STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135091	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Idaho Falls	2725 East 17th Street Idaho Falls, ID 83406

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and staff interview, it was determined the facility failed to honor residents Do Not Resuscitate (DNR) and Do Not Intubate (DNI) orders. This was true for 1 of 1 resident (Resident #5) whose record was reviewed for code status. This deficient practice created the potential for harm or adverse outcomes if residents' wishes were not followed or documented. Findings include:Resident #5 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic kidney disease and diabetes.A facility investigation documented on [DATE], Resident #5 was found unresponsive by CNA staff and nursing staff were notified. Nursing staff performed an assessment and determined Resident #5 was a DNR. LPN #1 then entered Resident #5's room with a POST document in hand and stated she was a full code and CPR was started. This POST document was later found to be for a different resident and not Resident #5. Nursing staff called 911 for an ambulance. When the ambulance crew arrived, facility staff had correctly identified Resident #5 was a DNR and CPR was stopped, and time of death was called at 3:30 PM.Resident #5's physician order dated [DATE] for code status was DNR. Resident #5's POST documented do not resuscitate and can use aggressive interventions to include positioning, oxygen therapy etc.Resident #5's care plan documented code status as DNR.On [DATE] at 2:05 PM, the Admissions nurse and RN #1 stated Resident #5 had been a DNR and CPR should not have been started on her.

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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(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 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 1 of 1 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 9/2/25 at 12:19 PM, during Hall 2 medication cart review, observed the narcotic accountability record, dated 9/1/25 to 9/2/25, with 1 licensed nurse signature not documented. On 9/2/25 at 12:32 PM, RN #1 stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart. On 9/2/25 at 12:40 PM, the Admissions Nurse stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart.