STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135144	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascadia of Nampa	900 N Happy Valley Rd Nampa, ID 83687

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and interviews, it was determined the facility failed to ensure residents were assessed for safety to self-administer medication. This was true for 3 of 19 residents (#49, #52 and #87) whose medications were observed at bedside. This failure created the potential for adverse outcome if residents were to administer their medication inappropriately. 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 facility will assess each request using a team-based approach. The assessment will consider the resident's ability to manage medications independently and safely, including bedside storage as appropriate.1. Resident #49 was admitted to the facility on [DATE], with multiple diagnoses including stroke and diabetes.On 12/3/25 at 9:14 AM, RN #3 entered Resident #49's room with a medication cup containing the resident's oral medication mixed with pudding. Resident #49 asked for her Dorzolamide (eye drops) to be administered first before her oral medications. RN #3 placed the medication cup on top of Resident #49's table and stated she brought the Brimonidine eye drops instead of the Dorzolamide eye drops. RN #3 then left the room, leaving the cup of medication, and came back with Dorzolamide eye drops and administered it to Resident #3's eyes. RN #3 then administered Resident #49's oral medications.On 12/3/25 at 9:45 AM, RN #3 was asked why she left the medication cup on Resident #49's overbed table to get the Dorzolamide eye drops. RN #3 stated she left the medication cup on the overbed table because she did not want to spill the medications. RN #3 added she would not leave the medications at resident's bedside if she knew the resident was confused.On 12/3/25 at 3:15 PM, CRN together with the RCM stated the medications should not have been left at Resident #49's overbed table.2. Resident #52 was admitted to the facility on [DATE], with multiple diagnoses including traumatic subdural (brain) hemorrhage with loss of consciousness and heart failure.A Comprehensive MDS assessment dated [DATE], documented Resident #52 had severely impaired-no vision or sees only light, colors or shapes; eyes do not appear to follow objects.On 12/1/25 at 8:53 AM, a medication cup containing white powder was observed on Resident #52's bedside table.On 12/1/25 at 3:20 PM, the RCM stated she had no idea what the white powder inside the medication cup was. When asked if the medication cup containing the white powder should be left at Resident #52's bedside table, the RCM stated No it should not be left at Resident #52's bedside table. The RCM stated if a medication was at Resident #52's bedside table she should have an assessment to self-administer the medication.On 12/3/25 at 2:18 PM, the RCM stated Resident #52 did not have an assessment to self-administer her medications.3. Resident #87 was admitted to the facility on [DATE], with multiple diagnoses including osteoarthritis and diabetes.On 12/1/25 at 8:48 AM, a ketoconazole (anti-fungal) cream was observed on Resident #87's overbed table. Resident #87 stated the ketoconazole cream was prescribed by his dermatologist and he applied it to his skin once or twice a day.On 12/1/25 at 3:14 PM, the RCM stated the ketoconazole should not be left in Resident #87's room. The RCM stated if a medication was at Resident #87's bedside table he should have an assessment to self-administer the medication.On 12/3/25 at 2:18 PM, the RCM stated Resident #87 did not have an assessment to self-administer his medications.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **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 accurate MDS Assessments. This was true for 1 of 5 residents (Resident #1) reviewed for accuracy of assessments. This deficient practice had the potential to create harm if residents did not have an accurate MDS assessment. Findings include:Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including hypertensive heart disease with heart failure and acute and chronic respiratory failure with hypoxia (low levels of oxygen in the body tissues).A Quarterly MDS assessment dated [DATE], documented Resident #1 was not receiving oxygen therapy.A care plan initiated 5/27/25, documented Resident #1 was to receive oxygen as ordered by the physician.On 12/1/25 at 12:03 PM, Resident #1 was observed in the dining room receiving oxygen via nasal cannula.On 12/2/25 at 3:44 PM, the MDS Coordinator reviewed Resident #1's MDS assessment dated [DATE]. The MDS Coordinator stated Resident #1's MDS assessment should have been coded Yes for oxygen.

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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 interviews, the facility failed to ensure coordination of assessments with the PASARR program for 1 of 2 residents (Resident #9) reviewed for PASARR coordination. This failure created the potential for residents with a mental disorders or intellectual disabilities to miss care and services in the most integrated care setting appropriate to their needs. Findings include:Resident #9 was admitted to the facility on [DATE] with multiple diagnoses including schizoaffective disorder, dementia, and lack of expected physiological development.Resident #9's record included an abbreviated PASARR Level II dated 10/1/25, which documented the admitting facility must complete a PASARR when it appears the resident's stay will exceed 30 days, and no later than the 40th calendar day after admission.On 12/5/25 at 10:46 AM, the LSW stated Resident #9's PASARR should have been submitted by 11/9/25. A review of Resident #9's record showed the PASARR was not submitted until 12/4/25, 26 days late.

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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 PASARR was accurately completed for 1 of 2 residents (Resident #44) reviewed for PASARR screenings. This deficient practice created the potential for harm if Resident #44 required, but did not receive, specialized services for mental health while residing in the facility. Findings include:The facility's PASARR policy revised 8/29/25, documented the facility would ensure that potential admissions were to be screened for possible serious mental disorders or intellectual disabilities and related conditionsResident #44 was admitted to the facility on [DATE], with multiple diagnoses including post-traumatic stress disorder.Resident #44's PASARR evaluation dated 10/2/23, documented on section 1. Does the individual have any of the following Major Mental Illnesses (MMI)? The Post-Traumatic Stress Disorder was not checked off for Resident #44.On 12/3/22 at 2:18 PM, the LSW reviewed Resident #44's PASARR. The LSW stated Resident #44 had diagnosis of PTSD and his PASARR Level I was not accurately completed. Resident #44 should have PASARR Level II assessment completed.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, review of the neglect investigation and clinical guidance, the facility failed to ensure resident's were provided treatment and care in accordance with professional standards of practice, and the residents goals and preferences when they did not identify and act upon Resident #60's physical and cognitive deterioration. This failure resulted in Immediate Jeopardy to Resident #60's health and safety when Resident #60 was not promptly assessed and treated for acute changes in condition, leading to hospitalization of sepsis (a life-threatening condition where the body's immune system has a severe and overwhelming response to an infection, causing damage to its own tissues and organs) and Stevens-Johnson Syndrome/Toxic Epidermal Necrolysis (a rare, severe, life-threatening skin disorder, often triggered by medications, causing widespread blistering and peeling of the skin and mucous membranes, resembling a severe burn, leading to fluid loss, infection risk, and intense pain).Immediate Jeopardy was identified on 12/4/25 at 12:31 PM and was determined to exist since 11/21/25, when the facility failed to ensure appropriate nursing response to Resident #60 when she displayed signs of sepsis. On 12/4/25 at 12:31 PM, the facility's Administrator was notified of the Immediate Jeopardy at F684 Quality of Care. On 12/5/25 at 6:10 PM, after the Survey Team verified implementation of the IJ removal plan, the facility Administrator was notified the Immediacy was removed on 12/5/25. The noncompliance remained at a scope and severity level of G (isolated actual harm) following the removal of the immediate jeopardy.Findings include:Review of the facility's policy titled, Resident Change of Condition revised 8/31/25, defined a change in condition as, A deviation from the resident's baseline health status, including but not limited to changes in: Functional ability, cognition, continence, significant weight fluctuations, behavior, or chronic disease status. The policy directed the nursing staff to notify the provider if any of the following occurred:Significant change or a trending change in vital signs (temperature, pulse, blood pressure, heart rate, and/or oxygen saturation.)Significant change in level of consciousness etc.It also directed Nursing staff to:Monitor and reassess the Resident until resolved, stable or transferred. Place the Resident on alert charting for additional observation, documentation, and response to any interventions. Documentation in the clinical record includes the following, but is not limited to: a. Date and time of discovery of the change in condition.b. Resident assessment (evaluation) of overall condition. c. Interventions completed and resident response, including any emergency care provided.d. Notification attempts and responses. The American Association of Post-Acute Care Nursing website, titled Nurse Assessment - Acute Changes in Condition, accessed 12/4/25, documented: The nurse must assess subtle changes and work with the medical team to differentiate normal changes of aging from acute changes in condition. Recognize symptoms and changes in vital signs, physical function, mental function, and body condition that could indicate acute conditions.Resident #60 was admitted to the facility on [DATE], with multiple diagnoses including aftercare following joint replacement surgery. Resident #60's MDS dated [DATE], documented she was cognitively intact. An admission progress note dated 11/13/25 at 2:33 PM, documented Resident #60 was alert and oriented on admission. The admission notes also documented Resident #60 complained of an itchy back.A physician's order dated 11/13/25, directed staff to apply hydrocortisone to Resident #60's rash two times a day.A Skin Inspection Evaluation dated 11/13/25, documented Resident #60 had a surgical incision on her right hip and bilateral bruising on both arms.The Skin Inspection Evaluation dated 11/13/25 did not include documentation of Resident #60's rash on her back.A Physician's Note dated 11/14/25, documented she was alert, awake, and able to follow commands. On 11/19/25, a Physical Therapy Progress note documented Resident #60 was disoriented and struggling with simple directions.Resident #60's record did not include documentation of notification to the provider of her cognitive change on 11/19/25.A Nursing Progress Note dated 11/19/25 at 04:01 AM, documented Resident #60 continued with a significant rash on her back. The progress note documented hydrocortisone cream was applied with no improvement to rash or itchy feeling. Resident #60 reported having changed her shirt due to moisture and her entire back feeling raw and sore.A Skilled Daily Progress Note dated 11/19/25 at 8:52 PM, documented Resident #60 was alert and oriented with the following respiratory issues: Shortness of breath or trouble breathing with activity and when lying flat. As well as a rash to upper back that was managed with hydrocortisone. The note also documented Resident #60 complained of increased itching to back and a non-urgent referral for dermatology was made.On 11/20/25, a Physical Therapy Progress note documented Resident #60 continues to present with increased confusion and nausea

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F 0689 Level of Harm - Minimal harm or potential for 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 observation, record review, and staff interview, it was determined the facility failed to provide accurate and quarterly smoking evaluations and did not follow the care plan. This was true for 1 of 2 residents (Resident #90) reviewed for smoking. This deficient practice had the potential for harm if smoking assessment evaluation safety procedures were not followed. Findings include: Resident #90 was admitted to the facility on [DATE] and 12/26/23, with multiple diagnoses including Alzheimer's, schizoid personality disorder, dementia, depression, and muscle weakness.A Comprehensive MDS assessment dated [DATE], documented Resident #90 was cognitively intact.a. The facility's Resident Assessment policy, revised 10/15/22, documented assessments are completed to analyze or evaluate the resident's physical and mental condition or abilities which may include smoking habits. Assessment accuracy is necessary to provide documentation of medical, functional, and psychosocial problems; assisting to identify resident strengths to maintain or improve. The care plan is reviewed and revised in conjunction with the updates.A Smoking Evaluation Report, dated 11/30/25, documented Resident #90 was an independent smoker, but was required to store his smoking paraphernalia at the nursing station.On 12/4/25 at 3:35 PM, Resident #90 was observed leaving the facility to smoke in the designated area. He was not observed stopping by the nursing station to get his smoking paraphernalia.On 12/5/25 at 7:44 AM, LPN #1 stated Resident #90 keeps his smoking paraphernalia with him, and it is not kept in the nursing cart. He keeps his smoking materials on his person to use when he wants to. On 12/5/25 at 8:34 AM, the DON, with the CRN present, stated Resident #90 is an independent smoker and keeps his smoking items locked up in his room. When asked if Resident #90's Smoking Evaluation Report from 11/30/25 was accurate, they confirmed it was not. The DON stated, Resident #90's smoking assessment should have identified he was able to keep his smoking paraphernalia locked in his room.b. The facility's Person-Centered Care Planning dated 9/10/25, documented each resident will have a person-centered, comprehensive care plan developed and implemented to reflect their individual preferences. The interdisciplinary team will ensure the plan is based on current assessments, supporting the residents' highest practicable level of well-being, and that is it reviewed and revised as needed.Resident #90's care plan, revised 11/30/25 informed staff Resident #90 was an independent smoker, but smoking paraphernalia should be stored at the nursing station.On 12/5/25 at 8:37 AM, the DON with the CRN in attendance, confirmed Resident #90's care plan was not accurate as it did not identify Resident #90 was able to keep his smoking paraphernalia locked in his room.c. Resident #90's care plan initiated 4/2/25, documented smoking evaluations should be completed quarterly, and with a change of condition which may affect the ability to manage smoking materials.A review of Resident #90's smoking assessments documented smoking evaluations were completed on 11/27/24 and 11/30/25.On 12/5/25 at 8:42 AM, the DON and CRN stated Resident #90 did not have quarterly smoking assessments from 11/27/24 through 11/30/25, and he should have had at least two additional smoking assessments in 2025.

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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 staff interview, it was determined the facility failed to ensure residents received respiratory services consistent with physician's order and/or their care plan. This was true for 1 of 3 residents (Resident #1) reviewed for oxygen use. This deficient practice created the potential for harm if Resident #1's respiratory needs were not met. Findings include:Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including hypertensive heart disease with heart failure and acute and chronic respiratory failure with hypoxia (low levels of oxygen in the body tissues) and overactive bladder.A physician's order dated 11/30/25, documented Resident #1 was to receive oxygen 1 liter per minute per nasal cannula to maintain her oxygen saturation greater than 90% every shiftA care plan initiated 5/27/25, documented Resident #1 was to receive oxygen as ordered by the physician.Resident #1 was observed without using her oxygen via nasal cannula on:12/2/25 at 9:11 AM, in the dining room.12/2/25 at 9:20 AM, in her room.On 12/2/25 at 9:46 AM, CNA #2 stated Resident #1 was to have oxygen all day and night. CNA #2 stated she did not notice Resident #1 was not using her oxygen when she wheeled her to her room.On 12/2/25 at 4:15 PM, the RCM stated Resident #1 should have used her oxygen continuously.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on policy review, observation, record review, and resident and staff interview, it was determined the facility failed to serve palatable food to facility residents who were interviewed about food temperature and taste. This was true for all residents who consumed food and coffee prepared by the kitchen and facility staff. This had the potential to create dissatisfaction with meals and decrease residents' quality of life. Findings include:The facility's Meal Service policy dated 9/15/25, documented the facility will ensure each resident receives a minimum of three nourishing, palatable, and well-balanced meals daily, consistent with their clinical needs, dietary orders, and care plan directives.1. During the survey, residents reported the food was not at the right temperature when it was served, the food was not consistently palatable, and the coffee tasted burnt, as follows:a. On 12/2/25 at 9:49 AM, Resident #1 stated, The food is awful. b. On 12/2/25 at 11:05 AM, Resident #6 stated the food was okay, but the portions are small and the temperature is not always right.c. During a State-Surveyor led Resident Council meeting on 12/2/25 at 3:45 PM, with 9 residents in attendance, there were various concerns about the food and coffee as follows: The food is always cold because the food cart sits [in the hallway], and the meals are cold before residents are served. The butter does not melt, and the coffee creamer does not mix because the food and coffee are too cold. The food is too salty, the vegetables are watery and overcooked, the meat is overdone, dry and tough, and the new coffee machines make the coffee taste burnt.2. On 12/3/25 at 12:25 PM, two lunch meal test trays, consisting of a regular diet on two different serving plates were loaded last onto the uncovered B-hall room tray food cart. Observations during tray line meal service showed hot food was dished onto cold plates. Some plate bottoms were placed onto a warmed insulated bottom and covered with an insulated top, while adaptable plates were covered with a metal lid containing a hole in the center, without a heated bottom.On 12/3/25 at 12:37 PM, the test trays were evaluated after all the resident meal trays had been delivered. Condiments (salt, pepper, butter) were not added to the tray to flavor the food. Food temperatures were measured by surveyors with the following results:a. Scoop Plate, no insulated bottom or top, showed temperatures were out of range for some foods, and the overall meal was bland without seasoning or flavor, as follows: Turkey- 111 F; Sweet potatoes- 124 F; Spinach -135 F, Cranberry juice- 48 F.b. Regular Plate, insulated top with heated insulated base, showed temperatures were out of range for some foods, and some foods were found to be bland without seasoning or flavor, as follows: Turkey- 109 F; Sweet potatoes- 144 F; Spinach 136 F, Apple juice - 47 F; Milk - 45 F; Pumpkin Cake-61 F.3. On 12/1/25, 12/2/25, and 12/3/25 surveyors were provided the same coffee residents received throughout the facility with the following results: the coffee was not palatable and had a burnt taste.On 5/5/25 at 10:39 AM, the Kitchen Manager confirmed the facility coffee had tasted burnt since facility staff were not familiar with working the new coffee machines and made the coffee too strong by not adjusting the boldness of the brew. The Kitchen Manager confirmed based on the results of the test trays and the quality of the coffee, the facility had not provided resident's food and coffee that was palatable, and at a safe and appetizing temperature.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, the FDA Food Code, and staff interview, it was determined the facility failed to ensure ice machines were cleaned, and resident freezers were not contaminated by non-food items, or undated, opened food. These deficiencies had the potential to affect all facility residents who consumed food or ice prepared by the facility. This placed residents at risk for potential contamination of food and adverse health outcomes, including food-borne illnesses. Findings include:1. The FDA Food Code Section 2-301.14 documented food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles; as well as during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands.On 12/3/25 from 11:00 AM to 11:30 AM, [NAME] #1 was observed preparing food for residents while wearing gloves, taking food temperatures, and cleaning the thermometer with a sani-wipe. [NAME] #1 was not observed performing hand hygiene by washing hands before donning gloves. At 11:36 AM, [NAME] #1 was observed grabbing an unwrapped hotdog bun with the original gloves from before serving resident food.On 12/3/25 at 11:37 AM, the Kitchen Manager stated the proper use of gloves includes hand hygiene by appropriate washing methods before and after glove use and whenever changing tasks. She acknowledged [NAME] #1 should have changed her gloves with appropriate hand hygiene after preparing food and taking food temperatures and before starting tray line. [NAME] #1 should also have used tongs or clean gloves when handling the hot dog buns. 2. The FDA Food Code Section 3-501.17 Ready-to-Eat, TCS food, date marking, documented marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded.On 12/1/25 at 8:23 AM, the following items were observed opened and undated:Tray line refrigerator and freezer: cheese, salsa, French fries. Walk-in freezer: breaded chicken pieces, breaded steak fries, and hoagie bread rolls. Large plastic bins in the main kitchen area containing dried mashed potatoes, flour, oatmeal, and sugar. On 12/1/25 at 8:40 AM, the Kitchen Manager stated food items should be stored with labels indicating date open and/or use by date, and the plastic bins should have been labeled appropriately.3. The FDA Food Code Section 4-602.11 Equipment Food-Contact Surfaces and Utensils documented surfaces of utensils and equipment contacting food that is not time/temperature control for food shall be cleaned in equipment such as ice bins and enclosed components of equipment such as ice makers, at a frequency specified by the manufacturer, or absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold.On 12/3/25 at 2:50 PM, it was observed in the Hall A Ice Room, the blue plastic scooper bucket had black residue on the bottom of the bucket where the ice scooper was stored. On Hall A and Hall B, the ice machines were observed to have a thin shiny pink layer on the interior plastic separator plate where the ice accumulates.On 12/3/25 at 3:03 PM, the Kitchen Manager stated the ice bucket should not have black residue and the interior plastic plates of the ice machines should not have a thin shiny pink layer. 4. FDA Food Code Section 6-403. 11 documented areas designated for employees to eat, drink, and use tobacco products shall be located so that food, equipment, and linens single-service and single use articles are protected from contamination.On 12/5/25 at 11:10 AM, it was observed in Hall A, the resident freezer had multiple food items (ice cream, stir fry meals, frozen shake) which were open and undated, and had visible layers of ice indicating the food had been defrosted and refrozen.On 12/5/25 at 11:13 AM, it was observed in Hall B of the resident's nourishment refrigerator food belonging to staff (open drink, iced coffee, whipped cream) was stored alongside resident nourishments. On 12/5/25 at 11:14 PM, the Kitchen Manager stated staff food is not supposed to be stored with resident food, and all resident food should be dated, labeled, and sealed (not visibly open.)

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	135144	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascadia of Nampa	900 N Happy Valley Rd Nampa, ID 83687

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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 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide a neutral and fair arbitration process and agree to arbitrator and venue. Based on the review of the Facility's Arbitration agreement and staff interview, it was determined the facility failed to ensure the facility's arbitration agreement provides the selection of a venue that is convenient to both parties. This was true for all residents who reside in the facility. This failure created the potential for residents to be inconvenienced or the inability to participate during the arbitration process. Findings include:The facility's Voluntary Agreement for Arbitration undated, documented an arbitration hearing arising under the Arbitration Agreement shall be held in the county where the facility is located before a board of three arbitrators.On 12/3/25 at 10:55 AM, after review of the arbitration agreement and the federal regulation requirement the Administrator stated the arbitration agreement was missing the regulatory requirement of a convenient location of arbitration for both parties.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 5 of 5 residents (#2, #16, #39, #49, and #61) when staff failed to perform effective hand hygiene during medication preparation, and for all resident's using the facility's laundry services. The facility failed to practice standard based precautions when preparing medications and handle, store, process, and transport linens to prevent the spread of infection. These failures created the potential for the spread of infection among all residents. Findings include: The CDC recommended the following procedure for hand hygiene with soap and water: Wet hands first with water, Apply the recommended amount of antibacterial soap, Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers, Rinse hands with water and use disposable towels to dry, and Use towel to turn off the faucet. The CDC guidelines also documented other entities had recommended cleaning hands with soap and water for approximately 20 seconds and documented either amount of time was acceptable. The facility's Hand Hygiene - Infection Control Policies and Procedures, revised 9/15/25, documented staff should perform hand hygiene: Before and after resident care; Before an aseptic procedure; Before moving from one soiled body site to a clean body site on the same resident; After contact with objects in resident's environment; Before and After assisting a resident with a meal; After any contact with blood or other body fluids, even if gloves are worn; Immediately after removal of PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. On 12/3/25 at 8:45 AM, RN #2 was observed preparing Resident #16's morning medications at the medication cart. RN #2 used hand sanitizer to clean her hands, removed a pill from house stock, and used the pill cutter to split the pill in half. During this process she dropped the two halves on the tabletop, she then picked 1/2 pill up with her fingers and placed it in the cup with the residents' other medications. RN #2 then picked up the remaining 1/2 of the pill with her fingers and returned 1/2 pill into the pill container. On 12/3/25 at 10:50 AM, the IP stated the observations described above were inappropriate forms of hand hygiene regarding medication administration. He stated during medication preparation; the nurse should never touch medications with an ungloved hand. The IP stated gloves should be donned, or a spoon or other tool should have been used to pick up the dropped medications and disposed of due to them being contaminated by the countertop. 2. RN #3 was observed without performing hand hygiene as follows: 12/8/25 at 9:14 AM, when she entered Resident #3's room to administer her insulin. RN #3 then removed her gloves, donned new gloves without performing hand hygiene, and administered Resident #3's Brimonidine eye drops. 12/3/25 at 9:33 AM, when she entered Resident #3's room to administer her oral medications. RN#3 then left to get Resident #3's Dorzolamide eye drops and came back without performing hand hygiene upon entering Resident #3's room. On 12/3/25 at 2:38 PM, the IP stated hand hygiene should be performed before entering and after exiting residents' room, and prior to administering medications. 3. On 12/3/25 at 8:58 AM, RN #1 prepared Resident #61's medications. RN #1 then entered Resident #61's room and administered medications. On Resident #61's overbed table was his upper and lower dentures. The dentures were not in a container and there was no barrier between the dentures and overbed table. On 12/3/25 at 9:02 AM, when asked about Resident #61's dentures not being in a container, RN #1 stated she could have educated Resident #61 better regarding the potential for infection. 4. Resident #2 was admitted to the facility on [DATE], with multiple diagnoses including anxiety, depression, and malnutrition. Resident #2's MDS comprehensive assessment dated [DATE], documented yes under the question indicating the use of a CPAP (a non-invasive mechanical ventilator.) On 12/1/25 at 10:28 AM, and on 12/2/25 at 10:05 AM, Resident #2's CPAP mask was observed uncovered, laying on the machines hose, on top of her nightstand. On 12/2/25 at 10:08 AM, Resident #2 confirmed the face mask is often sitting out with no cover. On 12/2/25 at 10:24 AM, RN #1 stated the CPAP mask was not stored in a sanitary condition and should be placed in a bag to ensure cleanliness. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. Resident #39 was admitted to the facility on [DATE], with multiple diagnoses including respiratory disorder, cough, and need for assistance with personal care. A physician's order dated 7/11/24, documented Fluticasone Propionate Nasal Suspension 50 mcg/ACT give 1 spray in each nostril two times a day for nasal congestion. On 12/1/25 at 8:55 AM, RN #2 was observed approaching Resident #39 with a vital cart. Inside the vital cart basket was a cup with a nasal spray. RN #2 proceeded to take the spray and administer one spray into each nostril. RN #2 was not observed performing hand hygiene prior to the administration of medication without gloves. On 12/1/25 at 9:06 AM, RN #2 stated she would normally don gloves prior to administration, but she did not today because it's the residents' home like environment. She also stated she did not feel she had breached infection control and confirmed she was not worried about infection control or cross contamination. 6. The facility's Laundry Services policy dated 10/8/25, documented nursing and laundry staff would follow procedures for handling, storing, processing and transporting linens to prevent contamination. It also documented wet linens are not to be left in laundry equipment overnight to prevent mildew and ensure timely processing. a. On 12/5/25 at 7:20 AM, during a laundry room inspection, two washers were observed to be full of wet clothing. The laundry staff stated the clothing in the washer at the time had been left from the night before, and she would be moving it into the dryer. On 12/5/25 at 7:30 AM, the laundry staff stated they often leave resident clothing in the washer and rewash it if it gets stinky. b. On 12/5/25 at 7: 25 AM, the laundry staff explained that after drying the residents clothing, if clothing needed to be labeled, she would take the clean laundry back to the dirty side of the laundry room to label it before delivering it to resident rooms. On 12/5/25 at 7:30 AM, the laundry staff confirmed the label maker was on the dirty side of the laundry room and if clothing was being labeled it should be rewashed before being taken to the resident's room. 12/5/25 at 8:10 AM, the Administrator stated laundry gets washed then labeled and then sent out to the resident's room. Upon visiting the laundry room, the Administrator confirmed the label machine was on the dirty side of the laundry room.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, review of McGeer's Criteria Surveillance for Infection, and staff interviews, it was determined the facility failed to ensure antibiotic stewardship was implemented and residents had appropriate clinical indications for the use of antibiotic. This was true for 1 of 1 resident (Resident #1) whose record was reviewed for antibiotic use. This deficient practice created the potential for Resident #1 to receive unnecessary treatment for a suspected urinary tract infection and/or develop multi-drug-resistant organism. Findings include:The facility's Antibiotic Stewardship policy revised 10/15/22, documented the facility focused on improving antibiotic use through an Antibiotic Stewardship program to ensure appropriate antibiotic usage are in place, to promote therapeutic and cost-effective care for the residents, and ultimately reduce the likelihood of developing multi-drug-resistant organism. The policy also documented the facility utilized McGeer's criteria to validate the infection, and to review culture and sensitivity reports routinely as part of the surveillance of the infection.The Revised MCGeer's Criteria for urinary tract infection with indwelling catheter documented both 1 and 2 must be fulfilled:1. At least one of the following sign or symptoms:Fever, rigors, or new-onset hypotension, with no alternate site of infection.Either acute change in mental status or acute functional decline with no alternate diagnosis and leukocytosis.New-onset suprapubic pain or costovertebral angle pain or tenderness.Purulent discharge from around the catheter or acute pain, swelling, or tenderness of the testes, epididymis, or prostate.2. Urinary catheter specimen culture with greater than 105 CFU/ml of any organism(s). Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including hypertensive heart disease with heart failure and acute and chronic respiratory failure with hypoxia (low levels of oxygen in the body tissues).Resident #1's progress notes documented the following:11/11/25 at 9:30 AM, an NP progress note documented Resident #1 had significant leaking from her urinary catheter. Resident #1 denied pain other than annoyance of being wet. The NP ordered urinalysis with culture and sensitivity.11/11/25 at 6:15 PM, a Nursing Progress note documented Resident #1 urine was hazy and straw yellow colored. Resident #1 was afebrile (no fever) and denied flank pain, suprapubic pain or burning sensation.11/14/25 at 9:00 AM, an NP progress note documented Resident #1's result suggested improper specimen collection or delay in delivery. The laboratory suggested to do a repeat specimen if the condition warrants it. 11/17/25 at 8:30 AM, an NP progress note documented Resident #1 continued to have significant leaking of urine from her urinary catheter and repeat urinalysis with culture and sensitivity was requested. 11/18/25 at 4:49 AM, a Nursing progress note documented Resident #1's urinary catheter was changed, and urine specimen was collected. Resident #1 was afebrile and no complaints of flank pain or dysuria (painful urination).11/18/25 at 6:02 PM, a Nursing Progress note documented Resident #1's urine sample was picked up by the laboratory.11/19/25 at 12:41 AM, a Nursing Progress note documented Resident #1 denied dysuria/urgency, no leakage noted from her urinary catheter.11/23/25 at 1:42 PM, a Nursing Progress note documented Resident #1's urinary catheter drained a straw-colored urine with trace sediments noted. 11/24/25 at 7:45 AM, an NP progress note documented repeat urinalysis was pending as the previous sample was not picked up by the laboratory in time. The NP also requested CBC and CMP for further follow-up on the concern with the foley/UTI as well as weakness that was reported at the end of last week. The NP also documented Resident #1 was not currently having an altered mental status, and the nurse had not reported Resident #1 as having altered mental status over the last couple of days.11/24/25 at 6:47 PM, a Nursing Progress note documented Resident #1's urine was noted to have a strong odor. She denied suprapubic pain, burning or flank pain. The urine specimen was picked up by the laboratory. Resident #1 was noted to be falling asleep more during the day in activities.11/25/25 at 9:53 PM, a Nursing Progress note documented Resident #1 was slightly weaker and drowsy during activities and in-between meals. She was afebrile and denied flank pain or suprapubic pain.11/26/25 at 10:20 PM, a Nursing progress note documented Resident #1's urine was noted to be cloudy and amber with blood tinge. A call was made to the laboratory to follow-up the urinalysis result. The laboratory reported they made a mistake, even though the test was abnormal they threw the sample [out] and did not perform a culture and sensitivity test. The NP was informed of Resident #1's increase in weakness and sleeping more than usual and her urinary catheter leaking urine with strong odor. An order was received to collect Resident #1's urine for urinalysis and culture and sensitivity test. The NP also gave an order to start Resident #1 with Augmentin (antibiotic) 875/125 mg two times a day for 14 days after her urine was collected.11/30/25 at 3:01 PM, an IP Progress note