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	12/01/2025

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to investigate resident grievances in a timely manner for four of four resident (Resident (R) 70, R15, R57, and R59) reviewed for resident council and eight of eight residents (R48, R8, R61, R77, R82, R4, R27, and R14) reviewed for repeated grievances of noise at night and concerns about customer service of 31 sample residents. This deficient practice had the potential to allow grievances to not be responded to in a timely manner for 93 residents.Findings include:Review of the facility's policy titled, Grievance Process, with a revision date of 08/29/25, revealed: Policy: Residents and their families have the right to file a complaint without fear of reprisal. Residents' rights should be protected when voicing complaints to maximize the quality of life for each individual and to promote customer satisfaction with facility care and services. The Grievance program is utilized to address the concerns of Residents, family members and visitors and the facility should make prompt efforts to resolve grievances. Definitions: Prompt efforts to resolve: This refers to a facility acknowledgement of a complaint/grievance and actively working toward resolution of that complaint/grievance. Procedure.7. The Nursing Home Administration/Designee is responsible for overseeing the grievance process, including receiving tracking, and conclusion/resolution.Responsibility of the Nursing Home administrator and/or Designee. 2. Ensuring that all grievances reports have been reviewed and addressed in a timely and appropriate manner and that concerned individuals feel that some type of resolution has been communicated, achieved, and maintained.1.Review of resident council minutes provided by the facility revealed grievances of noise from night shift. Multiple residents complained of noise during the meeting on 04/16/25. During the meeting on 05/21/25 many residents complained of the noise at night. R70 had stated during the 06/18/25 meeting that the staff came into the room at 4:00 AM and made a noise waking her up. During the 09/17/25 meeting, multiple residents complained of noise in the early morning.During a resident council meeting on 10/01/25 at 1:33 PM, the residents were asked if they had any resolution to the grievance of the noises at night. R15, R57, R59, and R70 confirmed there had been no resolution shared with them and the noise level at night was still loud.2. Review of a complaint investigation in June 2025 revealed there was an undated form in which R48 complained about the roommate's television being loud. R48 asked Certified Nursing Assistant (CNA) 5 to turn it down. CNA5 stated to R48 that the roommate had rights. R48 stated in the statement that she had rights also. R48 stated CNA5 was rude to her.Review of the Complaints/Grievances Log provided by the facility revealed R48 was not on the log for June 2025. The grievance did not appear until 08/20/25.3. a. Review of R8's undated admission Record in the electronic medical record (EMR) under the Profile tab revealed R8 was admitted to the facility on [DATE].Review of the five day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/09/25 in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R8 was moderately impaired in cognition.During an interview on 09/29/25 at 3:15 PM, R8 stated staff came into his room at 2:00 AM, 2:30 AM, and 3:00 AM. R8 stated staff knocked on the door and sometimes turned the lights on when they came in. R8 stated it interrupted his sleep and was concerning. R8 stated he did not know why staff did this.b. Review of R61's undated admission Record in the EMR under the Profile tab revealed R61 was admitted to the facility on [DATE].Review of the quarterly MDS with an ARD of 08/19/25 in the EMR under the MDS tab revealed a BIMS score of nine out of 15 which indicated R61 had moderately impaired cognition.During an interview on 09/29/25 at 2:04 PM, R61 stated a staff member recently came into his room around 2:00 AM, knocked loud on the door and turned the light on. R61 stated this woke him up and he asked the staff member not to knock on his door so loud. R61 stated the staff member then wrote on the whiteboard the name of the CNA and nurse for the day, turned off the light and left the room. R61 stated he heard knocking on his door three times more that night although no one came into the room.c. Review of R77's undated admission Record in the EMR under the Profile tab revealed R77 was admitted to the facility on [DATE].Review of the quarterly MDS with an ARD of 09/11/25 in the EMR under the MDS tab revealed a BIMS score of 15 out of 15 which indicated R77 was cognitively intact.During an interview on 10/02/25 at 11:13 AM, R77 stated staff came into his room at 3:00 AM to offer him ice water. R77 stated he asked them what they were doing. R77 stated they were checking his trash can and delivering ice water. R77 stated They should not be in my room. It wakes me up.4. Review of R82's admission Record in the EMR under the Profile tab revealed R82 was admitted to the facility on [DATE]; diagnoses included

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 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 interview, record review, and policy review, the facility failed to ensure an allegation of physical abuse was reported timely to the Administrator and to the State for one out of four Facility Reported Incidents (FRIs) (Resident (R) 82) reviewed for abuse of 31 sample residents. This failure had the potential for abuse to occur and/or continue.Findings include:Review of the facility's policy titled, Abuse, dated 03/01/24, revealed Allegations of verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, and neglect of the resident as well as mistreatment, injuries of unknow source, exploitation, deprivation of foods and services by staff, and misappropriate of resident property are reported to the CEO [Chief Executive Officer] immediately and the state agency. a. Within 2 hours if there was alleged abuse or serious bodily injury as a result of an event. b. Within 24 hours if the event that caused the injury did not involve abuse or did not result in serious bodily injury.Review of the undated admission Record in the electronic medical record (EMR) under the Profile tab revealed R82 was admitted to the facility on [DATE]; and diagnoses included Parkinson's disease with dyskinesia (difficulty in performing or controlling voluntary movements). Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/02/25 in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R82 was cognitively intact. R82 was impaired in range of motion (ROM) to both upper extremities. R82 required supervision or touching assistance with dressing and partial/moderate assistance with showers/baths. Review of the Care Plan to address activities of daily living (ADLS), dated 02/27/24, under the Care Plan tab of the EMR, revealed [R82] has ADL self-care and mobility deficit r/t [related to] DX [diagnosis] of Parkinson's, failure to thrive, malnutrition, HX [history] of falls, muscle weakness, tremors, and muscle spasms. Interventions in pertinent part included Personal Hygiene: [R82] requires supervision/touching assistance with his personal hygiene cares. Dressing: [R82] requires supervision/touching assistance with upper and lower body dressing and set up/clean up with footwear donning. Bathing: [R82] requires partial/moderate assistance with bathing with assistance of 1.Review of a Nurse's Note late entry for 06/26/25 at 6:45 PM by the Unit Manger/Registered Nurse (RN) 1 in the EMR under the Progress Notes tab, revealed Resident came into Unit Managers office, asking to speak to this nurse. Resident began by stating he wanted to move to a new facility. Nurse stated that that was his right and asked why he was feeling this way. Resident stated that he was angry with [Certified Nursing Assistant (CNA) 4]. Resident described an incident that happened earlier in the day, when [CNA4] was assisting resident to get dressed. [CNA4] pulled resident's shirt down and caught the fabric on resident's umbilical hernia. Resident stated, I told him he was ripping my Fucking guts out. Resident reports that [CNA4] stopped pulling on the shirt and told resident not to say the F-word to him. Resident admitted he continued to swear at [CNA4], and stated, I have a right to say what I want in my own room. Resident reports that [CNA4] Just walked out of my room. Nurse offered resident a room change to another hall with different CNAs, and resident was happy about that idea. Nurse spoke with [CNA4] on hall and instructed him to have another aid provide care for resident. [CNA4] agreed. Discussed event that occurred earlier in the day, and [CNA4] reported the same facts. He had caught the shirt on resident's umbilical hernia, stopped when resident screamed and swore at him, informed resident he did not appreciate being spoken to like that, and when resident continued swearing at him, he left the room having completed his cares and left patient safe and clean.Review of R82's Grievance Resolution Form, dated 06/28/25 at 6:42 PM and provided by the facility revealed R82's concern as follows: On 06/27 [R82] was being changed by [CNA4] and when [CNA4] was taking off [R82's] shirt from behind it got caught on [R82's] hernia, when this happened [R82] told [CNA4] to stop. When he [CNA4] didn't [R82] then stated [CNA4] stated Stop! Your pulling my fucking guts out! [R82] then stated [CNA4] told him he had no power to stop him and You can't go anywhere. [R82] also stated he told the eve CNAs what happened to try and report it and nobody would listen/help him.Review of the Five-Day Follow Up Investigation Report, dated 07/07/25 and provided by the facility, revealed the initial report was made to the State on 06/30/25 at 3:00 PM, four days after R82's initial report. The investigation summary revealed, The alleged victim alleges that on 06/27 (interviews with staff and witness indicate the actual incident occurred 6/26) the alleged perpetrator [CNA4] intentionally caused pain to the alleged victim's umbilical hernia while helping the alleged victim get dressed. The alleged victim stated that he told the alleged perpetrator to stop and then the alleged perpetrator continued to assist him to help him dress further

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview, record review, and review of facility policy, the facility failed to ensure the resident did not receive the wrong dose contributing to a significant medication error for one of 31 sampled residents (Resident (R) 106) reviewed for medication orders. This deficient practice had the potential to over medicate residents by not following the physician orders.Findings include:Review of the facility's policy titled, Management and Destruction of Controlled Substances, with a date of 11/28/17, revealed Policy: The facility follows a process for management and destruction of controlled substances. Procedures.e. Chief Nursing Officer/designated RN should regularly audit the inventory records to validate accuracy.Review of R106's admission Record located under the Profile tab in the electronic medical record (EMR) revealed an admission date of 05 15/25 with diagnoses of aftercare following surgical amputation, acquired absence of right leg below the knee, and end stage renal disease.Review of R106's Physician Orders located under the Orders tab in the EMR revealed on 05/14/25, an order for hydromorphone oral tablet four milligrams (mg); give one tablet by mouth every six hours for pain. On 06/06/25, the order was written to decrease the hydromorphone oral tablet to four mg; give 0.5 tablet by mouth every six hours for pain.Review of the Controlled Drug Record dated 05/15/25- 07/11/25 and provided by the facility, revealed 14 occasions in which. R106 received a whole four mg pill instead of the ordered two mg.During an interview on 10/03/25 at 11:17 AM, the Registered Pharmacist (RP) stated the pharmacy received the order on 06/10/25. The RP stated that the interface between pharmacy and the facility did not communicate when there was a narcotic order. The RP further stated that the narcotic order must be ordered with a hard copy of the order. The RP was asked about the 14 times in which the medication was given at the wrong dose. The RP stated that it was not caught, and it should have been. The RP agreed the order was not followed.During an interview on 10/03/25 at 11:36 AM, Licensed Practical Nurse (LPN) 9 was asked about the medication order. LPN9 stated the medication should have been taken out of the pack and half the pill given and the other half wasted. It does appear to have been given in whole pill form. LPN9 was asked if any of the initials were on the narcotic sheet. LPN9 stated yes, her initials were on the form, and it looked like she had given a whole pill. LPN9 was asked if the physicians order was followed. LPN9 stated, no.During an interview on 10/03/25 at 12:18 PM, the Director of Nursing (DON) was asked about the wrong dose medication being given to the resident. The DON stated he had to look at a report. At 1:36 PM, the DON returned and stated the orders should have been called to the pharmacy when the order was initially ordered. The DON was shown the 14 opportunities in which the medication was given the wrong dose. The DON agreed the resident was given the wrong dose of medication.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, document review, staff interviews, and facility policy review, the facility failed to ensure appropriate storage of medication and vaccine supplies in one of two facility medication rooms. This failure created the potential for residents to experience a negative outcome related to potentially expired/undated and/or improperly refrigerated medications, immunizations, or immunization supplies. Findings include:Review of the facility's policy titled, Medication Storage -Refrigerator/Freezer Policy, dated [DATE], read, in pertinent part, The facility will ensure that medications which require refrigeration are stored appropriately per manufacturer's instructions; and 2. The facility should monitor the temperature of medication storage areas at least once a day. 3. The facility should monitor the temperature of vaccine storage twice a day; and Safe temperature for refrigeration is between the range of 36 degrees F (Fahrenheit) and 46 degrees F.Review of the facility's policy titled, Medication Management Policy, dated most recently revised [DATE], read, in pertinent part, Medication and treatment supplies are not used beyond their expiration dates; and Medications are discarded by the expiration date unless indicated by the pharmacy and/or manufacturer's instructions to discard sooner.Observation conducted along with the Director of Nursing (DON) in the facility's medication storage room located on the 300 hallway on [DATE] at 11:48 AM revealed one vial of open and undated Tuberculin Skin Testing Solution in one of the two refrigerators located in the medication room. The testing solution packaging indicated the solution had been dispensed from the pharmacy to the facility on [DATE]. In addition, temperature logs to indicate temperatures were monitored for both refrigerators in the medication room (one for storing medication and one for storing immunization materials), could not be located to ensure the management of refrigerator temperatures were within the appropriate range. The Tuberculin (TB) Skin Testing Solution instructions, located on the TB Skin Testing solution box located in the facility's medication room indicated, Tuberculin skin test solution must be discarded 30 days after it is first opened or if it has passed its expiration date, whichever comes first; and store refrigerated at 2-8 C (35-46 F) and protected from light to ensure potency. During an interview with the DON on [DATE] at 11:55 AM, he stated his expectation was multi dose vials, including tuberculin testing solution, should be labeled when opened and discarded within 28 days after opening. The DON stated he was not sure where the refrigerator temperature logs were, but he would look for them. He stated he expected the logs to be posted on the door of each refrigerator. During a follow-up interview with the DON on [DATE] at 12:18 PM, he provided a log, dated [DATE], for one of the medication room refrigerators. The log did not indicate which refrigerator the temperatures were being logged for and the DON stated he was not able to tell which log he was providing. He stated the log had been found in the Unit Manager's Office. The DON confirmed the logs were expected to be located on the door of each refrigerator and labeled appropriately to indicate which refrigerator was being monitored. The DON confirmed both refrigerators in the medication room (one for the storage of medication and one for the storage of immunization/supplies) were expected to be monitored at least daily. He indicated he thought the refrigerator used to store immunizations and immunization supplies was supposed to be monitored twice daily to ensure stability of the immunization supplies.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and facility policy review, revealed the facility failed to ensure enhanced barrier precautions (EBP) and hand hygiene were performed after emptying a nephrostomy bag and performing incontinent care for one of 31 sampled residents (Resident (R) 9) reviewed for infection control. This deficient practice had the potential to allow residents to be exposed to pathogens that could cause an infection.Findings include:Review of the facility's policy titled, Transmission-Based Precautions Conventional Plan,revised on 06/16/25, revealed Policy: To protect residents from the spread of infection through the implementation of infection control practices and precautions, Hand hygiene is the single most important factor in the prevention or spread of infection.Hand hygiene indicated, utilizing Alcohol Based Hand Rub (ABHR) and/ or hand washing with soap and water. a. Before and after contact with a resident, b. Before and after contact with objects and surfaces in the resident's environment, c. Before and after wearing gloves, d, Before and after wearing personal protective equipment e. Before eating or assisting a resident with meal f. After using the restroom. Enhanced Barrier Precautions (EBP) are recommended for the use in resident rooms when residents have any of the following conditions, but do not require contact precautions.b. indwelling medical devices, central line, urinary catheter, feeding tube, tracheostomy/ventilator care. A peripheral intravenous line (not a periphery inserted central catheter) is not an indwelling medical device.b. Wear a gown whenever anticipating that clothing will be have direct contact with the resident or potential contaminated environmental surfaces or equipment surfaces or equipment in close proximity to the resident.Review of R9's admission Record located under the Profile tab in the electronic medical record (EMR) revealed an admission date of 09/15/25 with diagnoses of diabetes, chronic kidney disease, and functional quadriplegia.Review of physician orders located under the Orders tab in the EMR revealed on 09/15/25 Enhanced barrier precautions for Nephrostomy Gown and gloves required for high-contact patient care (dressing, bathing, transferring, incontinence or toileting care, dressing, changing linens, or device or wound care). Gown and gloves are not required when not performing high- contact care.On 09/29/25 at 10:56 AM, an observation was made when staff came into R9's room to give her pain medication. Licensed Practical Nurse (LPN) 5 and Certified Nursing Assistant (CNA) 11 started to give cares. LPN5 emptied R9's nephrostomy bag into a measurable container. LPN5 wore only gloves while she emptied the bag and then emptied the container down the toilet. LPN5 came out of the bathroom and threw her gloves in the trash and donned a new pair without hand hygiene. LPN5 went to bed to help CNA11 perform cares. R9 had a bowel movement. CNA11 wore a pair of gloves and cleaned R9's incontinence. CNA11 reached into the wipes after wiping R9's buttock and proceeded to pick up clean depends and place it under R9 without changing gloves or performing hand hygiene between the dirty and clean.During an interview 09/29/25 at 11:13 AM, LPN5 was asked about emptying the nephrostomy bag and pouring the urine down the toilet without a gown on. LPN5 stated Yes, should have had a gown on because the resident is on EBP. LPN5 was asked if she should have washed her hands or used the ABHR before donning the second pair of gloves. LPN5 stated Yes.During an interview on 09/29/25 at 11:14 PM, CNA11 was asked if the gloves should have been changed in between going from dirty to clean. CNA11 stated Yes should have changed gloves and performed hand hygiene before putting on clean gloves. During an interview on 10/04/25 at 11:23 AM, Infection Preventionist (IP) was asked about the observation. The IP stated, The expectation is that staff wash their hands when entering room and before they start any cares. Both the LPN and CNA should have changed gloves after they performed hand hygiene. The IP stated that the LPN should have had a gown on when emptying the nephrology bag. That is the expectation