

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Lewiston Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8th Street Lewiston, ID 83501	

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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETES HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview it was determined the facility failed to update a resident's care plan for 1 of 17 residents (Resident #54) reviewed for care plan accuracy. This deficient practice created the potential for harm if resident's care plan was not current for health care interventions. Findings include: Resident #54 was admitted to the facility on [DATE] with multiple diagnoses including COPD (Chronic Obstructive Pulmonary Disease: an irreversible lung disease that progressively makes breathing difficult), dependence on supplemental oxygen, diabetes, dementia, depression, and cognitive communication deficit. A physician's order, dated 5/31/23, documented Resident #54 was to receive oxygen at 2 liters/minute via nasal cannula continuously. This order was discontinued on 6/21/23. Resident #54's care plan, dated 6/5/25, documented Resident #54 had COPD with oxygen dependence; however, it did not address Resident #54 was no longer using oxygen. On 8/19/25 at 4:15 PM, the CNO stated Resident #54 no longer had an oxygen machine and added we should have updated her care plan when the order was discontinued on 6/21/23.</p>

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: 135021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Lewiston Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8th Street Lewiston, ID 83501	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview it was determined the facility failed to follow a dietary restriction related to a food allergy. This was true for 1 of 1 resident (Resident #14) whose medical record was reviewed for food allergies. This deficient practice had the potential to cause harm or death related to anaphylaxis (a severe, potentially life-threatening allergic reaction) when staff failed to follow dietary restrictions related to food allergies. Findings include: Resident #14 was admitted to the facility on [DATE] with multiple diagnoses including dementia, diabetes, high blood pressure, depression, and anxiety. Resident #14's admission MDS assessment, dated 6/18/25, documented Resident #14 was not cognitively intact. A review of Resident #14's care plan documented the resident had an allergy to aspirin, peanuts, and pollen. A nursing progress note, dated 8/19/25 at 3:16 PM, documented Resident #14 mistakenly ate a peanut butter sandwich. On 8/20/25 at 5:30 PM, the CNO stated a facility staff gave Resident #14 a peanut butter sandwich on 8/19/25 when she asked for something to eat. The CNO reported the facility staff did not check Resident #14's medical record prior to giving the peanut butter sandwich. She added, when the facility nurse was informed Resident #14 had eaten a peanut butter sandwich, the nurse immediately notified the physician, the facility administration, and the resident's representative. The facility nurse was directed by the doctor to monitor the resident for signs and symptoms of allergic reaction. As of 8/20/25 at 5:30 PM, the CNO reported Resident #14 had not experienced any signs or symptoms of an allergic reaction. The CNO stated the snack room had a binder to record all resident food allergies to keep staff educated on resident needs. The CNO added the allergen binder had not been updated and was not where it belonged in the snack room on 8/19/25.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Lewiston Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8th Street Lewiston, ID 83501	

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)
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident and staff interviews, it was determined the facility failed to ensure resident's pain was effectively managed and treated. This was true for 1 of 3 residents (Resident #31) reviewed for pain management. This deficient practice created the potential for harm should residents not receive effective pain management. Findings include:Resident #31 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including lymphedema (accumulation of fluid due to disruption of lymphatic flow for a variety of reasons) and congestive heart failure (when the heart is unable to pump enough blood to meet the body's needs, leading to a buildup of fluid in the body).A physician's order, dated 8/13/25 documented Resident #31 was to receive the following medications:- hydrocodone -acetaminophen (narcotic pain medication) oral tablet 10-325 mg, one tablet every four hours as needed for pain level of 1-5.- hydrocodone -acetaminophen oral tablet 10-325 mg, two tablets every four hours as needed for pain level of 6-10.Resident #31's August 2025 MAR, documented the physician's order was not followed. Resident #31 received the hydrocodone -acetaminophen oral tablet 10-325 mg incorrectly on the following instances:- 8/14/25 at 1:17 PM, one tablet of hydrocodone -acetaminophen 10-325 mg for a pain level of 0- 8/14/25 at 7:33 PM, one tablet of hydrocodone -acetaminophen 10-325 mg for a pain level of 6- 8/16/25 at 7:03 PM, two tablets of hydrocodone -acetaminophen 10-325 mg for a pain level of 4- 8/17/25 at 3:44 AM, two tablets of hydrocodone -acetaminophen oral tablet 10-325 mg for a pain level of 4- 8/17/25 at 7:52 PM, two tablets of hydrocodone -acetaminophen oral tablet 10-325 mg for a pain level of 5- 8/18/25 at 3:59 PM, two tablets of hydrocodone -acetaminophen oral tablet 10-325 mg for a pain level of 5On 8/21/25 at 9:476 AM, the CNO with the Clinical Resource Nurse present, stated Resident #31's physician's orders were not followed and the nurse should have reviewed the physician's orders after assessing Resident #31's pain level.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Lewiston Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8th Street Lewiston, ID 83501	

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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview it was determined the facility failed to ensure significant medication errors were prevented. This was true for 1 of 6 residents (Resident #14) reviewed for significant medication errors. This failed practice had the potential for harm if medications were not administered according to physicians orders. Findings include: Resident #14 was admitted to the facility on [DATE] with multiple diagnoses including dementia, diabetes, high blood pressure, depression, and anxiety. Resident #14's Admissions MDS assessment, dated 6/18/25, documented Resident #14 was not cognitively intact. A physician's order, dated 6/18/25, documented Resident #14 was to receive the following medications: -Namenda (a dementia medication), give 5 mg by mouth once per day [AM/morning.] -Carvedilol (a blood pressure medication), give 6.25 mg by mouth two times per day [8:00 AM; 5:00 PM.] A physician's order, dated 6/19/25, documented Resident #14 was to receive the following medications: -Amlodipine Besylate oral tablet (a blood pressure medication), give 10 mg by mouth one time per day [AM.] -Hydrochlorothiazide (a blood pressure medication), give 12.5 mg by mouth one time per day [AM.] -Losartan Potassium (a blood pressure medication), give 100 mg by mouth one time a day [AM.] -Sertraline HCl Oral Tablet (an antidepressant), give 150 mg by mouth one time per day [AM.] -Budesonide Inhalation Suspension (for COPD), 1 mg/ 2 ml, 1 dose inhaled orally two times a day [AM; PM.] A physician's order, dated 7/23/25, documented Resident #14 was to receive the following medications: -Fluticasone-Salmeterol Inhalation Aerosol Powder 250-50 mcg (for COPD), 1 puff inhaled orally two times per day [AM; PM.] Resident #14's MAR was reviewed from June - August 2025, with the following AM medications documented as not received: Resident Sleeping: - 6/25; 6/29; 6/30- 7/2; 7/4; 7/8; 7/9; 7/11; 7/15; 7/18; 7/20; 7/23; 7/24; 7/28 - 8/1; 8/11; 8/12; 8/17; 8/20 Resident Refused: -7/1 Resident #14's care plan, initiated on 6/18/25, documented the use of antipsychotic medication related to unspecified psychosis and dementia. The care plan directed staff to give medications as ordered by the physician, and to monitor and document the effectiveness and potential side effects including over-sedation and lethargy, and to notify the physician as indicated. Nursing progress notes, dated 6/18/25 through 8/19/25, documented the following: -On 8/15/25, an SBAR was submitted with the statement: Resident [#14] prefers to sleep in until 11:00 AM most days per direct care staff. [The facility staff] are having issues waking her up early to give her [morning medications.] -No further documentation regarding the effects of medication, missed medications, or notification to the physician was found. On 8/20/25 at 5:27 PM, the CNO stated there was no documentation in Resident #14's medical record regarding her 'sleeping' and missing medication until 8/15/25. She verified there were no staff to physician notifications in Resident #14's medical record regarding the multiple days of missed medication as documented in the MAR due to Resident #14 sleeping. On 8/21/25 at 11:14 AM, the CNO stated the facility does not have a policy relating to when the doctor should be notified, but best practice would be to notify the doctor within 24-48 hours, depending upon the medication. The physician should have been notified in June 2025 of Resident #14's missed medications.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Lewiston Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8th Street Lewiston, ID 83501	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, review of the Food, Drug, Administration (FDA) Food Code, and staff interview, it was determined the facility failed to ensure staff food and physical therapy ice packs were stored separately from resident food in a freezer, resident food was not dated correctly, and pest control measures were not followed. This was true for the 66 residents who consumed food stored and 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 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 8/21/25 at 9:27 AM, it was observed in the A-Wing Resident Snack freezer, therapy ice packs were stored with two packages of raw beef burgers labeled for employee use. On 8/21/25 at 9:35 AM, in the El Bistro Resident refrigerator, an open and incorrectly dated orange juice (dated use by 11/25) was observed. In the freezer, therapy ice packs were stored with 3 open and undated ice cream containers. On 8/21/25 at 9:40 AM, the Culinary Director stated, staff food, like the beef burgers and physical therapy ice packs should not be stored with resident's food items. She stated all food should be labeled with the resident's name, open date, and use by date. The Culinary Director stated the orange juice was not correctly dated, the ice cream should have been dated, and staff needed more education on how to properly label and date resident foods. 2. The FDA Food Code Section 6-501.111 Controlling Pests documented the premises shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the premises by: (A) Routinely inspecting incoming shipments of food and supplies; (B) Routinely inspecting the premises for evidence of pests; (C) Using methods, if pests are found, such as trapping devices or other means of pest control., and (D) Eliminating harborage (a hiding place for pests) conditions. On 8/21/25 at 10:04 AM, two kitchen dumpsters were observed with their lids left open. Dumpster #1 was immediately outside the kitchen door and had multiple flies surrounding the trash inside it. Dumpster #2 located in an enclosed area on the property was observed with garbage and leaves piled around it on the ground. On 8/21/25 at 10:25 AM, the Maintenance Director stated the leaves and trash surrounding dumpster #2 was normally cleaned every Monday when the garbage was collected, but had not been cleaned on 8/18/25. He stated the [Pest Control Company] came to the facility every two weeks. The Maintenance Director stated all facility staff are instructed to close the dumpster lids after use and the lids should not have been left open.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Lewiston Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8th Street Lewiston, ID 83501	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Lewiston Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8th Street Lewiston, ID 83501	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 infection prevention standards were followed. This was true for 1 of 1 resident (Resident #40) whose intravenous (IV) medication administration was observed. This failure created the potential for harm if infectious pathogens (any organism that causes disease) were introduced to his peripherally inserted central catheter (PICC- a thin tube placed in a vein in the arm passed through to the large vessels near the heart). Findings include: The National Library of Medicine web page, World Health Organization (WHO) Guidelines on Hand Hygiene in Health Care, article dated 2009, accessed 8/25/25, documented indications for hand hygiene included to perform hand hygiene before handling an invasive device for patient care and after contact with inanimate surfaces and objects (including medical equipment) in the immediate vicinity of the patient. The CDC Infection Control, Standard Precautions for All Patient Care, web page, dated 4/3/24, accessed on 8/25/25, documented Standard Precautions are used for all patient care. They're based on a risk assessment and make use of common sense practices and personal protective equipment use that protect healthcare providers from infection and prevent the spread of infection from patient to patient. The web page instructs to perform hand hygiene after contact with a contaminated surface and use personal protective equipment (PPE) when needed for Standard Precautions (when you anticipate that you will come in contact with blood or other infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment). The facility's IV Fluid Administration checklist, undated, documented directions for infection control as Perform hand hygiene. Apply gloves. Use infection control measures and standard precautions during the entire procedure with the rationale, Prevents the transmission of microorganisms. Resident #40 was admitted to the facility on [DATE] with multiple diagnoses, including sepsis (a life-threatening, extreme response to an infection that causes the immune system to damage the body's organs and tissues), pneumonia, and diabetes. On 7/3/25, Resident #40 was diagnosed with osteomyelitis (a bone infection) and had a PICC line placed in his inner right upper arm for IV antibiotic administration. Resident #40's physician orders documented an order, dated 8/14/25, for an antibiotic, vancomycin hcl intravenous solution 1250 mg/ 250 ml, administer 1250 mg once a day, intravenously, over 1 hour, for osteomyelitis. On 8/21/25 at 9:20 AM, LPN #1 was observed preparing Resident #40's IV vancomycin. LPN #1 walked into Resident #40's room while introducing herself, she then hung the bag of vancomycin on the IV pole with pump near his bed while explaining she was there to administer his IV antibiotic. LPN #1 was observed washing her hands with soap and water, then dried them, she put on a clean reusable PPE gown, and put on gloves. LPN #1 was observed closing the resident's divider curtain with her gloved right hand when the resident asked her to. She was then observed gathering an alcohol wipe and sterile 10 ML saline solution syringe from a plastic bag hanging on the IV pole, feeding the IV tubing through the pump, pressing the IV pump buttons to set the rate of delivery, then primed the medication tubing using the prime button on the IV pump with her right hand, while holding the open end of the IV tubing over the garbage can with her left hand. The open end of the IV tubing stayed in LPN #1's left hand while she opened a sterile 10 ML saline solution syringe and alcohol wipe. LPN #1 accessed one of the two ports on Resident #40's PICC line by removing the cap, she then scrubbed the opening of the port with the alcohol swab, then attached the saline syringe, and verified the PICC line was functioning appropriately. LPN #1 then attached the open end of the IV tubing and began delivery of the IV vancomycin by pressing start on the IV pump. LPN #1 was not observed to change her gloves or perform hand hygiene after touching the divider curtain and IV pump in Resident #40's room before accessing his PICC port. On 8/21/25 at 10:24 AM, LPN #1 stated she should have performed hand hygiene and changed her gloves after touching things in Resident #40's room before accessing his PICC port. On 8/21/25 at 10:26 AM, the CNO stated nurses should always perform hand hygiene and put on clean gloves before accessing an IV site.</p>		