STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135134	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bennett Hills Rehabilitation and Care Center	1220 Montana Street Gooding, ID 83330

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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 0689 Level of Harm - 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 record review, review of the State Agency's Long-Term Care Reporting Portal, staff interviews, and review of the facility policies, the facility failed to ensure residents were free from accidents. This was true for 1 of 2 residents (Resident #8) reviewed for transportation. This failure caused injury for this resident. Findings include:The facility's Transportation Policy/Procedure policy revision date 12/30/25, documented Loading Passengers - insert the four tie down mechanisms to the fixture on the floor. Make certain that they are secured, and locked in. The facility's Fleet Safety Program manual revision date 4/14/21, documented employees are expected to operate vehicles safely to prevent accidents which may result in injuries and property loss. Resident #8 was initially admitted to the facility 11/21/25, and readmitted [DATE], with multiple diagnoses including dependence on renal dialysis and diabetes. On 4/28/26 at 3:00 PM, reviewed the facility's investigation. Based on the facility's investigation:-on 12/27/25 at 8:12 AM, Resident #8 fell backwards in his wheelchair, hitting his head and back on the back door of the facility van while being transported back from his dialysis treatment. Resident #8 reported pain in his neck after the fall.- Resident #8 was sent to the hospital for evaluation.-on 12/27/25, the facility van was inspected by the Maintenance Supervisor and no issues or concerns were found. The facility determined the incident had occurred because the straps had not been connected correctly to Resident #8's wheelchair and had come loose during the transport resulting in his wheelchair falling backwards.The facility's investigation substantiated the failure to prevent injury to a resident when the van driver did not secure the resident's wheelchair properly before transporting him. On 4/28/26 at 3:54 PM, the Administrator stated she (the Driver) did not latch the front wheels of Resident #8's wheelchair and she should have. These findings represent past non-compliance with this regulatory requirement. The facility did the following:The resident was immediately taken to the emergency room for evaluation. The resident's wheelchair and the facility van continued to be inspected throughout the week. No issues noted. Van inspections completed for the 2014 van on 9/30/25, 10/31/25, 11/30/25, 12/31/25, 1/31/26, 2/27/26, and 3/31/26. No issues noted. Van inspection completed for the 2021 van on 9/30/25, 10/31/25, 11/30/25, 12/31/25, 1/31/26, 2/27/26, and 3/31/26. Issue noted = cracked windshield. Facility staff and other residents interviewed, and no issues noted. A laminated pre-departure checklist created, completed, and placed in each van on 1/2/26. A new competency completed with transportation employees on 12/30/25 - 1/2/26. Competency audits were done weekly for 4 weeks, then monthly for 4 months starting 1/5/26. After the completion of the monthly competency, competency tests will be done quarterly. The facility's Transportation policy was revised 1/2/26 and updated the post incident response to policy (if injury call facility or 911, don't handle situation yourself). The resident continued to be monitored for psychosocial harm and latent injuries until 1/2/26. No psychosocial harm or latent injuries noted. The incident, van inspections, and staff competencies will be reviewed by QAPI. Staff were In-service regarding proper communication and proper action post incident occurring with transport team completed 1/2/26. There was sufficient evidence the facility corrected the non-compliance as of 1/2/26, as there was no further resident accidents involving transportion in the (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 0689 Level of Harm - Actual harm Residents Affected - Few	facility van after this date. At the time of the survey, the facility was in substantial compliance and therefore does not require a plan of correction.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **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 residents were provided with a clean, safe, homelike environment. This was true for all residents who resided in the facility whose environment were observed. This deficient practice created the potential for harm if residents were embarrassed by and/or felt the disrepair in the facility was unacceptable, disrespectful, or undignified or residents were injured due to unsafe areas in the facility. Findings include: The facility's Safe, Homelike Environment policy, dated October 2007, documented the facility would provide a safe, clean, comfortable, and homelike environment.The following areas were observed:On 4/27/26 and 4/28/26 - observed South Hall shower with: - moderate amount of strands of black hair in the shower drain - broken tiles with jagged edged holes in shower stall tiles - cracks in multiple shower tiles - dark residue matter in the shower tile grout. - multiple small round holes in shower stall walls On 4/28/26 at 3:58 PM, the Maintenance Supervisor stated he was concerned about a trip hazard and should fix the tiles. On 4/29/26 at 6:58 AM, observed resident room [ROOM NUMBER]-A with the resident's prior night's dinner tray with dishes and a full bowl of vegetables sitting on his bed. On 4/29/26 at 9:17 AM, observed the East Hall shower room with multiple missing floor tiles and dark black residue debris between shower floor tiles. On 4/29/26 at 9:27 AM, observed North Hall shower room with missing tiles on the floor at the door frame and in the middle of the shower room floor. The shower drain with a half dollar size brown formed matter and moderate amount of dark strands of hair in the drain. On 4/27/26 at 10:50 AM, observed in room [ROOM NUMBER]-A: - two metal bars sticking out of the wall to the left of the commode. - the inside side of bathroom door was missing approximately 3 X 2 piece of wood, by the hinges. - the vent in the bathroom had a thick gray substance. On 4/27/26 at 11:17 AM, the Maintenance Supervisor stated the brackets were missing the roll of toilet paper and he should have cleaned the vents and fixed the door. On 4/27/26 11:23 AM, observed room [ROOM NUMBER] with a hole on the outside of the bathroom door. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/27/26 at 3:50 PM, observed in room [ROOM NUMBER]: - to the left of the bed, two holes each approximately 3- 4 in size. - observed the door to the bathroom had been removed. On 4/27/26 at 3:57 PM, Resident #49 (room [ROOM NUMBER]) stated the holes in the wall were there when she moved into the room and there has not been a door into the bathroom since she moved in. On 4/28/26 at 12:05 PM, observed in the dining room: - a thick, gray substance on the vent by the television. - thick, long cobwebs on the ceiling by the dividing beam. On 4/28/26 at 12:25 PM, observed the vents on the east hall ceiling with a gray substance. On 4/29/26 at 11:04 AM, the Maintenance Supervisor stated the vents should have been cleaned, the toilet paper holder had been fixed but came off again, and room [ROOM NUMBER]'s bathroom should have had a door on it. On 4/29/26 at 11:22 AM, the Administrator stated the dining room ceiling and vents should have been cleaned by housekeeping staff and had not been. On 4/29/26 at 11:41 AM, observed the kitchen ceiling, pipes, and the vents with a thick, gray, fuzzy substance. On 4/29/26 at 11:42 AM, the DM stated the kitchen did have a cleaning schedule, but it did not include the ceiling, vents or pipes. She also stated it was the Maintenance Supervisor job to clean that area.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to refer residents for further mental health evaluation when residents stayed beyond a 30 day exemption for 1 of 1 resident (Resident #7) and the facility failed to request a Level II Pre-admission Screening and Resident Review (PASARR) for 2 of 3 residents (#10 and #38) reviewed for 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:Resident #7 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including right femur fracture and schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior).On [DATE] at 9:20 AM, Resident #7's Level II PASRR dated [DATE], documented a 30-day exemption rehabilitation, directing staff that if he stayed beyond 30 days, the facility must submit the most current MDS, MD orders, social notes and psych notes to BLTC. Resident #7's medication record had no documentation any additional information had been submitted to BLTC after the 30-day extension expired. Resident #10 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (progressive lung disease characterized by increasing breathlessness) and Bipolar II disorder.On [DATE] at 9:10 AM, Resident #10's Level I PASRR completed on [DATE], noted bipolar disorder with an onset date of [DATE], but the facility had not requested a Level II PASRR.Resident #38 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and dementia.On [DATE] at 3:38 PM, Resident #38's Level I PASRR dated [DATE], documented depressive and anxiety disorders with delusional disorder and REM Sleep behavior disorder, and the following medications, Haldol and Depakote. Based on the documented diagnoses and medications, the facility requested a Level II PASRR.The Level II PASRR dated [DATE], for Resident #38 documented under comments, participant has depression, anxiety, delusional disorder, and REM sleep behavior disorder; medications prescribed for mental health were Haldol and Valproic Acid/Depakote.Resident #38's diagnoses in her medical record had not listed depressive and anxiety disorders, delusional disorder or REM Sleep behavior disorder.Resident #38's physician orders for current and discontinued medications had not documented Haldol or Valproic Acid/Depakote as being prescribed for the resident. On [DATE] at 2:33 PM, the DON stated the documented information in Resident #38's Level I PASRR was incorrect and should have been corrected but had not been.On [DATE] at 8:43 AM, the DON stated additional information should have been submitted to mental health for Resident #7 and a Level II PASRR should have been requested for Resident #10 and had not been.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, resident and staff interview, and record review, it was determined the facility failed to ensure professional standards of practice were followed for 2 of 2 Residents (#7 and #26) reviewed for quality of care. This failed practice had the potential to adversely affect or harm residents whose care and services were not delivered according to accepted standards of clinical practices. Findings include: Resident #7 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including right femur fracture and schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior). On 4/28/26 at 2:49 PM, observed an albuterol and fluticasone inhaler in Resident #7's room on his bedside table. Resident #7 stated the nurses gave it to him and let him keep it in the room because they sometimes cannot make it down to his room quick enough. On 4/28/26 at 3:35 PM, Resident #7's medical record had no documentation that a physician had ordered an inhaler medication. On 4/28/26 at 3:40 PM, Resident #7's medical record had not documented that a self-administration assessment had been completed for the inhaler medication. On 4/29/26 at 4:30 PM, the DON stated Resident #7 should not have the inhaler in his room because there was no order for it. Resident #26 was admitted to the facility on [DATE], with multiple diagnoses including acute embolism and thrombosis of left popliteal vein (blood clot) and depression. On 4/27/26 at 11:34 AM, observed Resident #26's Sage boots (pressure prevention) were lying in the chair next to the resident's bed. On 4/27/26 at 11:38 AM, LPN #1 stated Resident #26 should have been wearing the Sage boots but had not been. On 4/27/26 at 12:08 PM, Resident #26's medical record documented physician order dated 4/6/26, Sage boots to bilateral feet at all times, document refusals. On 4/27/26 at 12:17 PM, Resident #26's medical record had not documented resident's refusal of Sage boots for 4/27/26. On 4/29/26 at 1:47 PM, the DON stated Resident #26 should have been wearing the Sage boots but had not been.

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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, staff interview, record review, and policy review it was determined the facility failed to ensure medications were properly stored, locked, and controlled medications were stored and kept secure from potential theft and/or diversion. This was true for 2 of 17 Residents (#18 and #26) and the facility. These deficient practices created the potential for adverse effects if residents self-administered medications inappropriately, undetected misuse of medications and/or diversion of controlled medications and had the potential to affect all residents who receive medication in the facility. Findings include: The facility's Self Administration of Medications policy, revision date 05/2023, documented; Procedures 2. If a resident desires to participate in self-administration, the interdisciplinary team will assess and periodically re-evaluate the resident based on change in the resident's status. 9. Appropriate notations of these determinations will be placed in the resident's care plan. The facility's Controlled Medications - Storage and Reconciliation policy, revision date 3/2025, documented; It is the policy of this facility to safeguard access and storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse using separately locked, permanently affixed compartments. The State Operations Manual, Appendix PP, updated 7/23/25, Schedule II-IV medications must be maintained in separately locked, permanently affixed compartments. Resident #26 was admitted to the facility on [DATE], with multiple diagnoses including acute embolism and thrombosis of left popliteal vein (blood clot) and depression. On 4/27/26 at 11:36 AM, observed one tube of zinc oxide on Resident #26's overbed table and one tube of antifungal cream on Resident #26's bedside table. On 4/27/26 at 11:37 AM, Resident #26 stated staff had left the tubes of medicine in his room and he could not apply the cream independently by himself. On 4/27/26 at 11:51 AM, Resident #26's medical record had not documented an Interdisciplinary Team (IDT) assessment for self-administration of medications. On 4/27/26 at 11:52 AM, Resident #26's medical record had not documented a physician order to leave medication at the bedside. On 4/28/26 at 3:07 PM, RCN stated Resident #26 should not have had the zinc oxide and antifungal medications left at his bedside. The following was observed for controlled medications. On 4/29/26 at 8:10 AM, observed two clear plastic cups each containing one bottle of Lorazepam nasal spray (Schedule IV controlled medication) stored on the medication refrigerator shelf. On 4/29/26 at 8:21 AM, the DON stated the Lorazepam had not been stored in an affixed box but should have been. Resident #18 was initially admitted to the facility on [DATE], and readmitted [DATE], with multiple diagnoses including congestive heart failure (a chronic condition where the heart cannot pump blood (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	efficiently enough to meet the body's needs) and diabetes. On 4/27/26 at 10:31 AM, observed on Resident #18's bedside table a tube of Biofreeze (topical pain reliever). On 4/27/26 at 10:45 AM, Resident #18 stated she uses the Biofreeze cream on her left knee but could not apply it herself, the staff apply it for her. On 4/27/26 at 10:58 AM, a record review of Resident #18's medical record did not document an order for the Biofreeze cream. On 4/27/26 at 11:39 AM, the ADON stated Resident #18 did not have an order or care plan for the Biofreeze cream, her family must have brought it in On 4/27/26 at 9:40 AM, observed the north hall medication cart had been left unattended, unlocked, and one medication drawer was left pulled open. On 4/27/26 at 10:46 AM, the DON stated the medication cart should not have been left unlocked with a drawer open unattended.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, it was determined the facility failed to ensure a resident's call light was within reach for 1 of 17 residents (Resident #45) reviewed for residents' rights. This deficient practice had the potential to cause harm if the resident could not call for assistance when needed or experienced an adverse medical event that required attention. Findings include: Resident #45 was admitted to the facility on [DATE], with multiple diagnoses including chronic kidney disease and chronic atrial fibrillation (irregular heart rate). On 4/29/26 at 7:51 AM, observed Resident #45 lying in bed with his call light plugged into the wall and hanging down the wall and under the head of his bed and not within his reach. Resident #45 unable to independently reach call light. On 4/29/26 at 7:53 AM, RN #1 stated Resident #45's call light should be within reach and had not been. On 4/29/26 at 3:48 PM, the RCN stated residents' call light should have been within reach and had not been.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to refer residents for further evaluation when residents were diagnosed with a major mental illness, intellectual disability, or a related condition. This was true for 1 of 3 residents (Resident #7) reviewed for Level II PASARR evaluations. This deficient practice had the potential to cause harm if resident's specialized services for mental health needs were not evaluated by an appropriate state-designated authority. Findings include: Resident #7 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including right femur fracture and schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior).Resident #7's Level I PASRR dated 3/23/26 had not documented the schizophrenia disorder diagnosis with an onset date 3/21/22.On 4/30/26 at 8:45 AM, the DON stated the schizophrenia diagnosis for Resident #7 should have been documented on the Level I PASRR 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 record review and staff interview, it was determined the facility failed to ensure residents' care plans were developed or revised to reflect current needs and interventions. This was true for 2 of 6 residents (#10 and #38) whose care plans were reviewed. This placed residents at risk of adverse outcomes if care and services were not provided due to care plans not being developed or revised as residents' needs changed. Findings include:Resident #10 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (progressive lung disease characterized by increasing breathlessness) and Bipolar II disorder.On 4/27/26 at 1:56 PM, Resident #10's care plan dated 3/25/26 to 6/23/26, had the following interventions missing.- At risk for impaired cognitive function/dementia or impaired thought processes. Date Initiated: 3/25/26- ADL Self Care Performance Deficit. Date Initiated: 3/25/26- At risk for falls r/t (SPECIFY) Date Initiated: 3/25/26- Has nutritional problem or potential nutritional problem (SPECIFY) r/t Date Initiated: 3/25/26- Has pressure ulcer or potential for pressure ulcer development (SPECIFY location) r/t Date Initiated: 3/25/26- Has acute/chronic pain (SPECIFY) r/t Date Initiated: 3/25/26Resident #10's prior care plan dated 6/3/24 to 4/5/26, had either resolved or cancelled for every issue noted and ongoing issues were not carried forward to the newest care plan.Resident #38 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and dementia.Resident #38's care plan was initially started on 2/11/26 and signed off on 2/19/26, 15 days after she was admitted on [DATE].On 4/30/26 at 8:42 AM, the DON stated Resident #10 and Resident #38's care plans should have been completed in a timely manner and had not been.

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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, record review, and interviews, it was determined the facility failed to provide respiratory services as ordered by the physician. This was true for 2 of 5 residents (#7 and #9) whose records were reviewed for respiratory services. This failure created the potential for residents to experience increased fatigue and low oxygen levels. Findings include: Resident #7 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including right femur fracture and schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior). On 4/27/26 at 11:25 AM, observed Resident #7's oxygen concentrator was set at 4 lpm, was turned on, and he was not using it during our visit. Resident #7 stated he only uses it at night or when he thinks he needs it during the day. Resident #7's physician oxygen order dated 3/23/26, documented oxygen continuously at 3 lpm via NC, every shift. On 4/29/26 at 4:39 PM, the DON stated Resident #7 should be using his oxygen at 3 lpm as ordered and was not. On 4/29/26 at 6:58 AM, observed during his medication pass Resident #7 sitting in his wheelchair in his room not wearing his oxygen. On 4/29/26 at 7:03 AM, observed LPN #2 ask Resident #7 why he was not wearing his oxygen and Resident #7 stated he had not needed it. On 4/29/26 at 7:04 AM, LPN #2 stated, Resident #7 should have been using his oxygen but had not been. Resident #9 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (a disease process which causes decreased ability of the lungs to function) and respiratory failure. On 4/27/26 at 10:28 AM and 4/28/26 at 2:27 PM, observed Resident #9 wearing his oxygen nasal cannula and the oxygen concentrator set at 2.5 L/min. On 4/28/26 at 2:31 PM, Resident #9's medical record documented a physician order dated 3/25/26, Oxygen continuously at 4 L via n/c every shift. On 4/28/26 at 2:49 PM, CNA #1stated Resident #9's oxygen had been set to 2.5 L/min and should have been set at 4 L/min via n/c. On 4/28/26 at 3:03 PM, the RCN stated Resident #9's oxygen had not been set at 4 L/min via n/c as ordered and should have been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135134	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bennett Hills Rehabilitation and Care Center	1220 Montana Street Gooding, ID 83330

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 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 1 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 Controlled Medications - Storage and Reconciliation policy, revision date 03.2025 documented. Procedure 8. A reconciliation or physical inventory of all controlled medications is conducted by two licensed nurses and is documented on an audit record at each shift change. On 4/29/26 at 7:59 AM, observed during the East Hall medication cart audit, the Narcotic Audit Shift Count sheets, with start date 2/14/26, and start date 4/1/26, with 1 licensed nurse signature not documented on 2/15/26 for 0600 count, on 2/15/26 for 1800 count, and on 4/6/26 for 0630 count. On 4/29/26 at 8:04 AM, LPN #3 stated two nurses should have signed the Narcotic Audit Shift Count sheet and had not. On 4/29/26 at 10:16 AM, the DON stated two nurses should have signed the Narcotic Audit Count sheets when they accepted the medication cart or released the medication cart and had not.