STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27375 Based on policy review, record review. observation, and resident and staff interview, it was determined the facility failed to ensure a resident's right for self-determination was honored. This was true for 1 of 2 residents (Resident #63) reviewed for choices. This deficient practice had the potential for Resident #63 to experience a decreased sense of well-being, lack of self-worth, and frustration when his preference for bed placement was not accommodated. Findings include: The facility's Resident Rights policy, undated, documented, Self-Determination: You have the right to self-determination through support of your choice, including the right to: make choices about aspects of your life in the facility that are significant to you. Resident #63 was admitted to the facility on [DATE], with multiple diagnoses including morbid (severe) obesity, pressure ulcer of the sacral (tailbone) region, spinal disc degeneration, and major depressive disorder. An MDS assessment, dated 4/9/24, documented was cognitively intact. During an interview on 6/3/24 at 11:18 AM, Resident #63 stated CNA #1 repositioned her bed without her consent. She stated she asked CNA #1 to turn her bed back up against the wall, and CNA #1 stated she repositioned the bed because it was easier for her to provide care for Resident #63. Resident #63 stated she liked her bed up against the wall because she usually leaned to the right side of her bed, and when lying in the bed in its current position she felt she was going to fall out of the bed. Resident #63 stated she told CNA #3 about CNA #1 repositioning her bed. During an interview on 6/4/24 at 2:57 PM, LPN #4 stated residents could have their beds positioned how they wanted in their rooms. LPN #1 stated she was unaware of why the bed was repositioned. LPN #1 stated she would have staff reposition the bed back to the way the resident liked it. During an interview on 6/6/24 at 10:32 AM, the SSD stated a resident had the right to self-determination; it was the staff's responsibility to explain the risk to the resident and family. During an interview on 6/6/24 at 2:42 PM, the DON stated a resident had a right to make their choices about their life while living in the nursing facility. The DON stated staff did not have the right to move a resident's bed without that resident's consent.

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27375 asBased on record review, policy review, observation, and resident and staff interview, it was determined the facility failed to implement storage of resident smoking materials as directed by residents' care plans. This was true for 2 of 2 residents (#57 and #67) whose care plans were reviewed for smoking. These failures placed residents in the facility at risk of negative outcomes if smoking materials were not stored safely due to lack of information in their care plan. Findings include: The facility's Smoking Policy, dated 10/15/22, documented Smoking paraphernalia is not permitted to be stored in the resident's room. This includes e-cigarettes and vaping devices/materials. 1. Resident #57 was admitted to the facility on [DATE], with multiple diagnoses including tobacco use. An MDS assessment, dated 4/18/24, documented Resident #57 was cognitively intact. Resident #57's Care Plan, dated 4/7/23, documented Resident #57 was an independent smoker and his smoking paraphernalia was stored in his room or in the nurse's cart. During an interview on 6/3/24 at 11:30 AM, Resident #57 stated he was an unsupervised smoker and had his own smoking products in his room. 2. Resident #67 was admitted to the facility on [DATE], with multiple diagnoses including nicotine dependence and use of cigarettes. An MDS assessment, dated 5/27/24, documented Resident #67 was moderately cognitively impaired. Resident #67's Care Plan, dated 4/7/23, documented Resident #67 a dependent smoker and his smoking paraphernalia was stored at the nursing station, in a locked box outdoors. During an interview on 6/3/24 at 11:30 AM, Resident #67 stated he smoked, and he kept his tobacco and lighter in his room. A red bag with tobacco in it was observed in his room. During an interview on 6/6/24 at 10:16 AM, LPN #5 stated residents that smoked were allowed to keep their smoking material in their rooms. During an interview on 6/6/24 at 10:19 AM, LPN #11 stated residents that smoked were not allowed to have smoking materials in their room. During an interview on 6/6/24 at 10:21 AM, CNA #6 stated if a resident were deemed a safe smoker, they could have smoking materials in their rooms. During an interview on 6/6/24 at 10:23 AM, RN #5 stated residents were not allowed smoking materials in their rooms. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/6/24 at 10:26 AM, RN #3 stated residents were not allowed smoking materials in their rooms and materials were kept somewhere at the nurses' station. During an interview on 6/6/24 at 10:28 AM, CNA #7 stated residents who smoked were not allowed smoking materials in their rooms. During an interview on 6/6/24 at 10:32 AM, the SSD stated he was not sure if residents could have smoking materials in their rooms. He further stated there were lockers outside at the smoking area for residents to keep their smoking materials. During an interview on 6/6/24 at 2:42 PM, the facility Administrator and DON both stated they were not familiar with the facility's smoking policy due to both being hired recently. They both agreed the facility's smoking policy and resident's care plan should be followed.

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F 0689 Level of Harm - 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** 27375 Based on policy review, record review, facility Incident Report review, staff interview, and resident and resident representative interview, it was determined the facility failed to ensure adequate supervision and intervention was provided during a resident's transfer to prevent falls. This was true for 1 of 3 residents (Resident #44) reviewed for falls. This resulted in harm to Resident #44 who sustained a hematoma on the right side of her face, eye, and jaw, and chest pain. Findings include: Resident #44 was admitted on [DATE] and readmitted on [DATE], with multiple diagnoses including abnormalities of gait and mobility, and contracture (rigidity of muscle or tendons resulting in a fixed deformity of a joint) of muscle to her right upper arm. An MDS assessment, dated 10/25/23, documented Resident #44 was cognitively intact and required extensive assistance for transfer with the support of two staff. Resident #44's Care Plan, dated 4/7/23, documented Resident #44 was a fall risk due to impaired mobility, weakness, deconditioning, spinal stenosis, dementia, history of falls, and psychotropic medication use. A facility Incident Report, dated 1/3/24, documented Resident #44 had a fall the morning of 1/3/24. The report documented the CNA reported to the nurse Resident #44 had her feet at the edge of her bed and while the CNA was getting the wheelchair positioned, Resident #44 started to slide out of bed. The CNA assisted Resident #44 and she fell forward on top of the CNA. The report further documented Resident #44 gave a different description of the fall, reporting she fell to the ground. When the nurse was notified of the fall, a hematoma [collection of blood under the skin] was noted on the right side of Resident #44's forehead. Resident #44's vital signs were obtained and ice was applied to the slightly swollen, bruising area. Initial interventions included the nurse notified Resident #44's spouse of the fall as well as the rounding provider and Resident #44 was sent to the hospital to rule out internal bleeding due to being on anticoagulants [blood thinners]. She returned the same day with no acute findings. Neurological checks were completed with no further findings. The report documented further interventions included the CNA was provided education on the same day of incident, on timeliness of notifying a Licensed Nurse along with transfer status and following the care plan, although unclear of incident details with investigation. The report documented Resident #44 was healing slowly but had facial bruising due to medication [anticoagulant]. The report further documented Resident #44's pain was at an acceptable pain level at a 5 out of 10 pain scale [0 being no pain and 10 being the worst pain], and tramadol [a narcotic pain medication] helped alleviate the pain. The hospital Emergency Department notes, dated 1/3/24, documented Resident #44 reported she was being moved by staff at the facility and was dropped hitting her head on the ground. She stated she did not have loss of consciousness but was on blood thinning medication. She also reported pain in the chest wall and described her pain as constant, nonradiating, aching pain, and nothing seemed to alleviate or exacerbate her symptoms. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A CT scan (an imaging test that helps to detect internal injuries and disease) of Resident #44's Maxillofacial region (bones and tissues of the jaw and lower face), dated 1/3/24, documented, Impression: 1. Hematoma in the right frontal scalp. Soft tissue swelling and hemorrhage of the right superficial face involving the periorbital [around the eye] preseptal soft tissues [eyelid], and the soft tissues overlying the right mandibular ramus/right parotid gland [right jaw area]. 2. Pertinent negatives: No fracture of the face or mandible [jawbone]. No globe rupture or retrobulbar hematoma. Normal temporomandibular joints. During an interview on 6/4/24 at 10:18 AM, Resident #44 stated on the day she fell she remembered a male CNA came into her room, put her on the sit to stand lift, took her to the bathroom, dressed her, and took her back to her bedroom and put her into her wheelchair. Resident #44 stated she remembered being in her wheelchair but does not remember how she got onto her bed, when she fell off her bed onto her face. She stated she did remember the fall. During a phone interview on 6/4/24 at 3:19 PM, Resident #44's husband stated on the day of the incident it was two to three hours after she had fallen before the fall was mentioned to staff. He stated he entered Resident #44's room around 10:23 AM and saw her eye was swollen and closed. He stated he was worried because his wife takes Eliquis (blood thinner). Resident #44's husband stated she was sent out to the hospital. During an interview on 6/5/24 at 10:45 AM, LPN #11, who was the unit manager, stated she did not witness the fall, but she was present the day of Resident #44's fall. LPN #11 stated CNA #2 was getting Resident #44 up for breakfast when CNA #2 walked away from Resident #44's bed and she fell . LPN #11 stated CNA #2 put Resident #44 in her wheelchair. CNA #2 brought Resident #44 out of the room with bruising to her face. LPN #11 asked Resident #44 what happened, and she stated she fell off the bed. LPN #11 further stated CNA #2 was terminated from employment at the facility after the incident. During a phone interview on 6/6/24 at 3:06 PM, LPN #2 stated she remembered Resident #44's incident when she had a fall. LPN #2 stated CNA #2 did not report the fall immediately. LPN #2 stated Resident #44 was up and going into the dining room when she asked her what happened to her face. LPN #2 stated Resident #44's roommate told her what happened, because Resident #44 could not remember. LPN #2 stated she assessed Resident #44, notified the provider and Resident #44's family.