STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135135	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Post Falls	460 North Garden Plaza Court Post Falls, ID 83854

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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 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 observations, record review, interviews, and policy review, the facility failed to ensure medication was not left at bedside unless a medication administration assessment was conducted for one of one resident (Resident (R) 97) reviewed for medications at bedside of 25 sample residents. This failure had the potential to result in residents consuming excess medications. Findings include: Review of the admission Record located under the Profile tab of the electronic medical record (EMR) revealed R97 was admitted on [DATE] with diagnosis which included muscle weakness. Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/12/25 and located under the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. Review of the EMR revealed there was no self-administration assessment completed for R97. Review of the Order Summary Report located under the Orders tab of the EMR, revealed an order, dated 08/08/25, for Tums Oral Tablet Chewable 500 mg (milligram). Give one tablet by mouth two times a day for indigestion. The Rolaids were not listed. During an observation and interview on 08/11/25 at 9:53 AM, R97 had a bottle of Tums, a small plastic medication cup with two Tums, and a container of menthol rub located on the resident's bedside table. R97 stated she took the Tums before her other medications, sometimes. She stated she had not taken it recently because her stomach was better. She confirmed the Tums, and the menthol rub were located on her bedside table. During an observation and interview on 08/12/25 at 4:08 PM, the resident had a half full bottle of Rolaids, and a container of menthol rub located on the bedside table. The resident was currently out of the room. When observed with Licensed Practical Nurse (LPN) 3, she stated they were not supposed to be there. LPN3 stated they confiscated medications on admission. LPN3 confirmed it should not have been here at bedside. She reviewed the resident's chart and stated the resident did not have a self-administration order. During an interview on 08/13/25 at 10:17 AM, the Director of Nursing (DON) stated there was an assessment form available in the EMR. The DON stated no medications were allowed at bedside without a self-administration assessment completed. Review of the facility's policy titled, Self-Administration of Medication, reviewed 09/16/24, revealed The facility will ensure that each resident who requests to self-administer medications is assessed by the interdisciplinary team (IDT) to determine if the resident is safe to self-administer medications.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, interviews, review of the facility's policies, the facility failed to ensure the code status of one resident of 25 sample residents (Resident (R) 99) was updated in the electronic medical record (EMR) to match the code status ordered. The deficient practice could result in a resident receiving cardiopulmonary resuscitation that did not want to be resuscitated.Findings included:A review of R99's "Profile" screen located under the "Profile" tab and the "Physician's Orders" located under the "Orders" tab of the EMR on 08/11/25 at 4:33 PM revealed "Full Code." The Profile screen of the EMR revealed R99 was her own responsible party.A review of R99's "Idaho Physician's Orders for Scope of Treatment (POST)" located under the "MISC" tab of the EMR, dated 08/11/25, had an "X" marked next to "Do not resuscitate" and was signed by both R99 and the physician. Review of R99's "Brief Interview for Mental Status (BIMS)" located under the "Assessments" tab of the EMR revealed a BIMS score of 8 out of 15 which indicated the resident had moderate cognitive impairment. Review of R99's care plan dated 08/11/25 revealed the resident's code status was "Do not resuscitate."Review of R99's EMR on 08/12/25 at 3:44 PM, still showed a code status of "Full code" and the "POST" was still marked "Do Not Resuscitate [DNR]." During an interview on 08/12/25 at 4:11 PM, Certified Nursing Assistant (CNA) 4 stated, "[R99's] code status is Full code," while looking in the EMR.During an interview on 08/12/25 at 4:18 PM, Licensed Practical Nurse Unit Care Coordinator (LPNUCC) 2 stated "We looked in POST binder - she is DNR," while looking in the POST binder. During an interview on 08/12/25 at 4:22 PM, Licensed Practical Nurse (LPN) 1 stated "[R99] is a full code" while looking in the EMR. Then LPN1 stated, "We also look in the POST binder. Here she is DNR. The POST binder is the most accurate. Normally, the code status in the computer is updated by the resident care manager [RCM (LPNUCC2)]. It definitely needs to be updated. I will find the RCM to update." LPN1 then proceeded to locate the RCM in LPNUCC1's office. During an interview on 08/12/25 at 4:30 PM, LPNUCC1 stated, "Normally social services would pass the code change to RCM to update order in computer since social services does not have the ability to update orders." Both RCMs (LPNUCC1 and LPNUCC2) were in the office updating the code status orders in the computer.During an interview on 08/12/25 at 4:33 PM, the Social Services Director (SSD) stated, "We get the POST signed by the doctor, scan it in, and we email all of the nurse managers regarding the change. The email regarding [R99] was sent on 08/11/25 at 3:01 PM and the DON responded, 'thank you' at 3:13 PM.Review of the email revealed the Social Services Assistant (SSA) sent an email on 08/11/25 at 3:01 PM that stated "[R99] has changed her status to DNR w/ [with] comfort measures. The provider here today has the POST and will get it signed." The DON responded at 3:11 PM "Thank you [SSA]."A review of the "Physicians Orders" located under the "Orders" tab of the EMR revealed the order for "DNR" was entered on 8/12/25 at 4:27 PM.During an interview on 08/13/25 at 11:28 AM, the SSA stated, "[R99's Power of attorney (POA)] came into the office on Monday, 08/11/25, and stated [R99] was requesting her code status to be changed to DNR. I consulted with [R99] regarding the change in code status as [R99] is her own responsible party."During an interview on 08/13/25 at 11:49 AM, the Director of Nursing (DON) stated, "We have to get a new POST signed by the physician. We now have a binder with POSTs, face sheets, and inventory sheets updated. If a POST isn't signed by physician, the order gets changed in [the EMR] at the time the POST is signed by the physician. If post has not yet been signed by the physician and something happens, then we would verify verbally with physician. We were notified by social services that [R99's] POST was updated. It was uploaded by social services on 8/11/25 on the day of the change. It should have been changed in [the EMR] on same day. Staff have been educated to verify code status in the POST book as the book is most accurate. Social services emails the change in the POST to the management team. When the email is sent regarding POST changes, we are not always at our email, so it should also be verbally communicated. Nurse on the cart or any manager could change the order in [the EMR]. I didn't see the email until the next day. Any manager should have changed the order. The manager should have responded to the email saying the order was updated and completed." The DON reviewed her emails and stated, "The email was sent at 3:01 PM on 8/11 and I responded at 3:13 PM. One of the RCM's should have updated the order and responded. I should have followed up to ensure it was changed and updated in the computer. The RCM on the 200 hall is brand new so he may not have known what to do. "Review of the facility's policy titled, "Advance Directives and Advance Care Planning" revised 08/02/22, included "Residents have the right to self-determination regarding their medical care. This includes the right of an individual to direct his or her own medical treatment, including the right to execute or refuse to execute

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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. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, record review, policy review and interviews, the facility failed to ensure competencies were completed for Registered Nurse (RN) 2 to administer ordered medications to residents for one of five nurses reviewed. The deficient practice resulted in one resident not receiving ordered insulin medication.Findings included:Review of R101's physician's orders, located under the EMR "Orders" tab, revealed an order dated 08/06/25 for "Humalog injection solution, Inject as per sliding scale: . 211 - 240 = 4; 241 - 270 = 5; 271 - 300 = 6; 301 - 330 = 7; 331+ = 8, subcutaneously before meals and at bedtime related to type 2 diabetes mellitus without complications.Review of R101's August 2025 "Medication Administration Record" located in the EMR "Orders" tab revealed, R101's blood sugar on 08/09/25 at 3:48 PM was 229 and required Humalog sliding scale insulin of 4 units to be administered which was not administered. On 08/09/25 at 8:05 PM, R101's blood sugar was 317 and 7 units of Humalog insulin was administered in accordance with physician order. Review of R101's progress note dated 08/09/25 at 3:47 PM, Registered Nurse (RN) 2 documented "Humalog not in facility."During an interview on 08/14/25 at 1:58 PM, RN2 stated, "I checked his [R101's] blood sugar at dinner time and his blood sugar was about 200. Fast acting insulin at 4:00 PM was not given because I didn't know that we had emergency stock insulin at the time. Another nurse on the floor just told me to just mark that it could not be given because it was not available. When I checked his blood sugar at 9:00 PM, it was higher about 300 and then a different nurse told me there was emergency stock, so I got the emergency stock insulin and gave him the dose according to the sliding scale. I hired on about a month ago and this was my first shift off orientation. I was not aware of any emergency stock medications available before to the 9:00 PM dose that was given."During an interview on 08/14/25 at 2:59 PM, the Director of Nursing (DON) stated, "The expectation is if the resident's insulin pen is not available, the medication is to be pulled from the emergency stock. Nurses should be oriented to emergency stock medications during orientation on the floor but I'm not sure if it's actually on the checklist. If not, it needs to be added." The DON obtained and reviewed [RN2's] nursing orientation checklist. The Nursing Orientation Checklist was signed by RN2, dated 08/14/25. The top rows of the Nursing Orientation Checklist had a date of "07/25" and the RN2's initials with arrows drawn down the columns including rows that did not have skills to be checked off. The checklist was not signed by any "Trainers" or the "Orientation Coordinator." The "Competency/Skills Checklist" had a date completed of "08/01/25," however, all spaces on the checklist were blank including "Documentation - medication/PRN Med Sheets." Emergency stock medications was not included on the checklists.During an interview on 08/14/25 at 4:27 PM, RN2 stated, "During orientation I was put with good nurses. The emergency medications never came up and so that was never discussed. There was an orientation checklist, but I did not see it. The nurse training me told me just to sign off that we went over it. There were some things that I was specifically oriented to but don't remember what specific things. "During an interview on 08/14/25 at 4:47 PM, the DON stated, "I'm not able to confirm if [RN2] had completed any items on the competency checklist. No nurse had signed off the orientation checklist as completed. Only [RN2] signed the checklist. I reviewed the orientation checklist and that the checklist contained items such as ventilators and implanted ports that are not areas that our facility cares for. Items such as emergency medication access was not included on the checklist and I want it added to the checklist. "Review of the facility's policy titled, "Competent Staff," dated 09/13/22, included "The facility will have sufficient nursing staff with the appropriate competencies and skills needed to provide nursing and related services to assure resident safety and maintain the highest level of care. The facility will evaluate educational needs to achieve competency throughout the clinical orientation period utilizing the competency skills checklists . Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in areas such as: . Medication management. The Staff Development Coordinator/designee will be responsible for maintaining training records."

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review, interviews, and facility policy review, the facility failed to ensure one of three residents reviewed for insulin of 25 sampled residents was free from significant medication errors when Resident (R) 101 did not receive Humalog (insulin medicine) on one occasion. This failure resulted in elevated blood sugar for R101.Findings include:Review of the facility's "Administration of Medication" policy, dated 02/13/23, revealed "The facility will ensure medications are administered safely and appropriately per physician Order to address residents' diagnoses and signs and symptoms . Significant medication error -This means one which causes the resident discomfort or jeopardizes his or her health and safety."Review of R101's physician's orders, located under the EMR "Orders" tab, revealed an order dated 08/06/25 for "Humalog injection solution, Inject as per sliding scale: if 0 - 120 = 0; 121 - 150 = 1; 151 - 180 = 2; 181 - 210 = 3; 211 - 240 = 4; 241 - 270 = 5; 271 - 300 = 6; 301 - 330 = 7; 331+ = 8, subcutaneously before meals and at bedtime related to type 2 diabetes mellitus without complications.Review of R101's August 2025 "Medication Administration Record" located in the EMR "Orders" tab revealed, R101's blood sugar on 08/09/25 at 3:48 PM was 229 and required Humalog sliding scale insulin of 4 units to be administered which was not administered. On 08/09/25 at 8:05 PM, R101's blood sugar was 317 and 7 units of Humalog insulin was administered in accordance with physician order. Review of R101's progress note dated 08/09/25 at 3:47 PM, Registered Nurse (RN) 2 documented "Humalog not in facility."During an interview on 08/14/25 1:05 PM, Licensed Practical Nurse (LPN) 7 verified in the medication cart that R101's Humalog insulin pen was available. Observation of R101's Humalog insulin pen revealed an open date of 08/10/25. LPN7 stated, "[R101] has had insulin available since he has been on the 200 hall. Humalog is available in the emergency stock in the medication room if the resident's insulin pen is not available." Observation of the emergency stock kit revealed four vials of Humalog insulin in the clear locked box.Review of R101's resident census revealed the resident was transferred from the 300 hall to the 200 hall on 08/08/25.During an interview on 08/14/25 at 1:16 PM, the Director of Nursing (DON) stated, "The pharmacy restocks emergency medications monthly. I am not aware of any resident being out of insulin and not having emergency stock insulin available. If insulin is removed from the emergency stock, it would be signed out on the sign out sheet." Observation of the emergency stock sign-out sheet on the 200 hall did not list R101 as having emergency stock insulin removed. During an interview on 08/14/25 at 1:58 PM, RN2 stated, "If insulin was available, then I would pull from emergency stock. [R101] did not have his fast-acting insulin in stock. I went to the 300 hall to get Humalog insulin from emergency stock about 9:00 PM. I checked his blood sugar at dinner time, and his blood sugar was about 200. Fast acting insulin at 4:00 PM was not given because I didn't know that we had emergency stock insulin at the time. Another nurse on the floor just told me to just mark that it could not be given because it was not available. When I checked his blood sugar at 9:00 PM, it was higher about 300 and then a different nurse told me there was emergency stock, so I got the emergency stock insulin and gave him the dose according to the sliding scale. I hired on about a month ago and this was my first shift off orientation. I was not aware of any emergency stock medications available before to the 9:00 PM dose that was given." During an interview on 08/14/25 at 2:59 PM, the DON stated, "The expectation is if the resident's insulin pen is not available, the medication is to be pulled from the emergency stock. Not administering insulin as ordered is considered a significant medication error."

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and policy review, the facility failed to ensure medications were labeled with open and discard dates and expired medications were disposed of and not made available on the medication cart for one of three medication carts and two of two medication storage rooms reviewed. This had the potential to cause medication errors, adverse medication reactions, and residents to receive suboptimal therapeutic actions of medications.Findings include:The following observations were made during the review of medication carts and medication storage rooms throughout the facility.During a review of the medication cart on the 100 hall on 08/13/25 at 2:56 PM with Certified Medication Aide (CMA) 1, a tube of "Skin Protectant Cream" was found in the bottom drawer with other tubes of cream. The tube had a resident name written on it but did not have an open or discard date. The date stamped from the manufacturer on the tube stated "Exp [DATE]." CMA1 confirmed the date and stated "The cream is expired and needs to be discarded." When asked where creams were stored, CMA1 stated "They are kept in the central supply room."During a review of the central supply room on 08/13/25 at 3:13 PM with Central Supply, the skin protectant cream was not found and Central Supply stated "skin protectant cream is out of stock. It would normally be here (pointing to the spot on the shelf)." A box of "Pepto Bismol Tablets" were found on the shelf with a date stamped on the box "Exp [DATE]." Central Supply verified the date and stated "yes, those are expired!" and through them in the trash. During a review of the medication storage room on the 200 hall on 08/13/25 at 3:42 PM with Licensed Practical Nurse (LPN) 6, a vial of tuberculin was found opened and not dated. LPN6 verified the vial was opened and not dated and stated, "The vial needs to be discarded since there is no open date, and we do not know how long it has been opened. If I was opening a new vial, I would check the expiration date on the vial and write the opened date on the vial. The vial would be good for 30 days from opening. The Resident Care Managers (RCMs) are responsible for checking the medication carts and medication rooms for expiration dates."During an interview on 08/13/25 at 4:17 PM, the Administrator deferred to the Director of Nursing (DON) regarding the labeling and expiration dates of medications including central supply. During an interview on 08/13/25 at 4:25 PM, the DON stated "The skin protectant cream came from the hospital when the resident returned yesterday. The nurse did not verify the expiration date prior to placing the tube of cream in the medication cart. The weekend manager is responsible for reviewing all the carts every weekend, following the checklist, making sure everything is dated and verify there is nothing in the carts that shouldn't be there. During the state window [time period when facility is due for their annual survey by the state agency], I jump in and help verify carts as well. When vials are opened, the expectation is that the nurses date the vial. If the vial is not dated, the vial is discarded, and education is provided to the nurses. The Central Supply Director is responsible for central supply expiration dates."Review of the facility's policy titled, "Storage and Expiration Dating of Medications and Biologicals," with a revised date of 08/01/24 included "Facility should ensure medications and biologicals that: have an expired date on the label; have been retained longer than recommended by manufacturer or supplier guidelines . are stored separate from other medications until destroyed or returned to the pharmacy or supplier. Facility staff should record the date opened on the primary medication container (i.e., vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened."