

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Silverton Health and Rehabilitation of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 405 West Seventh Street Silverton, ID 83867	
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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</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 the discharge process notified required entities. This was true for 4 of 4 residents (#2, #7, #39, and #50) whose discharges were reviewed. The failure of the facility to notify the Office of the State LTC Ombudsman of each residents' discharge denied the residents added protection and advocacy of their right from being inappropriately transferred or discharged . Findings include:</p> <ol style="list-style-type: none"> 1. Resident #2 was admitted to the facility on [DATE] with multiple diagnoses including muscle weakness, dementia, and a history of falls. Resident #2's record documented she required a transfer to the emergency department on 12/9/25 after a fall. The record documented a coordinated discharge with the receiving facility but did not include documentation the Ombudsman was notified of her discharge. 2. Resident #7 was admitted to the facility on [DATE] for care following a surgery and treatment of multiple abscesses (pus-filled, infected pockets of fluid) on various parts of her body. Resident #7's record documented she was discharging home on [DATE] after meeting goals and she no longer required skilled nursing care. The record documented a coordinated discharge but did not include documentation the Ombudsman was notified of her discharge. 3. Resident #39 was admitted to the facility on [DATE] with multiple diagnoses including dementia, diabetes, and neuropathy. On 8/8/25, Resident #39 required transfer to the emergency department for a cellulitis infection on her right lower leg. Her record included documentation her transfer was coordinated with the receiving hospital but did not include documentation the Ombudsman was notified of her transfer. 4. Resident #50 was admitted to the facility on [DATE] with multiple diagnoses including heart failure and COPD. Resident #50 required transfer to the emergency department on 12/14/25 and 12/28/25 for exacerbation of his COPD. His record documented the transfer was coordinated with the receiving hospital but did not include documentation the Ombudsman was notified of his transfer on either date. On 1/8/26 at 12:20 PM, the Administrator stated the facility did not inform the Office of the State LTC Ombudsman of Resident #2, #7, #39, and #50's discharges. 		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 135058
		If continuation sheet Page 1 of 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Silverton Health and Rehabilitation of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 405 West Seventh Street Silverton, ID 83867	
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 observation, record review, and staff interview, it was determined the facility failed to ensure residents were provided treatment and care in accordance with professional standards of practice, and the residents goals and preferences. This was true for 1 of 15 residents (Resident #35) whose records were reviewed for quality of care. This failure created the potential for harm for Resident #35 when she experienced a change in condition, was not provided a nursing assessment, and diagnostic testing was delayed. Findings include: Resident #35 was admitted to the facility on [DATE] with multiple diagnoses including chronic respiratory failure, diabetes, dementia, depression, and muscle weakness. On 12/26/25 at 11:18 AM, a doctor/nursing communication note documented Resident #35 continued to experience dizziness and weakness in her upper body as assessed by nursing. The medical provider documented a follow-up would be scheduled. On 12/30/25 at 12:00 AM, a physician's history and physical note documented a urine analysis collection was pending for Resident #35 related to dysuria (pain when urinating) and altered mental status. On 1/4/26 at 2:21 PM, a nursing progress note documented Resident #35 was experiencing increased weakness and difficulty while transferring. Physical therapy was notified to complete an evaluation at the soonest availability. On 1/6/26 at 6:12 AM, a nursing progress note documented Resident #35 had a tick, dropping arms and head and staff were directed to collect a urine specimen as resident was soiled during the evaluation and was usually continent. On 1/7/26 at 9:35 AM, a nursing progress note documented a urinalysis (UA) and culture was collected and sent to [local laboratory]. On 1/7/26 at 6:39 PM, the [local laboratory] faxed results of the urinalysis to the facility with results documenting Resident #35 had a positive UA, indicating infection. On 1/8/26 at 11:44 AM, Resident #35's POA called the facility and requested that Resident #35 be transported to the ER for further evaluation as the POA believed Resident #35 isn't right. On 1/8/26 at 12:00 PM, the facility transferred Resident #35 to the ER via non-emergent services. A review of Resident #35's vital signs records documented her vitals including blood pressure, heart rate, and oxygen saturation were taken on 1/6/26 and 1/8/26. On 1/8/26 at 2:16 PM, when asked why Resident #35 had not had a urine culture taken prior to 1/7/26, the DON stated facility staff usually complete medical orders within 24-hours if a STAT order is not also placed. When asked why the UA had not been completed on or around 12/30/25, no response was given. The DON also stated unless there is a medical order for vitals to be taken daily, they are only done once every 30-60 days, and Resident #35 had her vitals taken on 1/6/26 and 1/8/26, which was more than usual for a resident to receive without a doctor's order. Resident #35's record did not include documentation of nursing assessment, vital signs, or UA collection related to her change in mental status and weakness between 12/30/25 and 1/6/26. On 1/8/26 at 12:56 PM, hospital records documented Resident #35 was being seen for signs and symptoms of weakness and dizziness lasting 1-2 weeks and was admitted to the hospital for further evaluation. The emergency room physicians assessment and plan for Resident #35 included: Weakness, expressive aphasia (inability to speak), stroke-like symptom, acute kidney injury superimposed on chronic kidney insufficiency, hyperkalemia (elevated potassium levels in the blood), and urinary tract infection. On 1/8/26 at 6:10 PM, the DON stated Resident #35 had been admitted to the hospital and started on antibiotics and fluids.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Silverton Health and Rehabilitation of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 405 West Seventh Street Silverton, ID 83867	
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, observation, and staff interview, the facility failed to ensure effective pain management was provided to residents. This was true for 1 of 1 resident (Resident #5) whose record was reviewed for pain management. This failure resulted in ongoing pain when Resident #5 was not evaluated to determine whether the current pain management plan was effective. Findings include: Resident #5 was admitted to the facility on [DATE] with multiple diagnoses including a right humerus (upper arm bone) fracture, head injury, and iron deficiency anemia. Review of the admission Care Conference evaluation dated 12/23/25 documented the following goals: Goal #1: Get pain under control Goal #2: Work with therapy A Pain Evaluation dated 12/23/25 documented Resident #5's acceptable pain level as 4/10. Review of Resident #5's MAR dated 12/23/25-1/7/26 documented the following pain management orders: Tylenol Extra Strength 500 mg, give 2 tablets by mouth three times daily for pain Oxycodone 5 mg, give 1 tablet by mouth every 8 hours as needed for severe pain The MAR documented 17 administrations of oxycodone between 12/23/25-1/7/26, with recorded pain levels ranging from 6/10 to 10/10. Review of physical therapy notes dated 12/23/25-1/7/26 documented: 12/24/25: Resident #5 had shoulder pain that created barriers to participate and required additional time. 12/29/25: Resident #5 was very upset with 10/10 pain and was described as very emotional and wanting to make gains with mobility to return home. 12/31/25: Resident #5 was observed with increased pain while lying in bed. Physical therapy requested nursing to administer a pain medication. On 1/5/26 at 3:05 PM, Resident #5 was observed sitting in a chair with her bedside table in front of her, guarding her right shoulder. On 1/5/26 at 3:08 PM, Resident #5 stated she was always in pain and reported she could not recall a time since admission when her pain had been under control. On 1/7/26 at 8:24 AM, during a medication administration observation, Resident #5 stated to MAC #1, I'm pretty much in pain all the time. On 1/8/26 at 11:46 AM, the DON stated she believed Resident #5's pain was well managed because the PRN pain medication results were effective. After reviewing the record, the DON did not identify documentation of reassessment or evaluation of the effectiveness of the pain management plan despite ongoing reports of pain levels above the resident's acceptable pain goal.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Silverton Health and Rehabilitation of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 405 West Seventh Street Silverton, ID 83867	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to ensure residents were supplied with routine medications as ordered. This was true for 1 of 1 resident (Resident #5) reviewed for medication availability. This failure created the potential for harm if Resident #5 experienced worsening anemia requiring timely supplementation. Findings include:Resident #5 was admitted to the facility on [DATE] with multiple diagnoses including a right humerus fracture and iron deficiency anemia.Review of Resident #5's medical record documented a physician order for:Ferrous Gluconate 324 mg, give 1 tablet by mouth once daily for supplementation.On 1/7/26 at 9:08 AM, during a medication administration observation, MAC #1 was observed preparing medications for Resident #5. When reaching the final medication, MAC #1 informed the surveyor that the Ferrous Gluconate was not available in the facility.On 1/7/26 at 9:10 AM, MAC #1 stated the physician's order had been implemented on 12/24/25, but the medication had not been administered. She stated the medication had been ordered but had not been available for administration.On 1/8/26 at 12:38 PM, the DON stated the facility obtained the medication on 1/1/26. She further stated Resident #5 was moved to a different room, and the medication was not transferred to the new medication cart for nursing staff to administer.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Silverton Health and Rehabilitation of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 405 West Seventh Street Silverton, ID 83867	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on observation and staff interview, the facility failed to ensure Schedule II controlled substances were stored in a permanently affixed, secured compartment. This failure created the potential for drug diversion and misappropriation. Findings include: On 1/7/26 at 4:05 PM, a storage and labeling audit was conducted with LPN #1. Upon entering the medication room, LPN #1 unlocked the medication refrigerator. The Schedule II drug compartment inside the refrigerator was observed to have a black lock attached to the drawer. Upon further inspection, the black lock detached from the drawer, leaving all Schedule II medications accessible. On 1/7/26 at 4:09 PM, LPN #1 confirmed the compartment was not appropriately secured. He stated that to ensure the safety of Schedule II medications, the compartment should remain locked at all times.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Silverton Health and Rehabilitation of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 405 West Seventh Street Silverton, ID 83867	
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 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident and staff interview, it was determined the facility failed to provide food which was palatable and within resident's preferred temperature. This was true for all residents eating meals prepared by the facility. This deficient practice created the potential for decreased quality of life, incomplete meal intake due to dissatisfaction with meals. Findings include:On 1/5/26 at 11:35 AM, Resident #6 stated that her cold salads were served warm as it was placed on the hot food plate under the plate cover. She stated she preferred her salads cold, and she did not know why salads were not served with the cold beverages.On 1/6/26 at 12:31 PM, Resident #22 refused her lunch tray. The surveyor observed the cold salad had been placed on the hot food plate under the plate cover. A cold fruit bowl and juice were located next to the hot food plate.A review of resident council meeting minutes from August 2025 - December 2025 documented residents were not happy with certain meals offering warm food items which should have been served cold. Comments were documented as follows:September 2025: A resident taking meals in their room stated the food was not served hot. Another resident stated that mashed potatoes were watery.October 2025: Residents stated concerns the hot food was not always hot when served to them, and the cold food was not always cold.On 1/8/26 at 11:36 AM, food temperatures were taken on the serving line. Two dishes, the chili macaroni (pureed) and the green peas (regular diet), had to be reheated before plating.On 1/8/26 at 4:12 PM, [NAME] #2 stated the food had been on the serving line for 30 minutes and should not have lost temperature so quickly.On 1/8/26 at 12:10 PM, the Hall Tray meal cart was taken to the facility's [NAME] and East hall for meal delivery, with all meals served to residents by 12:24 PM.On 1/8/26 at 12:35 PM, a test tray was sampled with the following results:Chili Macaroni Casserole - 120? FPeas 119? FToast 94? FCantaloupe 51? FApple Juice 53? FMilk 51? FSalad 56? [NAME] 1/8/26 at 12:41 PM, the RD agreed that smaller cold salads should be kept on the cold side and not on the hot plate. The RD agreed the temperatures measured on the test tray were out of parameters.On 1/8/26 at 3:50 PM, the DM stated he did not know why the food was not keeping appropriate temperature on the steam table and stated the steam table may need to be replaced. The DM agreed the cold food items should not be placed on the hot plates or under the plate covers.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Silverton Health and Rehabilitation of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 405 West Seventh Street Silverton, ID 83867	
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 - 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>Based on observation, staff interview, and the FDA Food Code, it was determined the facility failed to provide a clean and sanitary environment when staff were observed without appropriate beard guard facial covers while in food preparation areas. This deficient practice created the potential for harm by placing residents at risk for potential foodborne illness, physical food contaminants, and adverse health outcomes. Findings include: The FDA Food Code Section 2-402.11 Effectiveness, documented, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, and linens. On 1/5/26 at 11:49 AM, [NAME] #1 was observed plating residents' food wearing a facial beard guard around his neck. When he made eye contact with the surveyor, he moved his beard guard over his chin and mouth with gloved hands and continued plating food. No hand hygiene was observed. On 1/6/26 at 11:58 AM, [NAME] #1 was observed plating residents' food without wearing a facial beard guard. On 1/8/26 at 11:54 AM, the DM stated all staff with facial hair should be wearing a facial beard guard. [NAME] #1 had not been wearing one on 1/5/26 and 1/6/26, and had shaved his facial hair before work on 1/7/26.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Silverton Health and Rehabilitation of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 405 West Seventh Street Silverton, ID 83867	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure resident records were maintained accurately and completely. This was true for 2 of 15 residents (#2 and #3) whose records were reviewed for accuracy. This failure created the potential for miscommunication and delayed treatment when documentation was missing or inaccurate. Findings include:1. Resident #2 was admitted to the facility on [DATE] with multiple diagnoses including muscle weakness, dementia, and a history of falls.Review of Resident #2's record documented an unwitnessed fall on 12/9/25 at 5:50 PM.Resident #2's record included an INTERACT Hospital Transfer Form dated 12/9/25, intended to document the resident's most recent condition prior to transfer. The vital signs listed on the form were dated 12/3/25, which was six days prior to the transfer.On 1/7/26, the ADON confirmed the INTERACT Hospital Transfer Form contained inaccurate information, as the vital signs did not reflect Resident #2's condition at the time of transfer.2. Resident #3 was admitted to the facility on [DATE] with multiple diagnoses including muscle weakness, visual hallucinations, and dementia.Resident #3's record included a physician order dated 12/1/25 directing staff to document the number of episodes per shift of the following target behaviors:Exit seekingHallucinationsDelusional statementsSexually inappropriate commentsThe order also directed staff to implement and document the following interventions:Provide 1:1 conversationProvide activities of choiceAssist the resident to a quiet and calm location; provide a snack and alternate activitiesReapproach the resident at a different timeReview of Resident #3's behavior monitoring records dated 10/1/25-12/31/25 documented multiple behavior episodes without corresponding interventions on the following dates:10/12/2510/16/2510/17/2510/18/2510/19/2510/20/2512/2/2512/9/2512/10/2512/11/2512/12/2512/16/2512/17/2512/18/2512/19/2512/20/2512/21/2512/22/2512/23/2512/24/2512/25/2512/26/2512/27/2512/28/2512/29/2512/30/2512/31/25. On 1/7/26 at 5:03 PM, the surveyor requested documentation of interventions implemented during the above behavior episodes. No additional documentation was provided.On 1/8/26 at 12:53 PM, the DON stated Resident #3's record accurately reflected the behaviors but did not accurately reflect the interventions used at the time the behaviors occurred.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Silverton Health and Rehabilitation of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 405 West Seventh Street Silverton, ID 83867	
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>**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 provide sanitary storage of PPE, and to perform appropriate hand hygiene. This was true for 2 of 15 residents (#6 and #33) whose staff infection control interactions were observed. This deficient practice created the potential for harm to residents if staff failed to provide appropriate infection control practices during wound care, medication administration, and PPE storage. Findings include: 1. Resident #6 was admitted to the facility on [DATE] with multiple diagnoses including stage 4 pressure ulcer of the right buttock (the most severe type of pressure damage, characterized by full-thickness skin and tissue loss), and paraplegia (paralysis from the waist down).</p> <p>Resident #6's care plan, dated 7/4/24, directed staff to use EBP to reduce the risk of MDRO transmission related to a suprapubic catheter and chronic wounds when providing direct care. The care plan further documented EBP should be used to prevent infection including the use of gown and gloves when providing high-contact resident care including dressing, changing linens, device, or wound care.</p> <p>On 1/5/26 at 3:02 PM, it was observed in Resident #6's closet, an unwrapped EBP gown stored on top of a pile of linen.</p> <p>On 1/5/26 at 3:12 PM, CNA #1 confirmed Resident #6's EBP gown in her closet was not in a plastic bag and was placed on top of Resident #6's personal linens.</p> <p>On 1/8/26 at 5:05 PM, the IP stated gowns are stored in their original plastic wrapping inside the upper area of the resident's individual closet as there is limited space inside their rooms. The IP stated Resident #6's EBP gown should have been stored within a plastic bag.</p> <p>2. On 1/8/26 at 10:00 AM, the ADON was observed preparing wound care supplies on top of the wound cart. No sanitation of the cart surface was observed prior to placing the supplies on the cart.</p> <p>The ADON performed hand hygiene and carried the wound care supplies into Resident #33's room. She placed the supplies on the back of the toilet.</p> <p>After attempting to position the resident, the ADON determined she was unable to perform wound care in that location. She assisted Resident #33 back into his wheelchair and positioned him near a rail by the restroom.</p> <p>The ADON obtained sanitizing wipes and sanitized Resident #33's bedside table. After the surface dried, she retrieved the wound care supplies from the restroom and placed them on the bedside table.</p> <p>The ADON performed hand hygiene, applied gloves, and initiated wound care. She removed the old dressing and cleansed the wound site. She then removed her gloves, performed hand hygiene, and applied clean gloves.</p> <p>The ADON applied skin prep and silver collagen to the wound bed, covered the wound with a dressing, removed her gloves, and performed hand hygiene.</p> <p>On 1/8/26 at 10:28 AM, the ADON stated she should have applied a barrier between the wound care items and the surfaces where the supplies were placed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Silverton Health and Rehabilitation of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 405 West Seventh Street Silverton, ID 83867	
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>3. On 1/7/26 at 8:00 AM, MAC #1 was observed sanitizing her hands and preparing medications. After completing preparation, she closed the medication cart drawers and locked the cart.</p> <p>MAC #1 carried a medication cup, a cup of water, and an inhaler to the resident's room. Upon entering, she placed the medication cup, inhaler, and water on the resident's bedside table.</p> <p>MAC #1 obtained a pair of gloves and applied them. No hand hygiene was observed prior to glove application.</p> <p>MAC #1 then assisted the resident with administration of the oral medication and inhaler.</p> <p>On 1/7/26 at 8:08 AM, MAC #1 confirmed she should have performed hand hygiene before applying gloves.</p>		