

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135051	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Canyon West of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 2814 South Indiana Avenue Caldwell, ID 83605	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603</p> <p>Based on observation, and resident and staff interview, it was determined the facility failed to protect and promote the rights of residents to be treated with respect and dignity in a manner that promoted enhancement of their quality of life. This was true for 1 of 18 residents (Resident #63). This deficient practice created the potential for psychosocial harm if residents felt they were not treated with dignity and respect. Findings include:</p> <p>The Centers for Medicare and Medicaid Services (CMS) State Operations Manual (SOM), Appendix PP, section 483.10(a)(1), documented: A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.</p> <p>Resident #63 was admitted to the facility on [DATE], with multiple diagnoses including metabolic encephalopathy (an underlying condition causing confusion, memory loss, and possible loss of consciousness), spinal stenosis in the cervical region (a narrowing of spaces in the spine compressing the spinal cord and nerves), and bed confinement status.</p> <p>On 2/3/25, at 10:30 AM, Resident #63 was observed in her bedroom calling out that she was hungry. LPN #1 stated Resident #63 was a feeder and had already been assisted with her breakfast.</p> <p>On 2/7/25 at 11:44 AM, the DON stated, if anyone is heard using the term 'feeder', the facility provided a written education proving that they had educated the staff on the appropriate and inappropriate usage of various descriptive language, and anyone requiring help to eat should be referred to as 'an assist.'</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
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>50603</p> <p>Based on observation, and resident and staff interview, it was determined the facility failed to ensure the residents had a homelike environment. This was true for 4 of 4 residents (#5, #13, #49, #55) observed dining with plastic cutlery. This deficient practice created the potential for psychosocial harm if residents felt isolated when they were not provided the same homelike environment as other residents. Findings include:</p> <p>On 2/3/25, at 12:27 PM, 4 of 4 residents in the independent dining room were observed eating their lunch with plastic cutlery.</p> <p>On 2/3/25 at 3:13 PM, the Dietary Manager (DM) stated, she ordered more silverware on 1/29/25 and is not sure when it was supposed to arrive but found more silverware that afternoon in storage to provide during meals.</p> <p>On 2/4/25 at 2:10 PM, Resident #5 stated, the residents in the independent dining room had been given plastic cutlery for both breakfast and lunch that day.</p> <p>On 2/5/24 at 12:45 PM, the DM stated, she was unaware why residents would have been given plastic cutlery when the facility had found additional silverware to accommodate all residents.</p>		

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<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** 48401</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure a resident was provided quality care when they were not administered their medications as ordered. This was true for 1 of 18 residents (Resident #7) whose bowel records and medication administration records were reviewed. This failure placed Resident #7 at risk for harm if she were to suffer discomfort or complications from constipation, such as bowel obstruction. Findings include:</p> <p>Resident #7 was admitted to the facility on [DATE] for care following a stroke, and had multiple diagnoses including a seizure disorder and fibromyalgia (a chronic condition which causes widespread pain).</p> <p>Resident #7's physician orders, with a start date of 3/6/24, documented the following bowel protocol medications:</p> <ul style="list-style-type: none"> -Milk of Magnesia Suspension (MOM) 1200 mg/15 ml, Give 30 milliliter orally as needed for no bowel movement for two (2) days. If no results within 24 hours, see Dulcolax Suppository order. -Dulcolax Suppository 10 mg, Insert 1 suppository rectally as needed for bowel care, give if no results from MOM. If no results in 24 hours, see Fleet Enema order. -Fleet Enema 7-19 gm/118 ml, Insert 1 unit rectally as needed for bowel care, give if no results from MOM and subsequent Dulcolax Suppository. Complete bowel assessment and notify MD if no results. <p>On 2/4/25 at 11:06 AM, Resident #7's electronic medical record (EMR) documented her last bowel movement was on 1/31/25.</p> <p>On 2/7/25 at 10:40 AM, Resident #7's EMR documented her last bowel movement was on 2/6/25. Resident #7's nursing progress notes did not document her bowel protocol was followed, and her medication administration record (MAR) did not document she had been given her bowel protocol medications as prescribed.</p> <p>On 2/7/25 at 11:20 AM, the Clinical Resource Nurse confirmed Resident #7's EMR did not contain documentation she had a bowel movement or bowel protocol medications between 1/31/25 and 2/6/25.</p> <p>On 2/7/25 at 11:30 AM, the DON stated the notification their EMR system shows to alert nurses regarding bowel movements was cleared by a nurse who failed to administer an as needed (PRN) medication, therefore oncoming nurses were not alerted Resident #7 required bowel protocol medication interventions.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>50981</p> <p>Based on staff interview and record review, it was determined the facility failed to provide the required Registered Nurse (RN) coverage for two of 92 days (8/18/24 and 8/25/24), reviewed for weekend staffing. This failure placed the residents at risk for inadequate assessments, delay in care and services by an RN, unmet care needs, and diminished quality of life. Findings include:</p> <p>As required, the facility provided payroll based data to CMS quarterly. Review of the Payroll Based Journal (PBJ) staffing data report for July 1-September 30, 2024, triggered excessively low weekend staffing during the fourth quarter of 2024. PBJ staffing defines a day as starting at 12 midnight to 12 midnight.</p> <p>The facility's employee timecards for RNs, Licensed Practical Nurses (LPNs), and Certified Nursing Assistants (CNAs) were reviewed for those weekend dates and documented the following:</p> <ul style="list-style-type: none"> -Sunday 8/18/24 documented zero RN hours worked, -Sunday 8/25/24 documented four RN hours worked. <p>On 2/7/25 at 1:00 PM, the Human Resources Staff Manager confirmed the RN scheduled to work on 8/18/24 called off and the facility was unable to get another RN to come in, and on 8/25/24 the facility had scheduled only one RN to work a total of 4 hours.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50603</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure kitchen equipment was maintained, cleaned, and sanitized. These deficiencies had the potential to affect the 71 residents who consumed food prepared by the facility. This placed residents at risk for potential foodborne illnesses and adverse health outcomes due to contaminated food services equipment. Findings include:</p> <p>The Food Drug Administration (FDA) Code, Section 4-602.12 Cooking and Baking Equipment: Food-contact surfaces of cooking equipment must be cleaned to prevent encrustations that may impede heat transfer necessary to adequately cook food. Encrusted equipment may also serve as an insect attractant when not in use.</p> <p>On 2/3/25 and 2/7/25, it was observed during the kitchen inspections and tray line observations, staff were using cookware (sheet pans, pots, and food skillets) which had black residue encrusted along the bottom rims, on the corners, and at least 1-inch along the top of the skillet pans.</p> <p>On 2/6/25, at 12:15 AM, a black rimmed stainless steel skillet was observed being used to make quesadilla's for the resident's lunch meal.</p> <p>On 2/7/25 at 11:10 AM the DM stated, dishes and cookware are cleaned and sanitized according to manufacturer instructions. However, she added, Nothing special is done for the stainless steel other than regular cleaning and sanitation. These pots, pans, and cookware have been in the facility for years, are black, and need to be replaced.</p> <p>On 2/7/25 at 11:11 AM, the Dietitian confirmed the cookware is approved stainless steel food grade pots, pans, and cooking sheets, but agreed they needed to be replaced as there was a black buildup on the skillets, pans, and pots.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50981</p> <p>Based on observation, policy review, and staff interview, it was determined the facility failed to ensure infection control practices were consistently implemented as they related to environmental cleaning. Failure to ensure the shower rooms were cleaned and disinfected to maintain a sanitary environment was true for 1 of 3 showers observed. This failure had the potential to impact all residents, staff, and guests in the facility. Findings include:</p> <p>The facility's Infection Prevention and Control Program, revised 10/15/22, documented measures to prevent infections and appropriate use of disinfectants.</p> <p>On 2/5/25 at 4:45 PM, the shower room on the 200 hall was observed with the Maintenance Director. He confirmed that there was a thick, fuzzy, raised black substance along the area where the wall meets the floor directly behind the movable shower chair and an area on the ceiling that looked like mold. The Maintenance Director stated it was the responsibility of the nursing staff to disinfect the shower between uses and he cleans the grout in the shower rooms monthly or sooner if notified by staff that there is a need. He added, based on his training with identifying and preventing the growth of mold, the amount of mold growth observed would have taken 3-4 weeks to reach that size, and should have been identified by every nursing staff who had assisted residents with using that shower.</p> <p>On 2/6/25 at 10:09 AM, CNA #1 stated, there was no onboarding training or expectations given to CNA's regarding cleaning or disinfecting the showers between resident use.</p> <p>On 2/6/25 at 10:55 AM, the Housekeeping Manager and Laundry Aid #1 both stated the resident shower rooms were cleaned at the end of their shift by spraying disinfectant spray on walls and behind the shower chair. They further stated any evidence of mold would be immediately alerted to the Maintenance Director.</p>		