STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135019	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchards of Cascadia, The	404 North Horton Street Nampa, ID 83651

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 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (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 0698 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 policy review, record review, the facility's Incident and Accident (I&A) Report, and staff interview it was determined the facility failed to ensure a resident receiving dialysis services were provided appropriate monitoring, emergency response, and staff intervention consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences. This was true for 1 of 3 residents (Resident #103) reviewed for hemodialysis. This deficient practice caused actual harm to Resident #103 when her central venous catheter (CVC) experienced a bleeding emergency, followed by loss of consciousness and a Full Code where Cardiopulmonary Resuscitation (CPR) was initiated, EMT called, and she was sent to the hospital where she was pronounced deceased after extensive interventions. Immediate Jeopardy was identified on [DATE] at 3:08 PM and was determined to exist since [DATE], when the facility failed to ensure appropriate nursing response to Resident #103 when her dialysis catheter began to bleed. On [DATE] at 3:08 PM, the facility's Administrator was notified of the Immediate Jeopardy at F698, Dialysis. On [DATE] at 1:30 PM, after the Survey Team verified implementation of the IJ removal plan, the facility Administrator was notified the Immediacy was removed on [DATE]. 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, Dialysis Off-Site Policy, revised [DATE], documented, The clinical staff provides ongoing assessment and oversight of the resident before and after dialysis treatments, including monitoring the resident's condition after treatments, monitoring for complications, implementing appropriate interventions, and using appropriate infection control practices.Review of the facility's policy titled, Resident Change of Condition Policy, dated [DATE], documented, Designate someone to stay with resident while physician is notified, if necessary; and Monitor and reassess resident's condition and response to interventions until stable or emergency personnel arrive and take over care for transfer to acute care.The National Library of Medicine website titled Care of a Central Line updated [DATE] and accessed on [DATE], documented: All healthcare professionals working in a setting with indwelling CVCs should receive annual training on central line care. Updates regarding indications for the placement of CVCs, maintenance of CVCs, and infection control measures should be included.The Pulmonary Hypertension Association: Best Practices in Catheter Care article, accessed on [DATE], documents: If blood is backing up the catheter or leaking out, use the clamp to close off the catheter if it is still leaking you must clamp off the line. Resident #103 was admitted to the facility on [DATE] with multiple diagnoses including end stage renal disease (ESRD). Resident #103's Minimum Data Set (MDS) dated [DATE], documented she was cognitively intact and receiving hemodialysis. A Physician's Order dated [DATE], documented Resident #103 had a right chest central venous catheter (CVC) in place for the administration of her dialysis and she was to receive the following:-Hemodialysis three times a week every Monday, Wednesday, and Friday.-Apixaban (a blood thinner) 5 mg two times a day for her irregular heart rate.A Dialysis Care Plan initiated on [DATE], documented Resident #103 had a central line in her right chest used by dialysis, and she attended dialysis every Monday, Wednesday, and Friday. The Care Plan directed staff to monitor Resident #103 for complications such as site discomfort, signs and symptoms of infection, phlebitis, occlusion, infiltration, displacement, and bleeding.The facility's I&A report documented that on [DATE], LPN #1 found [Resident #103] standing naked with her dialysis catheter leaking blood from the red port only it was flowing onto the floor and down her chest due to the clamp the line with the red end was unclamped and there was no end cap. LPN #1 clamped the line, left to obtain a cap, and returned to find the clamp unclipped again and blood was visibly flowing from the line. The resident was then escorted down the hallway by a CNA without continuous licensed nurse supervision of the access site. Bleeding occurred in the resident's room [Resident #103] was slumped back with her back on the bed and her feet were on the floor. There was blood noted coming from the catheter and had leaked onto the bed and it was also noted on the floor in front of where her feet were followed by loss of consciousness, absent respirations and pulse. CPR was initiated until EMS arrival.The facility was unable to provide evidence that the nursing staff had been trained or deemed competent in responding to dialysis access emergencies. On [DATE] at 3:08 PM, the Director of Clinical Services (DCS) stated that the facility had not provided such training and expected nurses to have learned these skills during their initial licensing preparation. In a follow up interview on [DATE] at 5:00 PM, the DCS acknowledged that the nurse should have applied a hemostat when the clamp failed and could not explain