and hitting head. Resident #1's medical record had not included documentation that the required pertinent medical information including care plan goals and advance directive information was provided to the receiving hospital for his 2/17/26 discharge. Resident #3 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including Parkinson's disease (a progressive loss of nerve cells causing muscle weakness and tremors) and chronic kidney disease. An eINTERACT Transfer Form Version 5.0 dated 2/22/26, documented Resident #3 was discharged to the hospital for laceration on right leg. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3's medical record had not included documentation that the required pertinent medical information including care plan goals and advance directive information was provided to the receiving hospital for her 2/22/26 discharge. An eINTERACT Transfer Form Version 5.0 dated 3/26/26, documented Resident #3 was discharged to the hospital for laceration to left 3rd toe. Resident #3's medical record had not included documentation that the required pertinent medical information including care plan goals and advance directive information was provided to the receiving hospital for her 3/26/26 discharge. The facility's Discharge or Transfer policy revision date 8/30/25, documented the facility will ensure the information that must be conveyed to the receiving provider for residents being transferred or discharged to another healthcare setting is provided in accordance with federal guidance. Resident #7 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including bipolar and anxiety. An eINTERACT Transfer Form V5 (an electronic tool that helps long-term care facilities effectively communicate critical resident information when transferring them to an acute care hospital) dated 9/21/25, documented Resident #7 was discharged to the hospital. Resident #7's medical record had not included documentation that the required pertinent medical information including care plan goals and advance directive information was provided to the receiving hospital for her 9/21/25 discharge. An eINTERACT Transfer Form V5 dated 9/25/25, documented Resident #7 was discharged to the hospital. Resident #7's medical record had not included documentation that the required pertinent medical information including care plan goals and advance directive information was provided to the receiving hospital for her 9/25/25 discharge. An eINTERACT Transfer Form V5 dated 10/19/25, documented Resident #7 was discharged to the hospital. Resident #7's medical record had not included documentation that the required pertinent medical information including care plan goals and advance directive information was provided to the receiving hospital for her 10/19/25 discharge. An eINTERACT Transfer Form V5 dated 11/2/25, documented Resident #7 was discharged to the hospital. Resident #7's medical record had not included documentation that required pertinent medical information including care plan goals and advance directive information was provided to the receiving hospital for her 11/2/25 discharge. 4. Resident #11 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including COPD (a group of lung diseases that block airflow and make it difficult to (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	breathe) and obstructive sleep apnea. An eINTERACT Transfer Form V5 dated 11/16/25, documented Resident #11 was discharged to the hospital for shortness of breath. Resident #11's medical record had not included documentation that the required pertinent medical information including care plan goals and advance directive information was provided to the receiving hospital for his 11/16/25 discharge. An eINTERACT Transfer Form V5 dated 2/23/26, documented Resident #11 was discharged to the hospital for pain, diarrhea, and elevated heart rate. Resident #11'smedical record had not included documentation that the required pertinent medical information including care plan goals and advance directive information was provided to the receiving hospital for his 2/23/26 discharge. An eINTERACT Transfer Form V5 dated 3/7/26, documented Resident #11 was discharged to the hospital. Resident #11's medical record had not included documentation that the required pertinent medical information including care plan goals and advance directive information was provided to the receiving hospital for his 3/7/26 discharge. 5.Resident #28 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including heart failure and COPD. An eINTERACT Transfer Form V5 dated 11/15/25, documented Resident #28 was discharged to the hospital due to altered mental status. Resident #28's medical record had not included documentation that the required pertinent medical information including care plan goals and advance directive information was provided to the receiving hospital for her 11/15/25 discharge. An eINTERACT Transfer Form V5 dated 3/19/26, documented Resident #28 was discharged to the hospital due to chest pain. Resident #28's medical record had not included documentation that the required pertinent medical information including care plan goals and advance directive information was provided to the receiving hospital for her 3/19/26 discharge. On 4/2/26 at 10:54 AM, the CNO stated the nurses had completed the eINTERACT charting in Point Click Care but had not documented what forms were sent to the hospital with them and should have.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, policy review, and staff interview, it was determined the facility failed to complete a baseline care plan for 2 of 2 residents (#4 and #70). This failure created the potential for harm when staff were not provided direction of care for resident. The facility also failed to provide a resident's baseline care plan to the resident or his/her representative for 5 of 7 residents (#7, #9, #11, #21, and #28) reviewed for baseline care plan. This failure placed residents and their representatives at risk of not being informed and having input in their care plan. Findings include:The facility's Baseline Care Plans policy, revised 9/3/25, documented the facility will initiate a baseline care plan for each resident within 48 hours of admission. The facility reviews and provides the resident and/or their representative with a summary of the baseline care plan and physician(provider) orders and in a language that the Resident and/or representative can understand. The medical record should contain evidence that the summary/orders were given to the Resident and/or Representative. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including chronic respiratory failure with hypoxia (a long-term, progressive inability of the lungs to oxygenate the blood sufficiently) and dementia. Resident #4's baseline care plan was signed and locked on 2/9/26, four days after being admitted to the facility. On 4/1/26 at 12:46 PM, the CNO stated Resident #4's baseline care plan should have been completed and locked within 48 hours of being admitted to the facility and had not been. Resident #70 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including diabetes and need for assistance with personal care. Review of Resident #70's medical record had not document a baseline care plan. On 4/1/26 at 10:40 AM, the CNO stated Resident #70 did not have a baseline care plan. Resident #7 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including bipolar and anxiety. A Quarterly MDS assessment, dated 4/2/26, documented Resident #7 was cognitively intact. Resident #7's CSCD-Care Plan 48 Hour form dated 8/14/25, had not documented she or her resident representative received a copy of the baseline care plan. Resident #9 was admitted to the facility on [DATE], with multiple diagnoses including COPD (a group of lung diseases that block airflow and make it difficult to breathe) and chronic kidney disease. A comprehensive MDS assessment, dated 2/24/26, documented Resident #9 was cognitively intact. Resident #9's medical record had not included documentation that a baseline care plan was provided and discussed with her or her resident representative. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #11 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including COPD and obstructive sleep apnea. Resident #11's medical record had not documented that a baseline care plan was provided and discussed with him or his resident representative. Resident #21 was admitted to the facility on [DATE], with multiple diagnoses including interstitial lung disease (a group of over 200 disorders causing inflammation or scarring in the lung tissue between air sacs, making it difficult to breathe and get oxygen into the bloodstream) and heart failure. Resident #21's medical record had not documented that a baseline care plan was provided and discussed with him or his resident representative. Resident #28 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including heart failure and COPD. Resident #28's medical record had not documented that a baseline care plan was provided and discussed with him or his resident representative. On 4/1/26 at 4:26 PM, the CNO stated there was no documentation that the residents or their representatives had received a copy of their baseline care plans.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, policy review, and staff interview, it was determined the facility failed to ensure medications available for residents were labeled, dated, and were secure and inaccessible to unauthorized staff and residents; this was true for 2 of 2 medication carts inspected and 1 of 1 treatment carts observed. This failure created the potential for residents to receive expired medications with decreased efficacy, the potential for adverse effects if residents self-administered medications inappropriately, and the potential for residents to obtain prescribed wound care supplies used for other residents and presented the risk for cross-contamination of wound care products stored in the treatment cart. Findings include:The facility's Medication Storage In The Facility policy effective date May 2019, documented the following: - All medications dispensed by the pharmacy are stored in the container with the pharmacy label. -Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal (See Section IE: DISPOSAL OF MEDICATIONS AND MEDICATION-RELATED SUPPLIES), and reordered from the pharmacy (See IC#: ORDERING AND RECEIVING NON-CONTROLLED MEDICATIONS FROM THE DISPENSING PHARMACY), if the current order exists. - Certain medications or package types, such as IV solutions, multiple dose injectable vials, opthalmics, nitroglycerin tablets, blood sugar testing solutions and strips, once opened, require and expiration date shorter than the manufacturer's expiration date to ensure medication purity and potency. - No expired medication will be administered to a resident. - All expired medication will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner. On 4/1/26 at 6:43 AM, medication storage observed of the Yellowstone Hall medication cart with LPN #1 present observed the following:- a bottle of eye drops with the illegible label and an open date of 12/20/25.- a bottle of eye drops with the illegible label and an open date of 2/20/26.- a bottle of glucose strips with no open date. On 4/1/26 at 6:56 AM, LPN #1 stated the eye drops are good for 30 days after opening and should have been wasted. The label is also faded and can't be read so the drops should not be used. The glucometer strips are good for 30 days after opening and should be thrown away since they were not dated when they were opened. On 4/1/26 at 9:47 AM, the CNO stated the eye drop bottles should be dated with open date and he would have to check the pharmacy policy on how long they are good for. On 4/1/26 at 3:22 PM, observed the treatment cart unlocked outside room [ROOM NUMBER]. On 4/1/26 at 3:28 PM, LPN #3 stated the treatment cart had medicated creams in it and should have been locked. On 4/2/26 at 9:57 AM, medication storage observation completed of the Mesa Falls Hall medication cart with RN #5 present observed the following: - undated bottle glucose test strips On 4/2/26 at 10:04 AM, RN #2 stated the test strips should have been dated when open and she was not sure how long they were good for after opening.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, 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. This was true for 1 of 1 resident (Resident #12) and the facility observed for infection control. These failures put residents at risk for cross contamination and infection. Findings include: The facility's Oxygen Administration, Safety, Storage & Maintenance policy, revision date 8/4/23, documented under Infection Control: - Change oxygen supplies weekly and when visibly soiled. - Store oxygen and respiratory supplies in bag labeled with resident's name when not in use.The facility's Inhalant (Nebulizer) Medication Administration policy revision date 9/16/25, documented the facility was to:- Follow standard of practice for medication administration, including the rights and infection prevention intervention, in addition to documentation requirements in the medical record.- Rinse nebulizer cup and mouthpiece/mask with warm water after use.- Air dry all parts on a clean paper towel in a designated area.The [NAME] TRUE METRIX Pro Glucose Meter manual, undated, documented: With ONLY PDI Super Sani Cloth Wipes (or any disinfectant product with the EPA* reg. no. of 9480-4), rub the entire outside of the meter using 3 circular wiping motions with moderate pressure on the front, back, left side, right side, top and bottom of the meter. Repeat as needed until all surfaces are visibly clean. Discard used wipes. (*Environmental Protection Agency.) 3. To Disinfect: Using fresh wipes, make sure that all outside surfaces of the meter remain wet for 2 minutes. Make sure no liquids enter the Test Port or any other opening in the meter.The following was observed for oxygen supplies storage: On 3/30/26 at 8:14 AM, Resident #37's CPAP was observed lying on his dresser, not covered. On 3/30/26 at 8:54 AM, Resident #14's nebulizer mask was observed hanging on her walker, not covered. On 3/30/26 at 9:00 AM, Resident #20's oxygen nasal cannula lying on the floor. On 3/30/26 at 9:11 AM, RN #6 stated Resident #20's oxygen tubing should not have been on the floor, it should have been in the oxygen bag, and the nebulizer should not be stored on the walker. On 3/30/26 at 9:12 AM, Observed RN #6 place Resident #20's oxygen tubing in her oxygen bag without cleaning it and then she placed her nebulizer mask on the dresser. On 3/30/26 at 9:22 AM, Resident #28's BIPAP mask was observed lying on the dresser, not covered. Resident #28's oxygen tubing was observed draped over her wheelchair, not covered. On 3/30/26 at 9:37 AM, Resident #9's VPAP mask was observed lying over the machine, not covered. On 4/1/26 at 11:19 AM, the IP stated a resident's oxygen tubing should be bagged when not in use and not on the floor. The nebulizer masks should be cleaned and dried after each use then put away. CPAP/BIPAP/VPAP should be cleaned and set up to be used at night. The following was observed for blood glucose monitoring: On 4/1/26 at 7:07 AM LPN #1 checked Resident #45's blood sugar using a glucometer and then wiped down the glucometer using a Sani wipe (disinfecting wipe) and then placed the glucometer back in the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	baggie. On 4/1/26 at 7:10 AM, LPN #1 stated the glucometer was used for multiple residents. LPN #1 stated the dry time for the sani wipe is 2-minutes but she did not realize it had to remain wet for 2 minutes. Resident #12 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (disease process causing decreased lung functionality), depression, and cardiomegaly (an enlarged heart). Resident #12's physician oxygen order dated 3/9/26, documented oxygen 3 LPM continuously per nasal cannula via O2 concentrator and/or tank. On 4/2/26 at 10:37 AM, observed Resident #12 in her room not wearing her oxygen nasal cannula. On 4/2/26 at 10:42 AM, observed CNA #13 enter Resident #12's room, CNA picked up the oxygen nasal cannula off the floor and assisted Resident #12 in placing her nasal cannula. On 4/2/26 at 10:45 AM, CNA #13 stated the oxygen nasal cannula and tubing should have been discarded and replaced before giving it to Resident #12. On 4/2/26 at 1:55 PM, the CNO stated oxygen supplies should be discarded and replaced weekly as ordered or when the supplies have been found on the floor and had not been.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and interviews it was determined the facility failed to ensure residents were treated with dignity and respect. This was true for 2 of 2 Residents (#23 and #70) reviewed for respect and dignity. This deficient practice placed residents at risk of embarrassment and diminished sense of worth. Findings include:The facility's Dignity policy dated 9/12/25, documented each resident has the right to be treated with dignity and respect. Under 2. Promoting resident independence and dignity while dining, such as avoiding: h. refraining from practices demeaning to residents, such as leaving urinary catheter bags uncovered.Resident #70 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including diabetes and need for assistance with personal care. On 3/30/26 at 12:02 PM, CNA #13 had removed Resident #70's shirt without pulling the privacy curtain. Resident #70's roommate was on her side of the room at this time and had observed Resident #70's shirt being removed. On 3/30/26 at 12:15 PM, Resident #70 stated she usually pulls the curtain so her roommate cannot see her being changed but she forgot. On 3/30/26 at 12:19 PM, CNA #13 stated she should have provided privacy to Resident #70 before she took her shirt off. Resident #23 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including enterocolitis due to clostridium difficile (a severe, often antibiotic-associated inflammation of the intestines caused by toxin-producing bacteria) and chronic obstructive pulmonary disease (progressive lung disease characterized by increasing breathlessness). On 3/30/26 at 2:53 PM, observed from the hallway, Resident #23's catheter bag, without a privacy bag or cover, was hanging on the left side of her bed, with the door open to her room and visible from the hallway. On 3/31/26 at 11:03 AM, RN #1 stated Resident #23's catheter bag had not been covered because the resident had just gotten back into her room, and the CNA must have forgotten to cover the bag. On 4/1/26 at 12:42 PM, the CNO stated Resident #23's catheter bag should have been covered or in a privacy bag and had not been.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure informed consent was obtained prior to initiation of psychotropic medications for 1 of 3 residents (Resident #12) reviewed for unnecessary medications. This deficient practice placed residents at risk of receiving medications without knowledge of the reason why medications were prescribed, the expected benefits, and the risks associated with the medications. Findings include:Resident #12 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (disease process causing decreased lung functionality), depression, and cardiomegaly (an enlarged heart). A physician order dated 11/27/25, documented Resident #12 was to start Aripiprazole 5 mg by mouth one time per day. On 4/1/26 at 9:48 AM, the CEO presented the surveyor with Resident #12's signed Psychoactive Medication Informed Consent document dated 1/16/26, listing Aripiprazole 5mg, Buproprion 150mg, and Fluoxetine 40 mg.On 4/1/26 at 9:49 AM, the CEO stated, Resident #12 should have signed a Psychotropic Medication Acknowledgement Consent prior to administration of Aripiprazole but had not.

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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 resident (Resident #59) 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 revised 9/16/25, documented residents may self-administer medications when it is determined to be safe and appropriate.the assessment will include whether bedside storage is appropriate.if self-administration is approved, a physician's order will be obtained and the care plan updated.Resident #59 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including paraplegia (paralysis of the lower extremities) and depression. On 3/30/26 at 10:07 AM, observed in Resident #59's room one bottle of Artificial Tears eye drops and one bottle of Prednisolone Acetate eye drops sitting on resident's side table. On 3/30/26 at 10:22 AM, LPN #1 stated Resident #59 should not have had the Artificial Tears and Prednisolone Acetate eye drops at his bedside. On 3/30/26 at 1:27 PM, review of Resident #59's medical record documented the IDT self-administration assessment dated , 3/17/26, under A. Assessment Criteria 15. Can correctly administer eye drops or eye ointments according to proper procedure, ?Not applicable' was highlighted. On 3/30/26 at 2:06 PM, Resident #59's medical record included physician orders for:- Prednisolone Acetate ophthalmic suspension 1%, start date 3/19/26- Artificial Tears ophthalmic solution 0.2-0.2-1%, start date 3/20/26 On 3/31/26 at 5:17 PM, the CNO stated Resident #59 should not have had eye drops at his bedside and had not been approved by IDT for self-administration of eye medications.

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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 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 1 of 22 residents (Resident #8) 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: Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including quadriplegia (paralysis of upper and lower limbs) and depression.On 3/31/26 at 9:02 AM, Resident #8's medical record contained a POST but had not documented an advance directive or documentation the facility informed or provided written information concerning the right to formulate an advance directive.On 3/31/26 at 10:48 AM, the Administrator provided the surveyor with a document titled, Understanding Advance Directives, with documented resident verbal consent and cosigned by two staff members dated 3/31/26. On 3/31/26 at 10:49 AM, the Administrator stated the facility only had POST documents for Resident #8.

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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 and interviews, it was determined the facility failed to ensure residents were provided with a safe, clean, and homelike environment. This was true for 2 of 22 resident rooms (#211 and #212), shower 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:The following areas were observed for clean and homelike environment: On 3/30/26 at 4:09 PM, observed Resident room [ROOM NUMBER]:Room door frame protective molding torn with sharp jagged edges. On 3/31/26 at 2:08 PM, observed Resident room [ROOM NUMBER]:Electrical wall outlet broken with jagged edges. On 4/1/26 observed:a.Grand Teton Hall - Shower room tile floor with broken tile and missing grout at entry door. b.Palisades Hall - Shower room wall heater with broken and rusted areas to the front and sides of the heater. The heater base broken with jagged edges and partially disconnected from the floor. The tile floor with dark black residue in the grout and around the floor drain. Several broken floor tiles in the middle of the shower room with open divets and dark black residue in the opened exposed areas. c.Mesa Hall - Shower room wall heater cover removed and lying on the floor next to the heater. Wall heater with exposed wire on the bottom side of the heater. On 4/1/26 at 4:23 PM, CNA #14 stated the shower rooms do not look like they have been cleaned and should have been. On 4/2/26 at 10:26 AM, accompanied by the Maintenance Director observed Palisades Hall shower room stall with large amount of dark strands of hair in the drain and on the shower stall floor. On 4/2/26 at 10:30 AM, the Maintenance Director stated he was unaware of the needed repairs to room [ROOM NUMBER]'s door frame molding, room [ROOM NUMBER] electrical outlet, the heaters needed to be repaired, and the shower rooms do not look like they have been cleaned and should have been.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure residents' hospital discharge instructions were reviewed upon admission to the facility to assure physician orders were in place to meet their medical needs. This was true for 2 of 2 residents (#9 and #37) whose records were reviewed. This failure placed these residents at risk of delayed respiratory care and assessments. Findings include:1. Resident #37 was admitted to the facility on [DATE], with multiple diagnoses including chronic respiratory failure with hypoxia (tissues are deprived of adequate oxygen causing shortness of breath) and obstructive sleep apnea.On 3/30/26 at 8:14 AM, observed in Resident #37's room, sitting on his dresser, a CPAP machine (a mask and air pump to keep airways open during sleep).On 3/30/26 at 8:16 AM, Resident #37 stated he uses the CPAP machine at night.On 4/2/26 at 10:48 AM, the CNO stated Resident #37 did not have an order for his CPAP, it was not on his care plan or on his MDS and should have been. 2. Resident #9 was admitted to the facility on [DATE], with multiple diagnoses including COPD and Chronic Kidney Disease.On 3/30/26 at 9:37 AM, observed in Resident #9's room, next to her bed, an AVAP machine (a non-invasive ventilator that automatically adjusts pressure support to maintain a target tidal volume, ensuring consistent breathing support for patients with chronic respiratory failure).On 3/30/26 at 9:43 AM, Resident #9 stated she uses the AVAP machine at night to help her breath while she sleeps.Review of Resident #9's hospital Transfer Orders dated 2/9/26, documented, AVAP Max IPAP 16-19 cmH20 Min IPAP 6-9 cmH2) Max EPAP 12-14 cmH2) Min EPAP 6-12 cmH20 Rate 8-12 BPM Tidal volume 380 ml O2 bleed in at 2-8 liters with humidification to maintain spo2 89-90% Q shift on at HS and off in AM.On 3/31/26, Resident #9's medical record had not documented a physician orders for her AVAP machine use.On 4/1/26 at 10:49 AM, the CNO stated the AVAP was not on Resident #9's orders and should have been.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to complete a significant change in condition or status assessment MDS within 14 days to accurately reflect the resident's status. This was true for 1 of 1 resident (Resident #4) whose medical record was reviewed. This deficient practice had the potential for negative outcomes if the resident was not assessed and cared for or monitored due to inaccurate assessments. Findings include:Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including chronic respiratory failure with hypoxia (a long-term, progressive inability of the lungs to oxygenate the blood sufficiently) and dementia.Resident #4's physician order dated 2/19/26, documented End of Life Care: Hospice Services.Resident #4's care plan documented hospice care started 2/19/26.On 3/31/26 at 5:10 PM, the MDS coordinator stated the facility had not completed a significant change in condition or status assessment MDS within 14 days of Resident #4 starting on Hospice care and should have.On 4/1/26 at 12:44 PM, the CNO stated the significant change in condition or status assessment MDS should have been completed on Resident #4 within 14 days of starting on Hospice care and had not been.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **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 Level 1 Pre-admission Screening and Resident Review (PASARR I), was completed correctly for 1 of 1 resident (Resident #13) reviewed for Level 1 PASARR screenings. This failure created the potential for harm if residents required, but did not receive specialized services for mental health while residing in the facility. Findings include:The facility's Pre-admission Screening and Resident Review (PASRR) Process dated 8/29/25, documented under Procedure1. Ensure Level I PASRR screening has been completed on potential admissions prior to admission. 2. A negative Level I screen permits admission to proceed and end (the) PASRR process during the initial admission process. 3. A positive Level I screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as PASRR Level II. 3a. When a Level II PASRR screening is warranted, it should be obtained (as well as determination letter) prior to admission.Resident #13 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including post-traumatic stress disorder and joint replacement surgery aftercare.Resident #13's Level 1 PASRR dated 3/3/26 and 3/13/26, had not documented he had Post-Traumatic Stress Disorder and anxiety disorders which would have triggered the need for a Level II PASRR.Resident #13's medical record dated 3/3/26, documented medical diagnosis of Post-Traumatic Stress Disorder, Chronic.On 3/30/26 at 12:00 PM, Resident #13 medical record had not documented a Level II PASRR had been completed.On 3/31/26 at 2:00 PM, the Resident Support Services Assistant stated the Level II PASRR dated 3/30/26, had just been completed and faxed to Mental Health for review.

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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 observation, policy review, interview, and record review, the facility failed to develop and implement resident's comprehensive person-centered care plan. This was true for 1 of 1 resident (Resident #13) whose care plan was reviewed. This deficient practice of not developing and implementing care plans placed residents at risk to their health and wellbeing with negative outcomes if services were not provided or provided incorrectly. Findings include:The facility's Comprehensive Care Plan and Conferences policy dated 9/3/25, documented the care plan will reflect the residents' individual conditions, risks, needs, behaviors, cultural values, and preferences, and will include measurable goals, appropriate interventions, and realistic timeframes.Resident #13 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including post-traumatic stress disorder and joint replacement surgery aftercare.Resident #13's medical record dated 3/3/26, documented medical diagnoses of Post-Traumatic Stress Disorder, Chronic.On 3/31/26 at 2:09 PM, Resident #13's care plan had not addressed his Post-Traumatic Stress Disorder diagnosis with any focus or interventions/tasks. On 4/1/26 at 12:47 PM, the CNO stated Resident #13's Post-Traumatic Stress Disorder diagnosis should have been care planned and had not been.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, policy review, and record review, it was determined the facility failed to ensure resident care plans were revised to reflect current needs and interventions. This was true for 2 of 22 residents (#2 and #12) whose care plans were reviewed. This placed residents at risk for adverse outcomes if care and services were not provided due to care plans not being revised as residents' needs changed. Findings include. The facility's Resident Care Plan Revisions policy, revision date 9/3/25, documented.updates to the care plan will occur as needed based on the residents' response to interventions or changes in condition. Resident #2 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including fracture of the right tibia (lower leg bone) and anxiety. On 3/30/26 at 8:19 AM, Resident #2's physician order dated 3/6/26 - Edema Management Right lower leg: edema, apply Tubi grip on AM, off PM. On 3/30/26 at 11:33 AM, observed Resident #2 sitting in her room not wearing a Tubi grip to her right lower leg. On 4/1/26 at 3:38 PM, during interview Resident #2 stated her right lower leg is swollen and has been for a while. On 4/2/26 at 10:33 AM, observed Resident #2 sitting in her room not wearing a Tubi grip to her right lower leg. On 4/2/26 at 11:06 AM, reviewed Resident #2's care plan with no documentation regarding Tubi grip to right lower leg. On 4/2/26 at 11:07 AM, Resident #2's TAR reviewed with no documentation regarding Tubi grip to right lower leg. On 4/2/26 at 1:17 PM, the CNO stated Resident #2's care plan and TAR should have been updated when the resident received physician orders for the Tubi grip and had not been. Resident #12 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (disease process causing decreased lung function), depression, and cardiomegaly (an enlarged heart). Resident #12's medical record documented physician order dated 3/9/26, Oxygen at 3LPM continuously per nasal cannula via O2 concentrator and/or tank. On 4/1/26 at 4:22 PM, review of Resident #12's care plan documented Oxygen Settings: -O2 via nasal prongs at 0-4L prn to maintain saturation at 90% or greater - date initiated 2/10/25.-Oxygen 2L/min continuously via NC - date initiated 6/24/25. On 4/1/26 at 4:25 PM, the CNO stated Resident #12's care plan should have been updated with the oxygen order dated 3/9/26, and had not 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 ensure physician orders were followed. This was true for 2 of 3 residents (#3 and #21) reviewed for quality of care. This failed practice placed residents at risk for discomfort and adverse effects, including potential for infection. Findings include:The facility's Standing Order - Bowel Protocol, signed date 12/18/25, documented: -Bowel Protocol Step 1: Senna 8.6mg 3 tablets PO at HS for constipation lasting >72 hours. -Bowel Protocol Step 2: Bisacodyl (Dulcolax) 5mg 3 tablets PO at HS for constipation lasting >96 hours.-Bowel Protocol Step 3: Bisacodyl (Dulcolax) suppository 10mg 1 suppository rectally at 10:00 for continued constipation morning after tablets.-Bowel Protocol Step 4: Fleets enema rectally at 12:00 for continued constipation 2 hours after suppository.-Special instructions: If no BM produced within 2 hours of enema, Call MD for further instruction.The facility's Infusion Therapy Responsibilities and Scope of Practice policy, revision date July 2016, stated:- Nursing Responsibilities in Infusion Therapy* Performing functions and procedures that are consistent with current standards of care, facility policies and procedures, and that are within the scope of the state nurse practice act. * Understanding of aseptic and sterile techniques and maintaining infusion equipment and medications in a way to avoid contamination. - Nursing Functions Specific to Infusion Therapy * Caring for and maintaining infusion equipment and catheters (peripheral and central venous access catheters). This includes flushing, dressing changes, site assessment, site rotation (for short peripheral catheters only), changing IV tubing and needleless connection devices. - Infusion Services/Product Provider Responsibilities in Infusion Therapy * Following stringent infection control procedures during preparation and distribution of infusion therapy products. Resident #3 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including Parkinson's disease (a progressive loss of nerve cells causing muscle weakness and tremors) and chronic kidney disease. Resident #3's medication administration record documented Resident #3 had the following medication orders; Senna Tablet 8.6 mg – give 1 tablet by mouth as needed for Bowel Protocol Step #1 – if no BM in 72 hours (Day 3). Order date 2/26/25. Bisacodyl Oral Tablet Delayed Release 5 mg – give 5 mg by mouth as needed for Bowel Protocol Step #2 – No BM in 96 hours (Day 4). Order date 2/26/25. Bisacodyl Rectal Suppository 10 mg – insert 1 suppository rectally as needed for Bowel Protocol Step #3 - if no BM by 10:00 following day after (Day 5) oral Bisacodyl. If no BM after 2 hours of suppository, give Fleet enema. Order date 2/26/25. Fleet Enema Rectal Enema (Sodium Phosphates) – insert 1 application rectally as needed for Bowel Protocol Step #4 – if no result 2 hours after suppository administer Enema. If no BM within 2 hours of enema, call MD for further instructions. Order date 2/26/25. On 3/30/26 at 2:01 PM, Resident #3's medical record documented she had a BM on 3/17/26 at 13:16 and not again until 3/22/26 at 13:58, over 96 hours later with no bowel management medications documented on the MAR as being administered between 3/20/26 and 3/22/26. On 3/30/26, Resident #3's medical record had not documented in the nursing progress notes that her (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician had been contacted 3/21/26 through 3/22/26, regarding no BM for over 96 hours. On 4/2/26 at 10:41 AM, the Regional Clinical Specialist stated nursing staff had documented Resident #3's bowel care medication refusals for 3/20/26 and 3/21/26 on the Bowel Care List worksheet and had not documented on the MAR or in the progress notes and should have. Resident #21 was admitted to the facility on [DATE], with multiple diagnoses including interstitial lung disease (a group of over 200 disorders causing inflammation or scarring in the lung tissue between air sacs, making it difficult to breathe and get oxygen into the bloodstream) and heart failure. On 3/30/26 at 8:26 AM, observed a PICC line to Resident #21's right upper extremity. The dressing to his PICC line site had not been dated. The edges of the PICC line dressing were loose. The PICC line tubing had not been secured. On 3/31/26 at 9:33 AM, LPN #2 stated there was no date on Resident #21's PICC line dressing and it should have been dated. LPN #2 also stated she was not working when the PICC line was put in and was not sure if it was still being used. Review of Resident #21's medical record documented a physician's order dated 2/25/26, for Ertapenem Sodium Injection Solution Reconstituted 1 GM (broad-spectrum antibiotic). Use 1 gram intravenously in the morning for sepsis r/t pneumonia until 3/1/26. On 3/31/26 at 9:38 AM, RN #4 stated she could not find orders for Resident #21's PICC line. She also stated the PICC line may have been discontinued but either way the PICC line should of been removed or had orders for it.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure adequate care and treatment was provided to 1 of 1 resident (Resident #59) reviewed for enteral tube use. This created the potential for harm if complications developed from improper medication administration via enteral access device practice. Finding include:The facility's Medication Administration Enteral Assess Device policy, release date 9/16/25, directed staff to follow the general professional standards for safe administration of medications and verify tube placement per facility protocol.Resident #59 was admitted to the facility on [DATE], with multiple diagnoses including paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease) and dysphagia (difficulty swallowing).Resident #59's physician's order dated 1/21/26, documented Enteral Tube: May Crush meds or use liquid form via tube. Check tube placement via auscultation prior to medication administration. On 4/1/26 at 9:00 AM, observed RN #2 administered 30 milliliters of water in Resident #59's enteral tube. RN #2 then placed 20 milliliters of hydroxyzine HCl liquid (anti-anxiety medication) in his enteral tube. RN # 2 then flushed Resident #59's enteral tube with 30 milliliters of water. RN #2 did not verify tube placement prior to medication administration.On 4/1/26 at 9:12 AM, RN #2 stated she was not sure what the facility's policy was on checking tube placement and residual prior to administering medication.On 4/1/26 at 9:46 AM, the CNO stated the facility's g-tube policy does not state to check residual or placement before feedings or medication administration. Placement is checked with a x-ray when it is put in only.

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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, policy review, manufacturer's PAP user manual, interview, and record review, the facility failed to ensure 3 of 4 Residents (#12, #13, and #53) received respiratory services as prescribed by the physician. This created the potential for residents to experience respiratory difficulties and impaired breathing. Findings include:The facility's BiPAP/CPAP Administration policy dated 9/12/25, documented the facility will provide non-invasive ventilation (NIV) using BiPAP or CPAP therapy in accordance with physician orders and professional standards of practice.[NAME] PAP therapy user manual undated, documented under oxygen safety information, when using oxygen with this system, a [NAME] Respironics pressure valve must be placed in-line with the user circuit between the device and the oxygen source. The pressure valve helps to prevent the back flow of oxygen from the user circuit into the device when the unit is off. Failure to use the pressure valve could result in a fire hazard. When using oxygen with this system, turn the device on before turning on the oxygen. Turn the oxygen off before turning the device off. This will prevent oxygen accumulation in the device. Explanation of the Warning: When the device is not in operation and the oxygen flow is left on, oxygen delivered into the tubing may accumulate within the device's enclosure. Oxygen accumulated in the device enclosure will create a risk of fire.Resident #12 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (disease process causing decreased lung functionality), depression, and cardiomegaly (an enlarged heart). Resident #12's physician oxygen order dated 3/9/26, documented oxygen 3 LPM continuously per nasal cannula via O2 concentrator and/or tank. On 3/30/26 at 9:27 AM, observed Resident #12 in her room not wearing her oxygen nasal cannula. On 4/1/26 at 3:27 PM, observed Resident #12 in her room not wearing her oxygen nasal cannula. On 4/2/26 at 10:37 AM, observed Resident #12 in her room not wearing her oxygen nasal cannula. On 4/2/26 at 12:52 PM, the CNO stated Resident #12 should have had her oxygen nasal cannula on continuously as ordered and had not. Resident #13 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including post-traumatic stress disorder and joint replacement surgery aftercare. 3/30/26 at 11:26 AM, observed with RN #3 present, Resident #13's oxygen concentrator was turned on with 3 1/2 lpm being bled into the CPAP device however the CPAP device was not turned on. A [NAME] Respironics pressure valve had not been installed on Resident #13's PAP device. Resident #13's TAR for CPAP setting were documented as CPAP Settings: CPAP with 2L/min at HS. CPAP settings at 7cm H2O, Ramp: 15 via full face mask CPAP- Fill humidifier with purified water at HS, every night shift related to obstructive sleep apnea (ADULT) dated 3/14/26. Resident #13's physician oxygen order dated 3/27/26, documented oxygen @ 3 liters via NC every shift related to obstructive sleep apnea (ADULT). On 3/30/26 at 8:45 AM, observed Resident #13 had not been using his O2 when visited. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135092	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Rock Health and Rehabilitation of Cascadia	840 East Elva Street Idaho Falls, ID 83401

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/31/26 at 11:00 AM, observed Resident #13 had not been using his O2 when visited. On 3/31/26 at 11:10 AM, RN #2 stated Resident #13 does not use his oxygen during the day and asked if there was an order for him to do so. Resident #53 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including acute osteomyelitis of right ankle and foot (serious, often chronic bone infection (usually Staphylococcus aureus) requiring prompt treatment to prevent permanent damage) and lumbar vertebra fracture. On 3/30/26 at 1:01 PM, observed Resident #53 had not been using the oxygen when the surveyor visited. Resident #53's medical record documented SpO2 on 3/29/26 at 10:21 of 88%, and on 3/30/26 at 10:57 of 88%, with both times documented he had not been on his supplemental oxygen and was using room air only. Resident #53's physician oxygen order was for 2 lpm continuously per nasal cannula to keep oxygen saturations at or above 90%. Resident #53's care plan documented monitor respiratory status and oxygen saturation, and oxygen at 2 LPM continuously per nasal cannula to keep oxygen saturation at or above 90%. On 4/2/26 at 10:46 AM, the CNO stated nursing staff should have made sure Resident #13 and Resident #53 were using their oxygen per physician's order, Resident #53's oxygen should not be allowed to bleed into the PAP device when it was not in use, and he was not aware of the requirement of the [NAME] Respironics pressure valve and was not aware if any PAP devices in the facility had the pressure valve.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, record review, and interviews, it was determined the facility failed to provide adequate pain management. This was true for 1 of 1 resident (Resident #53) whose medical record was reviewed. This failure created the potential for residents to experience continual pain and distress. Findings include:The facility's Pain Assessment and Management policy dated 9/2/25, documented under Procedure, Pain Management, 2. The facility should address/treat the underlying causes of the pain, to the extent possible, a. developing and implementing both non-pharmacological and pharmacological interventions/approaches to pain management.Resident #53 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including acute osteomyelitis of right ankle and foot (serious, often chronic bone infection (usually Staphylococcus aureus) requiring prompt treatment to prevent permanent damage) and lumbar vertebra fracture.Resident #53's physician order dated 2/11/26, and 3/20/26, documented Hydrocodone-Acetaminophen Oral Tablet 5-325 MG, every 4 hours as needed.Resident #53's care plan dated 11/10/25, documented facility will attempt non-pharmacological pain intervention as part of treatment plan.On 3/30/26 at 1:38 PM, Resident #53's MAR documented no attempt to use non-pharmacological pain management prior to administering pain medications on 3/17/26, 3/18/26, 3/20/26, 3/23/26, 3/24/26.On 4/1/26 at 3:50 PM, the CNO stated Resident #53 should have had non-pharmacological pain management offered prior to administering the hydrocodone medication and had not been.

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F 0726 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on personnel record review, policy review, facility assessment, resident record review, and staff interviews, it was determined the facility failed to ensure employees were competent to care for resident needs. This was true for 1 of 5 nurses observed for medication administration. This failure had the potential to affect all residents in the facility and increased the risk of harm to residents. Findings include:The facility's Medication Administration policy revision date 9/10/25, stated if parameters are indicated, take (or delegate to appropriate qualified staff to take) vital signs prior to preparing the medication. Resident #21 was admitted to the facility on [DATE], with multiple diagnoses including Interstitial lung disease (a group of over 200 disorders causing inflammation or scarring in the lung tissue between air sacs, making it difficult to breathe and get oxygen into the bloodstream) and heart failure.On 3/30/26 at 9:35 AM, LPN #2 gave Resident #21 his medication which included his Metoprolol Succinate ER (beta-blocker used to treat high blood pressure). After Resident #21 was done taking his medication LPN #2 checked his blood pressure.Resident #21's physician's order dated 2/26/25, stated Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG (Metoprolol Succinate). Give 12.5 mg by mouth in the morning for Hypertension Hold for SBP < 100 or Heart Rate < 50.On 3/31/26 at 3:59 PM, the CNO stated the nurse should have checked Resident 21's vital signs before giving him his medication.Review of LPN #2's Medication Administration- oral competency form documented she had completed training. The form documented Vital sign parameters are taken per facility practice before pouring medication.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and staff interview, it was determined the facility failed to ensure nurse staffing information was 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:On 3/30/26 at 4:17 PM, the following dates and times were missing daily staffing sheets or staffing data on the daily staffing sheets. - 5/6/25 No RN or LPN data listed for day and evening shifts - 9/8/25 No RN or LPN data listed for evening shift - 9/19/25 No CNA data listed for day/evening/night shifts - 12/7/25 Daily staffing sheet missing - 12/20/25 Daily staffing sheet missing - 12/21/25 Daily staffing sheet missing - 12/22/25 Only 1 RN for 8 hours listed for evening shift, no licensed nurses scheduled for day or night shifts.On 3/31/26 at 4:00 PM, the Staffing Coordinator stated the missing staffing data and sheets from those dates listed should not have been missing but was.