STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135138	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Teton Healthcare of Cascadia	3111 Channing Way Idaho Falls, ID 83404

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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 policy review, observation, record review, and interviews, it was determined the facility failed to ensure residents were initially assessed to determine if they were safe to self-administer medications for 1 of 1 resident (Resident #49). This failure created the potential for adverse effects if residents self-administered medications inappropriately. Findings include:The facility's Self-Administration of Medications policy dated 11/28/17, documented under Procedure 2. the interdisciplinary team determines that it is safe for the resident to self-administer drugs before the resident is allowed to do so, and the decision is periodically reviewed according to the resident's status. Procedure 2b. documented the determination of who will be responsible (resident or the nursing staff) for storage and documentation of the administration of drugs, as well as the location of the drug administration. Procedure 4. documented appropriate notation of these determinations is documented in the resident's medical record and care plan.Resident #49 was admitted to the facility on [DATE], with multiple diagnoses including metabolic encephalopathy (a reversible, acute, or chronic brain dysfunction caused by systemic illness, toxins, or chemical imbalances) and acute respiratory failure with hypoxia (acute hypoxic (or hypoxemic) respiratory failure is a critical condition where the lungs cannot adequately transfer oxygen to the blood).On 3/2/26 at 8:02 AM, observed Resident #49 had OTC Refresh eye drops on her overbed table. Resident #49 stated, she keeps them in the room for when she needs them.Resident #49's medical record documented no patient assessment for self-administration of medications and no documentation in her care plan to allow self-administration of medications.On 3/3/26 at 1:38 PM, the RN Clinical Resource Nurse stated Resident #49 should not have Refresh Eye drops in her room and she had not yet been assessed for self-administration of said medication.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 policy review, observation, record review, and staff interview, it was determined the facility failed to ensure a resident's call light was within reach for 2 of 17 residents (#4 and #5) 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: The facility's Call Light Response Time policy, revision date 10/15/22, documented. Procedure 1. Resident Access a. Call light systems are expected to be available, within reach, at the bedside and in toileting and bathing areas.Resident #4 was initially admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including unspecified psychosis (symptoms of a significant disconnection from reality, such as hallucinations, delusions, or disorganized behavior) and muscle weakness. On 3/2/26 at 8:07 AM, observed Resident #4 sitting at her side table in the middle of her room eating breakfast and her call light was tied around the nightstand drawer handle behind her next to the bed and not within her reach. Resident was unable to independently reach call light. On 3/2/26 at 8:12 AM, CNA #1 stated Resident #4's call light should be within reach and had not been. Resident #5 was admitted to the facility on [DATE], with multiple diagnoses including hemiplegia (paralysis to one side of the body) and diabetes. On 3/2/26 at 2:55 PM, observed Resident #5 reclining in his bed and his call light was on his bedside table to the left side of his bed, which was not within his reach. Resident #5 stated he could not reach his call light where it had been placed after staff helped him with cares. On 3/2/26 at 3:02 PM, CNA #1 stated Resident #5's call light should have been within reach and had not been. On 3/4/26 at 3:18 PM, the CNO stated resident call lights should be within the resident's reach and had not been.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to provide the Notice of Medicare Non-Coverage (NOMNC) (CMS- 10123 form) for 1 of 1 resident (Resident #81) reviewed for beneficiary protection notification. This deficient practice had the potential to cause financial harm or distress for residents when they were not informed of their potential liability for payment when their Medicare Part A benefits ended. Findings include: Resident #81 was admitted to the facility on [DATE], with multiple diagnoses including post-surgical repair of fracture left femur and muscle weakness.On 3/4/26 at 1:20 PM, during record review the NOMNC documented .effective date coverage of your current skilled nursing facility services will end on 11/18/25, however; the NOMNC had a signature of resident and resident's representative on 11/17/25.On 3/4/26 at 1:35 PM, review of Social Services Note dated 11/17/25 12:12, documented Social Services spoke with daughter via telephone about the NOMNC issued for last covered day of 11/18/25.On 3/4/26 at 1:40 PM, the CEO stated the NOMNC for Resident #81 should have been signed 48 hours prior to the end of covered skilled nursing services and had not been.

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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. Based on observation and staff interview, it was determined the facility failed to ensure residents were provided with a safe, clean, comfortable, and homelike environment. This was true for the facility. This deficient practice created the potential for diminished quality of life and safety risk including potential for infections and cross-contamination. Findings include:On 3/2/26 at 12:22 PM, observed two large dining room ceiling vents with brown hairy-like debris covering 1/3 of the inside of each vent and a small strip of red confetti-like paper in one vent.On 3/2/26 at 12:23 PM, observed brown/black discoloration on the ceiling around the other dining room ceiling vents.On 3/2/26 at 12:34 PM, the CEO stated the vents should have been cleaned and had not been.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and staff interview, it was determined the facility failed to ensure a written notice of transfer and bed hold policy was provided to the resident or their representative when residents were transferred to the hospital. This was true for 1 of 2 residents (Resident #23) reviewed for transfers. This deficient practice created the potential for psychosocial distress if residents and their representatives were not made aware of or able to exercise their rights related to transfers from the facility. Findings include:The facility's Discharge or Transfer policy revised 8/30/25, documented under NOTICE OF TRANSFER OR discharge: 1. The facility must provide the resident, the resident's representative (if any), and the Office of the State Long-Term Care Ombudsman with a written notice at least 30 days before the resident is transferred or discharged , except when .c. The resident's urgent medical needs require an immediate transfer.The facility's Bed-Hold policy revised 9/9/25, documented Facilities are required by Federal regulation to have policies addressing holding a resident's bed during periods of absence such as hospitalization or therapeutic leave. Additionally, facilities provide this written information about these policies to residents prior to and upon transfer for such absences.Resident #23 was initially admitted to the facility on [DATE], with multiple diagnoses including diabetes, heart failure, and cirrhosis.On 9/22/25, Resident #23 was transferred to the ER. Resident #23's medical record did not document he received a written Notice of Transfer or Bed Hold policy.On 2/8/26, Resident #23 was transferred to the ER. Resident #23's medical record did not document he received a written Notice of Transfer or Bed Hold policy.On 3/3/26 at 4:00 PM, the RN Clinical Resource Nurse stated they could not locate the Notice of Transfer or the Bed Hold for Resident #23's ER transfers on 9/22/25 or 2/8/26.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review, policy review, and interview, it was determined the facility failed to ensure a baseline care plan was developed within 48 hours of resident's admission. This was true for 2 of 3 Residents (#2 & #73) reviewed for baseline care plan. This failure created the potential for harm when the care plan failed to provide direction for care. Findings include:The facility's Baseline Care Plans policy revised date 10/15/22, documented under Procedure 1. A baseline plan of care is developed within 48 hours of admission to address the immediate needs of the residents and will be utilized/updated as needed until a comprehensive care plan can be developed and implemented. Resident #2 was admitted to the facility on [DATE], with multiple diagnoses including end stage renal disease (the final, irreversible phase of kidney failure where kidneys no longer function sufficiently on their own, requiring dialysis or a transplant for survival) and acute respiratory failure with hypoxia (acute hypoxic (or hypoxemic) respiratory failure is a critical condition where the lungs cannot adequately transfer oxygen to the blood). Resident #2's baseline care plan was initiated on 2/2/26, but not locked or completed until 2/3/26, which exceeds the required 48 hours baseline care plan requirement. On 3/3/26 at 9:28 AM, the RN Clinical Resource Nurse stated a baseline care plan is not completed until locked. On 3/4/26 at 10:54 AM, the CNO stated baseline care plans are not completed until locked. On 3/4/26 at 11:01 AM, the RN Clinical Resource Nurse stated Resident #2's baseline care plan had not been completed within 48 hours and should have been. Resident #73 was admitted to the facility on [DATE], with multiple diagnoses including Necrotizing Fasciitis (a rare, life-threatening bacterial infection that destroys skin, fat, and muscle tissue), and diabetes with diabetic polyneuropathy (a common, progressive nerve disorder caused by high blood sugar damaging peripheral nerves). A closed record review, (meaning the resident has been discharged) on 3/3/26, indicated Resident #73's baseline care plan was not completed until 12/29/25, 5 days after her admission. On 3/3/26 at 9:20 AM, the RN Clinical Resource Nurse stated the baseline care plan should have been created within 48 hours of admission 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, 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 1 of 6 residents (Resident #3) 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.Resident #3 was initially admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including acute and chronic respiratory failure and other abnormalities of breathing. On 3/2/26 at 8:07 AM, during interview Resident #3 stated his left arm is swollen and has been for a while. On 3/2/26 at 8:08 AM and 3/5/26 at 9:52 AM, observed Resident #3 sitting in his room not wearing a compression glove to the left hand and Tubi grip sleeve to his left arm from the wrist to the shoulder. On 3/2/26 at 11:03 AM, during record review noted Resident #3 physician order dated 9/16/25 - Compression glove to left hand, Tubi grip sleeve to left arm from wrist to shoulder every day and night shift for edema. On 3/2/26 at 11:06 AM, Resident #3's care plan reviewed with no documentation regarding compression glove to left hand and Tubi grip sleeve to left arm. On 3/5/26 at 10:17 AM, the RN Clinical Resource Nurse stated Resident #3's care plan should have been updated when the resident received physician orders for the compression glove and Tubi grip sleeve and had not been.

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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, record review, 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 3/3/26 at 1:50 PM, observed the Daily Staffing sheets for February 2025 through July 2025, noting the name of the facility and LPN hours were not listed on any of these sheets.On 3/4/26 at 10:35 AM, the CEO stated the LPN hours, and name of the facility should have been on the daily staffing sheet from February 2025 through July 2025 but were not.

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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 and staff interview, it was determined the facility failed to ensure controlled medications were tracked and kept secure from potential theft and/or diversion. This was true for 2 of 2 medication carts reviewed. This failure created the potential for undetected misuse and/or diversion of controlled medications and had the potential to affect all residents who received controlled medication in the facility. Findings include:On 3/3/26 at 8:52 AM, observed during the 400 Hall medication cart audit the narcotic accountability sheet, dated 3/2/26 to 3/3/26, with 1 licensed nurse signature not documented on 3/3/26. On 3/3/26 at 8:53 AM, RN #2 stated two nurses should have signed the narcotic accountability sheet and had not. On 3/4/26 at 8:44 AM, observed during the 100 Hall medication cart audit the narcotic accountability sheets, dated 2/6/26 to 2/12/26, 2/13/26 to 2/20/26, and 3/1/26 to 3/3/26 with 1 licensed nurse signature not documented on 2/11/26, 2/12/26, 2/13/26, 2/19/26, and 3/3/26. On 3/4/26 at 8:48 AM, RN #4 stated two nurses should have signed the narcotic accountability sheet when they accepted the medication cart or released the medication cart. On 3/4/26 at 3:15 PM, the CNO stated two nurses should have signed the narcotic accountability sheet when they accepted the medication cart or released the medication cart and had not.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **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 physician orders documented adequate indications, diagnosis, or duration for use when residents were prescribed antibiotics. This was true for 1 of 4 residents (Resident #14), reviewed for antibiotic use. This failed practice had the potential to cause significant harm if the resident was to develop an antimicrobial resistance or toxicity. Findings include:The facility's Physician/Providers Orders Policy, revised 9/12/25, documented under Procedure the following:2. Ensure each medication order includes:Resident nameDrug name and strengthIndication or diagnosisDosage, frequency, route, and durationOther monitoring/parameters required by state or federal regulationThe facility's Unnecessary Medications Policy, revised 9/10/25, documented The facility will ensure that each resident's medication regimen is free from unnecessary medications. This includes medications prescribed in excessive dose, without adequate indications for use, without appropriate monitoring, or in the presence of adverse consequences that indicate the medication should be reduced or discontinued. Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including spinal stenosis in the lumbar region (a narrowing in the spinal canal in the lower back) and neurogenic bladder (nerve damage that prevents the bladder from properly storing or emptying urine).Resident #14's physician order dated 9/22/25, documented Gentamicin Sulfate Injection Solution (Gentamicin Sulfate). Use 400 mg via irrigation every day and night shift for Inject 60cc solution into bladder via foley. Clamp for 30 minutes then unclamp.Resident #14's physician order for the Gentamicin Sulfate did not document an adequate indication or diagnosis and indicated the duration as indefinite. On 3/3/26 at 1:37 PM, the ACNO stated the order for Gentamicin dated 9/22/25, should have had an indication for use and duration but had not.

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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. Based on observations, record review, and staff interviews it was determined the facility failed to ensure medications were not expired and were secure and inaccessible to unauthorized staff and residents. This was true for the facility. This failure created the potential for residents to receive expired medications with decreased efficacy and potential for harm to a resident if they obtain medications which were left unattended and unsecured by staff. Findings include: The facility's policy, Medication Storage & Labeling, dated 10/13/25, documented.Procedure 2. Storage Requirements a. General Medications: i. Store in locked compartments (cabinets, carts, medication rooms), ii. Maintain clean, sanitary conditions: prevent contamination.5. Disposal a. Expired or discontinued medications must be removed promptly and disposed of per facility policy and DEA guidelines to prevent diversion. On 3/2/26 at 8:50 AM, observed in the Medication Storage room with LPN #1 present the following:Three bottles of Rena Vite 100 tablets with a manufacturer printed expiration date of 1/2026Two bottles of Melatonin 1mg with a manufacturer printed expiration date of 2/2026One bottle of Multi Vitamin 1000 tablets with a manufacturer printed expiration date of 2/2026One bottle of Pro Stat Liquid Protein 30 ounces with a manufacturer printed expiration date of 2/2026Two bottles of Anti-dandruff shampoo with Selenium Sulfide 1% with a manufacturer printed expiration date of 2/2026 On 3/2/26 at 9:02 AM, the CNO stated the expired medications should have been removed from the Medication Storage room and had not been. 2. On 3/4/26 at 12:12 PM, observed the 100 Hall medication cart unlocked and unattended by staff. On 3/4/26 observed between 12:12 PM and 12:16 PM, three staff members walk by the medication cart without acknowledging the cart was unlocked and unattended. On 3/4/26 at 12:17 PM, observed RN #4 walking down 100 hallway and approached the unlocked and unattended medication cart. On 3/4/26 at 12:18 PM, RN #4 stated the medication cart should not have been left unlocked when leaving the cart unattended. On 3/4/26 at 3:16 PM, the CNO stated the medication cart should not have been left unlocked when the nurse left the cart unattended. 3.The following was observed during the medication cart audits. On 3/4/26 at 12:21 PM, the 100 Hall medication cart was audited with RN #4 present. The following medications were observed loose in the bottom of the medication cart drawer 2 and medication cart drawer 3: - 1 medium blue colored capsule with DCX 30 printed on capsule - 1/2 white colored capsule with D 02 imprinted on capsule - 1 medium white colored round tablet with M imprinted on tablet on one side and C37 imprinted on other side - 1 medium round light brown tablet with 60 imprinted on tablet - 1/2 tablet light blue with 540 imprinted on one side - 1 small white round tablet with TV imprinted on one side and 4 numbers (2204) imprinted on the other side - 1 bottle of Multi Vitamin with manufacturer printed expiration date 2/2026 On 3/4/26 at 12:30 PM, RN #4 stated the pills should not have been loose in the medication cart and the medication cart drawers should have been cleaned to remove any loose pills. On 3/4/26 at 12:33 PM, the CNO stated the pills should not have been loose in the medication cart and should have been destroyed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on the FDA Food Code, policy review, observation, and interview, the facility failed to ensure food was appropriately stored, distributed, and labeled, cooking equipment was free of encrustation, and the floors were properly cleaned and sanitized. This deficient practice had the potential to affect all residents who received meals prepared in the facility's kitchen. This placed residents at risk for potential contamination of food and adverse health outcomes including food-borne illnesses. Findings include:The FDA Food Code 2022, 3-501.17 documented, Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking . refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.The FDA Food Code 2022, 4-601.11, documented, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations.The facility's Food Safety & Storage policy dated 11/28/17, documented the following under Labeling and Rotation:Opened or repackaged food must be labeled with contents and use-by-date.Food removed from original packaging must be labeled with its common name, unless clearly identifiable, and use-by or expiration date.Ready-to-eat food held longer than 24 hours must be labeled with preparation and use-by-dates.On 3/2/26 between 8:00 AM - 8:20 AM, observed the following:- the walk-in refrigerator contained 11 individual salads dated 3/1/26.- the walk-in freezer contained chocolate pieces on a cookie sheet that was not covered, labeled, or dated.- the clean pots and pans storage rack contained muffin pans that were encrusted on the front and back of the pans.- the drain hole under the food prep sink had a split grate covered in black dirt and grime-like substance reaching beyond the opening of the hole onto each side of the tiles surrounding the drain hole.- underneath the counters, handwashing sink, and food prep sink where the floor and wall meet, had a thick layer of dirt, food, and grime.On 3/2/26 8:40 AM, the CFM stated the salads should have been used on 3/1/26 and discarded them.On 3/4/26 at 11:40 AM, the CFM stated the floor underneath the food prep sink was dirty and he had scrubbed it the previous day (3/3/26). The CFM and Dietician confirmed the encrustation on the muffin pans and stated they would replace them.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Teton Healthcare of Cascadia	3111 Channing Way Idaho Falls, ID 83404

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review it was determined the facility failed to ensure infection control prevention practices were maintained to provide a safe and sanitary environment during medication administration. This was true for 1 of 4 residents (Resident #60) observed for infection control. These failures put residents at risk for cross contamination and infection. Findings include:The facility's policy, Medication Administration, revision date, 12/18/21, 9/10/25, documented.Procedure 9. a. Remove medication from the storage receptacle (container, bottle, or blister pack) without directly touching the medication.Resident #60 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (a progressive lung disease that restricts airflow causing breathing difficulty) and diabetes.Resident #60's physician orders documented fifteen morning medications for resident including Colace 100 mg - 1 soft gel capsule by mouth.On 3/4/26 at 8:30 AM, observed RN #3 place all fifteen medications in a medication cup and enter Resident #60's room. Resident #60 stated she did not want the Colace; RN #3 removed the Colace capsule from the medication cup with her ungloved finger and provided the medication cup to Resident #60. On 3/4/26 at 8:37 AM, RN #3 stated she should have used a spoon or donned gloves to remove the Colace from the medication cup and had not. On 3/4/26 at 3:18 PM, the CNO stated RN #3 should not have used her ungloved finger to remove the medication from the medication cup.