STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135051	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyon West of Cascadia	2814 South Indiana Avenue Caldwell, ID 83605

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of the Idaho Food Code, the facility failed to appropriately store, distribute, and label foods. This deficient practice had the potential to affect all residents who received meals prepared in the facility's kitchen. This placed residents at risk for potential contamination and use of spoiled foods, and adverse health outcomes including food-borne illnesses. Findings include:The Idaho Food Code, revised February 2021, stated, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking . refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.On 4/12/26 at 9:30 AM, observed the following in the kitchen with the food service manager.- In the dry food storage area - a container of garlic powder with a use by date of 12/18/24, a container of chili powder with a use by date of 2/25/25, an opened bag of taco seasoning with no opened date or use by date, a container of chocolate sauce with a use by date of 3/13/26.- In the refrigerators - cut onions in a container with use by date of 4/10/26, an opened undated bag of cut cabbage, a tray with bagged cheese and an unsealed bag of salami with liquid in it that had leaked on to the tray that held both the cheese and salami, ham in a container with no use by date, small individual cups labeled as salad (dressing) with a prepped date of 3/28, but no use by date.- In the freezers - opened undated bag of chicken wings, opened unsealed and undated box of seasoned beef patties.- In the clean pan area - a skillet with encrusted food on the inside and outside of the pan.On 4/12/26 at 10:10 AM, the Food Service Manager stated the opened food items should have been closed and sealed correctly, all food items needed use by dates, and the encrusted pan should have been cleaned correctly.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, record review, and staff interview, it was determined the facility failed to ensure nurse staffing information was accurate and posted daily for each shift. This failed practice had the potential to affect all residents residing in the facility and their representatives, visitors, and others who wanted to review the facility's staffing levels. Findings include:On 4/13/25, during review of the facility Daily Staffing sheets, the surveyor observed the following issues: - September 2025 - 23rd, 24th, 25th, 26th: Missing census data on the Daily Staffing sheets.- September 2025 - 27th, 28th, 29th: Missing Daily Staffing sheets. - January 2026, 18th, 19th, 20th: No nursing data (number of hours worked by nurses) documented on Daily Staffing sheets.On 4/16/26 at 10:26 AM, the CNO and Director of Clinical Resources stated the Daily Staffing sheets should not have been missing, nor missing required data but were.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents were assessed for safety to self-administer medication. This was true for 1 of 1 resident (Resident #2) reviewed for self-administration of medication. This failure created the potential for adverse outcomes if Resident #2 self-administered inhaler medication and received too much or too little of the medication. Findings include:The facility's Self-Administration of Medications policy revised 9/16/25, documented residents may self-administer medications when it was determined to be safe and appropriate.Resident #2 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (COPD - a group of lung disease characterized by increasing breathlessness) and diabetes.Resident #2's physician's order dated 4/9/26, included an Albuterol Sulfate (inhaler) HFA Inhalation Aerosol solution mcg/act, one puff inhale orally every four hours as needed for shortness of breath, and he may keep the medication at his bedside.A Self-Administration of Medication Evaluation dated 3/24/26, documented Resident #2 was fully capable of administering nebulizer treatments after set-up by the nurse.Review of Resident #2's physician's order did not include an order for him to use a nebulizer.On 4/12/26 at 10:53 AM, an inhaler was observed on Resident #2's over the bed table. Resident #2 stated he had asthma, and used the inhaler when he needed it. When asked how often he uses the inhaler, Resident #2 stated, sometimes two times a day.On 4/13/26 at 9:40 AM, Resident #2 was observed taking two puffs of the inhaler albuterol. On 4/13/26 at 4:36 PM, the CNO stated Resident #2 had an assessment to self-administer his inhaler. Surveyor told CNO that an assessment to self-administer the inhaler was not found in his record. CNO stated she would look for Resident #2's assessment to self-administer the inhaler.On 4/14/26 at 10:15 AM, the CNO stated she was unable to find Resident #2 was assessed to self-administer the inhaler and he should have one.

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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** Based on record review, policy review, SOM Appendix PP, and staff interview, it was determined the facility failed to ensure comprehensive centered care plans' interventions were implemented. This was true for 1 of 20 residents (Resident #2) whose care plans were reviewed. This failure created the potential for harm should Resident #2 experience complications and receive inappropriate or inadequate care. Findings include:The State Operations Manual Appendix PP dated 7/23/25, documented, The comprehensive care plan must reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented.The facility's Comprehensive Care Plans revised 9/3/25, documented the facility will ensure that each resident has a timely, person-centered comprehensive care plan developed and maintained in accordance with professional standards of practice. The care plan will reflect the resident's individual conditions, risks, needs, behaviors, cultural values, and preferences and will include measurable goals, appropriate interventions, and realistic timeframes.Resident #2 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including diabetes, and chronic obstructive pulmonary disease.A physician's order dated 12/27/25, directed staff to administer apixaban (anticoagulant) oral tablet 5 mg by mouth two times a day to Resident #2.A care plan initiated 12/27/25, documented Resident #2 was on anticoagulant therapy and staff were directed to give the medications as directed by the physician and monitor/document the effectiveness and potential side effects: abnormal bleeding/bruising, black stools, pink-tinged urine, leg/pain swelling, nausea and vomiting, sudden onset of chest pain/shortness of breathing, and to notify the physician as indicated.Review of Resident #2's records did not include documentation he was being monitored for the side effects of his anticoagulant.On 4/14/26 at 10:15 AM, the CNO stated Resident #2 did not have monitoring for his anticoagulant and there should be a monitor.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of records, policy review, and staff interviews, it was determined the facility failed to ensure residents' comprehensive care plans were revised timely and as needed. This was true for 2 of 20 residents (#8 and #11) whose care plans were reviewed. This deficient practice created the potential for residents to receive inappropriate or inadequate care due to inaccurate information in their care plans. Findings include:The facility's Resident Care Plan Revisions policy revised 9/3/25, documented when a resident's condition, response to treatment, or care needs change, the facility would promptly review and revise the care plan to reflect those updates. 1. Resident #11 was admitted to the facility on [DATE], with multiple diagnoses including hypertension, dysphagia (difficulty swallowing), and bilateral hearing loss. A care plan revised 3/10/24, documented Resident #11 used an antidepressant related to depression, and appetite. Review of Resident #11's Medication Administration Record, documented that the Mirtazapine (antidepressant) had been discontinued on 4/6/26. On 4/14/26 at 1:14 PM, the CNO stated Resident #11's care plan should have been updated when her antidepressant was discontinued due to her refusal to take the medication. 2. Resident #8 was readmitted to the facility on [DATE], with multiple diagnoses including pneumonia, diabetes, respiratory disorders, respiratory failure, shortness of breath, and pulmonary edema (the abnormal accumulation of fluid in the lungs, which impairs oxygen exchange). A physician's order dated 2/4/26, documented for Resident #8 to receive oxygen at 2 LPM continuously per nasal cannula via O2 concentrator and/or tank. A review of Resident #8's care plan directed staff to provide oxygen therapy as ordered via nasal cannula. Resident #8 was observed on the following dates and times not wearing her nasal cannula: -On 4/13/26 at 8:45 AM, while eating breakfast. -On 4/13/26 at 2:15 PM, while lying in bed. -On 4/14/26 at 9:30 AM, while sitting up in a chair. On 4/15/26 at 1:44 PM, LPN #3 stated Resident #8 frequently did not wear her nasal cannula or BiPAP, and staff were verbally instructed to ensure she wore her nasal cannula or document if she did not. On 4/15/26 at 1:46 PM, after a review of Resident #8's medical record, LPN #3 was unable to find any notes to or from staff directing them to ensure Resident #8 wore her cannula or to document it in her medical record. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/26 at 3:02 PM, the facility provided a physician's note dated 4/13/26, which documented Resident #8 refused to wear her nasal cannula and BiPAP, and requested a consideration to reduce oxygen requirements and/or physician's orders. On 4/15/26 at 3:03 PM, the CNO stated Resident #8's care plan related to nasal cannula and BiPAP refusal behaviors should have been updated on 4/13/26, when the physician saw her.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interviews, it was determined the facility failed to ensure physician's orders for bowel care were followed. This was true for 1 of 4 residents (Resident #8) reviewed for bowel care management. This deficient practice created the potential for residents to experience discomfort related to constipation. Findings include:Resident #8 was readmitted to the facility on [DATE], with multiple diagnoses including pneumonia, diabetes, respiratory disorders, respiratory failure, shortness of breath, and pulmonary edema.Physician's orders documented the following:-Miralax oral powder, 17 gm/scoop, give 17 gm by mouth two times a day for bowel care mix with at least 4 oz fluid of choice, ordered 3/16/26.-Bisacodyl EC Oral Tablet Delayed Release 5 mg, give 1 tablet by mouth one time a day for constipation prevention, ordered 3/16/26.-Senna plus oral tablet 8.6-50 mg, give 2 tablets by mouth two times a day for bowel care, ordered 2/16/26.-Senna oral tablet 8.6 mg, give 3 tablets by mouth as needed for bowel protocol step #1 if no BM in 72 hours (day 3), ordered 3/24/26.-Bisacodyl Oral Tablet Delayed Release 5 mg, give 3 tablets by mouth as needed for bowel protocol step #2 if no BM in 96 hours (day 4), ordered 3/24/26.-Bisacodyl Rectal Suppository 10 mg, insert 1 suppository rectally as needed for bowel protocol step #3 if no BM by morning following after (day 5) completing oral bisacodyl, ordered 3/24/26.A review of Resident #8's medical record documented she did not have a bowel movement from 4/9/26 through 4/12/26 (4-days).A review of Resident #8's MAR dated 4/9/26 to 4/13/26, documented she did not receive bowel protocol step #1, step #2, or step #3.No records were available for 4/12/26 related to bowel care.On 4/14/26 at 9:35 AM, the ACNO confirmed Resident #8's MAR did not document she had received bowel protocol medication on 4/12/26 or 4/13/26. She confirmed there were no progress notes related to Resident #8's refusal or education provided by staff.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, record review, and interviews, it was determined the facility failed to provide respiratory services as ordered by the physician. This was true for 2 of 6 Residents (#1 and #20), and providing oxygen without a physician's order for 1 of 6 residents (Resident #89), whose records were review for respiratory services. This failure created the potential for residents to experience increased fatigue and low oxygen levels, or having oxygen provided without physician oversight. Findings include:The facility's Oxygen Administration, Safety, Storage and Maintenance policy dated 8/4/23, directed staff to document procedure/administration in resident medical record, provide ongoing documentation of routine and PRN oxygen use, notify physician as indicated with resident changes of condition and/or complications with supplemental oxygen use, and to store oxygen and respiratory supplies in bag labeled with resident's name when not in use. 1. Resident #1 was initially admitted to the facility on [DATE], and readmitted to the facility on [DATE], with multiple diagnoses including paranoid schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior) and chronic obstructive pulmonary disease (progressive lung disease characterized by increasing breathlessness). On 4/12/26 at 10:38 AM, Resident #1 was observed not wearing his oxygen cannula. RN #2 entered Resident #1's room to empty his half full urinal and left his room without addressing that he was not wearing his oxygen cannula. Resident #1's physician oxygen order dated 8/4/25, documented oxygen at 2 LPM continuously per nasal cannula via O2 concentrator and/or tank, as tolerated or allowed. Resident #1's care plan dated 12/5/25, documented oxygen therapy as ordered via nasal cannula. On 4/16/25 at 10:28 AM, the CNO and Director of Clinical Resources stated the RN should have addressed Resident #1 not wearing his oxygen cannula. 2. Resident #20 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including stroke and diabetes. On 4/13/26 at 12:41 PM, Resident #20's CPAP mask was sitting on the bedside table not covered or bagged. On 4/16/25 at 10:30 AM, the CNO and Director of Clinical Resources stated the RN should have addressed Resident #20's unbagged CPAP mask sitting on the bedside table. 3. Resident #89 was admitted to the facility on [DATE], with multiple diagnoses including acute and chronic respiratory failure with hypoxia (low oxygen in the blood) and asthma. On 4/12/26 at 2:39 PM, Resident #89 was observed with an oxygen concentrator next to her bed with an attached nasal cannula and oxygen tubing located on the floor. Resident #89 stated her nasal cannula is normally stored on top of her oxygen concentrator and hoped that staff would change out the cannula as it had fallen on the floor. Resident #89 stated she had been using oxygen at 4 LPM since her admission on [DATE]. On 4/13/26 at 8:46 AM, Resident #89's nasal cannula was observed hanging over the oxygen (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concentrator. Resident #89 stated neither the oxygen tubing nor nasal cannula were replaced, but staff had added a sticker with the date of 4/13/26 onto the oxygen tubing. A review of Resident #89's medical record on 4/12/26 and 4/13/26 did not document a physician's oxygen order. A review of Resident #89's care plan did not document oxygen therapy until 4/13/26. On 4/13/26 at 3:14 PM, it was observed Resident #89's oxygen concentrator was set at 4 LPM. On 4/13/26 at 3:37 PM, the CNO confirmed the oxygen concentrator was set at 3.5 LPM. Resident #89 disagreed with the CNO and stated she had been using oxygen at 4 LPM as she did while at home. On 4/13/26 at 3:48 PM, the CNO confirmed there was an oxygen order dated 4/13/26 for 2 LPM. She further stated, Resident #89's oxygen should not have been set at 3.5 or 4 LPM. When asked if oxygen is normally provided to residents without a physician's order, the CNO stated, a physician's order should have been received before Resident #89 was placed on oxygen.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and staff interviews, it was determined the facility failed to have an RN on duty for at least 8 consecutive hours a day. This created the potential for harm if routine and/or emergency nursing services went unmet and had the potential to affect all residents residing at the facility. Findings include:On 4/13/25, during review of the facility Daily Staffing sheets and licensed nurse timesheets, the surveyor noted the facility only had 3 hours of RN coverage in a 24 hour period for August 10, 2025.On 4/14/26 at 3:36 PM, the Director of Clinical Resources stated an RN had not worked for at least eight hours during August 10, 2025, and should have.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **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 medications were stored securely. This was true for 1 of 1 resident (Resident #5) whose medication was observed in the room with no physician orders, and a medication cup with pills observed on the medication cart unattended. This deficient practice created the potential for harm if residents picked up and took medication not prescribed to them. Findings include:The facility's policy, Medication Storage & Labeling, released 10/13/25, stated, The facility will ensure that medications are stored and labeled in accordance with CMS regulations, state law, and acceptable professional principles to ensure safety, efficacy and compliance.1. Resident #5 was admitted to the facility on [DATE], with multiple diagnoses including toxic encephalopathy (a brain dysfunction caused by toxic exposure to toxins) and acute respiratory failure with hypoxia (sudden inability to oxygenate the blood).On 4/13/26 at 10:08 AM, Resident #5 was observed storing a bottle of Lactaid (provides lactase enzymes for lactose intolerance) in her bedside nightstand. Resident #5 stated she was sensitive to milk, and takes Lactaid one or two tablets as needed. On 4/15/26 at 10:07 AM, LPN #1 reviewed Resident #5's MAR for Lactaid, and stated she did not have an order for Lactaid, then stated, I will get them out of the room.2. On 4/14/26 at 9:30 AM, LPN #1 left the medication cart and entered a resident's room, a medication cup containing a small pill was observed unattended on top of the medication cart. When asked about leaving the medication out, LPN #1 stated, I shouldn't have done that.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and record review, it was determined the facility failed to ensure an Enhance Barrier Precaution was implemented. This was true for 1 of 1 resident (Resident #89) whose medication administration was observed. This deficient practice created the potential for the spread of infection and its associated complications. Findings include:Resident #89 was admitted to the facility on [DATE], with multiple diagnoses including nicotine dependence, hypertension, anxiety, and insomnia.A physician's order dated 4/10/26, directed staff to administer meropenem (an antibiotic) intravenous solution reconstituted one gram three times day for septic shock related to urinary tract infection.A care plan revised 4/12/26, documented Resident #89 was on enhanced barrier precautions to reduce the risk of MDRO (multiple drug-resistant organism) transmission related to PICC (Peripherally Inserted Central Catheter). The care plan directed staff to use gowns and gloves when performing high-contact resident care (dressing, bathing, transferring, incontinence or toileting care, dressing, changing linens, or device or wound care).An Enhanced Barrier Precaution signage was observed posted on Resident #89's door.On 4/14/26 at 3:39 PM, LPN #2 entered Resident #89's room with the meropenem medication in her hand. LPN #2 performed hand hygiene and donned gloves. LPN #2 sanitized the PICC's line needle connector cap, flushed the line with normal saline and then administered the meropenem. LPN #2 was not observed to put on a gown before accessing Resident #89's PICC line.On 4/14/26 at 3:40 PM, LPN #2 stated she forgot to put on the gown. She stated she should have put on the gown before accessing Resident #89's PICC line.On 4/14/26 at 4:14 PM, the IP stated, Yes, gown is required prior to administering the antibiotic. The nurse should have worn a gown.