STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135058	A. Building B. Wing	07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silverton Health and Rehabilitation of Cascadia	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)
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 observation, staff and resident interviews, and policy review, it was determined the facility failed to ensure resident's comprehensive care plans were revised to reflect current needs and interventions. This was true for 1 of 12 residents (Resident #3) reviewed for care plans. This placed residents at risk of adverse outcomes if care and services were not provided due to care plans not being revised as residents' needs changed. Findings include: The facility's policy titled, Comprehensive Care Plans and Conferences, 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 residents' individual conditions, risks, needs, behaviors, cultural values, and preferences, and will include measurable goals, appropriate interventions, and realistic timeframes. The plan will be created, reviewed, and revised by an interdisciplinary team familiar with the residents' status and care needs, with active involvement from the residents and their representative, when applicable. Updates to the care plan will occur as needed based on the residents' response to interventions or changes in condition. Resident #3 was admitted on [DATE], with multiple diagnoses including chronic kidney disease (a long-term condition where the kidneys are damaged and slowly lose their ability to filter waste and excess fluid from the blood), muscle weakness, and difficulty walking. A review of Resident #3's care plan, initiated 5/7/26, had a focus which documented, [Resident #3] has impaired mobility with risk for falls related to use of assistive device for ambulation. An intervention for this focus documented, Keep call light and bedside table items within reach. On 7/7/26 at 2:25 PM, Resident #3 was observed sitting in his chair next to the bed. The call light was clipped to the wall, on the opposite side of the bed, out of reach for Resident #3. Resident #3 stated, [The call light] is always over there. On 7/7/26 at 2:51 PM, the RCNA observed the call button was clipped to the wall out of reach of Resident #3, who was seated in the chair. The RCNA confirmed the call button was out of Resident #3's reach. When asked where the call light should be, the RCNA stated, It should be clipped to the bed next to the chair. On 7/10/26 at 10:41 AM, the CNO stated, Resident #3 spent most of his day in his chair, and he had the call light clipped to the wall on the opposite side of the bed as he did not like it clipped on the bed. When asked if his preference to have his call light clipped to the wall out of reach on the opposite side of the bed was care planned, the CNO stated, No.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135058	A. Building B. Wing	07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silverton Health and Rehabilitation of Cascadia	405 West Seventh Street Silverton, ID 83867

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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 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 record review, policy review, and staff interview, it was determined the facility failed to monitor vital signs as ordered by the physician. This was true for 1 of 12 residents (Resident #46) whose records were reviewed for quality of care. This deficient practice created the potential for harm if physician's orders were not followed, and if out-of-parameter vital signs were not monitored for resident safety. Findings include:The facility's policy titled, Vital Signs, revised 8/30/25, documented vital signs will be taken as ordered by the provider, which include oxygen saturation, temperature, blood pressure, and pulse. Vital signs must be documented in the resident's medical record immediately after measurement, abnormal or concerning vital signs, per resident's established baseline, must be reported to the licensed nurse for assessment and appropriate intervention. If a Resident shows signs of distress or a sudden change in condition, vital signs must be taken promptly, even if not scheduled.The National Library of Medicine, accessed 7/15/26, documented individuals with chronic obstructive pulmonary disease (COPD; a progressive and irreversible lung condition that restricts airflow, making it difficult to breathe) and conditions associated with chronic respiratory failure, oxygen should be titrated to achieve a target oxygen saturation range of 88-92%.Resident #46 was admitted to the facility on [DATE], with multiple diagnoses including COPD with acute exacerbation, chronic respiratory failure with hypoxia (an ongoing, long-term condition where the lungs cannot properly transfer enough oxygen into the bloodstream), and congestive heart failure (when the heart muscle does not pump blood as effectively as it should).A physician's order dated 5/19/26, documented Resident #46 was to have her vital signs taken once a day during the day shift.Resident #46's June 2026 MAR documented the following:-6/5/26: Oxygen saturation of 87%. There were no follow-up vital signs documented.-6/6/26: No documented vital signs.A review of Resident #46's nursing progress notes did not document any follow-up vital sign monitoring or document that oxygen saturation was below 88%.On 7/9/26 at 3:57 PM, the CNO stated on 6/5/26 there was no documentation in Resident #46's record that any follow-up measures or monitoring were completed related to the low oxygen record, and there should have been documentation. The CNO also stated, on 6/6/26 the night shift did record vitals, they just did not input them into medical record as they should have been, nor did they document why the vitals were not taken during the day shift as ordered by the physician.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, it was determined the facility failed to complete an assessment for a wheelchair alarm prior to implementation. This was true for 1 of 5 residents (Resident #18) whose record was reviewed for comprehensive assessments. This deficient practice created the potential for psychosocial harm if Resident #18 felt restrained and physical harm if Resident #18 was not properly assessed prior to restraint placement. Findings include:The facility's policies, titled, Physical Restraints, revised 9/16/25, and Position Change Alarm Use, dated 9/16/25, defined Position Change Alarms as alerting devices intended to monitor a resident's movement emitting an audible sound when the resident moves in certain ways; the Interdisciplinary team (IDT) will conduct a thorough assessment to determine the appropriateness of restraint use. The decision to use a position change alarm is based on a comprehensive assessment of the resident's needs.Resident #18 was admitted to the facility on [DATE], with multiple diagnoses including muscle weakness, difficult walking, repeated falls, and dementia.Resident #18's care plan for impaired mobility with risk for falls, dated 3/8/26, documented a wheelchair alarm was included as an intervention.A Bed Safety and Transfer Device Evaluation dated 4/28/26, documented the bed/chair alarm did not restrict mobility.Resident #18's record did not include an initial Restraint Evaluation dated on or around 3/8/26 identifying the comprehensive evaluation of the chair alarm.On 7/9/26 at 2:14 PM, the CNO stated a Restraint Evaluation had not been completed prior to having the chair alarm placed for Resident #18 on 3/8/26.