

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Mountain Valley of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE  601 West Cameron Avenue Kellogg, ID 83837	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50981</b></p> <p>Based on staff interview, record review, and review of the State Long Term Care Reporting System, it was determined that facility failed to ensure residents were free from misappropriation of property and exploitation. This was true for 1 of 1 residents (Resident # 39) reviewed for abuse, neglect, misappropriation of resident property and exploitation. This failed practice created the potential for all facility residents to experience exploitation and misappropriation of property. Findings include:</p> <p>The facility's Abuse policy, revised 3/2024, stated the facility would prevent all types of abuse, neglect, misappropriation of residents' property and exploitation.</p> <p>The CMS SOM, Appendix PP, dated 8/8/24, defined:</p> <ul style="list-style-type: none"> <li>- Exploitation, as taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion.</li> <li>- Misappropriation of resident property, as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consents.</li> </ul> <p>Resident #39 was admitted to the facility on [DATE] with multiple diagnoses including diabetes, infection of left artificial hip, congestive heart failure, active smoker, and atrial fibrillation (an irregular heart rate).</p> <p>Resident #39's Annual MDS, dated [DATE], documented Resident #39 was cognitively intact.</p> <p>A Facility Reported Incident, dated 9/4/24, included an investigation summary which documented on 9/3/24, resident #39 told staff he gave \$1,500 to an employee for first and last month's rent for an apartment for them to share.</p> <p>The investigative summary documented Dietary Aide #1 admitted to taking \$1500 cash from Resident #39 and paying first and last months' rent for a new apartment but could not provide any receipts or proof his name was added to the lease. The facility's investigation substantiated Resident #39 gave money to Dietary Aide #1 to rent an apartment.</p> <p>On 5/1/25 at 11:00 AM, the Administrator confirmed Dietary Aide #1 accepted money from Resident #39.</p> <p>(continued on next page)</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>These findings represent past non-compliance with this regulatory requirement. The facility did the following:</p> <ul style="list-style-type: none"> <li>-Resident representative was notified.</li> <li>-Dietary Aide #1's employment was terminated for unprofessional conduct related to accepting funds from a resident.</li> <li>-All staff were given an in-service training discussing gifts &amp; gratuities, conflict of interest, employee resident relationships, and review of the Abuse and Neglect Policy. Training completed on 9/4/24.</li> </ul> <p>There was sufficient evidence the facility corrected the non-compliance as of 9/4/24 as there were no further exploitation and misappropriation of property reported after this date.</p> <p>At the time of the survey, the facility was in substantial compliance and therefore does not require a plan of correction.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50603</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure residents' MDS documented correct assessment information. This was true for 3 of 16 residents (#12, #46, and #57) whose records were reviewed for accuracy. This deficient practice had the potential for negative outcomes if residents were not assessed and/or monitored due to inaccurate assessments. Findings include:</p> <p>Appendix PP of the SOM, revised 8/8/24, documented assessments must accurately reflect the resident's status.</p> <p>1. Resident #12 was admitted to the facility on [DATE], and readmitted on [DATE] with multiple diagnoses including heart attack, chronic atrial fibrillation (irregular heart beat), and language disorder following a heart attack.</p> <p>The Significant Change MDS assessment, dated 1/24/25 documented Resident #12 was receiving hospice care.</p> <p>A review of Resident #12's record documented Resident #12 was discharged from hospice on 1/7/25.</p> <p>On 5/1/25 at 10:34 AM, MDS Nurse #1, with MDS Nurse #2 present, stated, When a resident goes off or on hospice we will do a Significant Change Assessment. It was an error [Resident #12] was marked on hospice on 2/7/25.</p> <p>2. Resident #46 was admitted to the facility on [DATE] with multiple diagnoses including dementia, diabetes, and high blood pressure.</p> <p>An Annual MDS Assessment, dated 2/25/25 documented Resident #46 was taking an anticoagulant medication. A review of active and discontinued physician's orders did not document any anticoagulant medications.</p> <p>On 5/1/25 at 10:36 AM, MDS Nurse #1, with MDS Nurse #2 present, stated, Resident #46 is taking an aspirin which is an antiplatelet, not an anticoagulant. The medication was incorrectly marked on the MDS as an anticoagulant.</p> <p>3. Resident #57 was admitted to the facility on [DATE] with multiple diagnoses including heart disease, high blood pressure, and dementia.</p> <p>An Annual MDS Assessment, dated 3/25/25 documented Resident #57 was taking an anticoagulant. A review of active and discontinued physician's orders did not document any anticoagulant medications.</p> <p>On 5/1/25 at 10:38 AM, MDS Nurse #1, with MDS Nurse #2 present, stated, Resident #57 is taking aspirin, an antiplatelet medication, not an anticoagulant. The medication was incorrectly marked on the MDS as an anticoagulant.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50981</p> <p>Based on observation, record review, SOM and policy review, and staff interview, it was determined the facility failed to ensure resident centered care plans were comprehensively written for 2 of 16 residents. This was true for residents (#11 and #48) reviewed for care plans. This deficient practice placed the residents at risk for harm when their care plans did not reflect the care necessary for each resident. Findings include:</p> <p>The CMS SOM, Appendix PP, dated 8/8/24, documented each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences, goals, and address the resident's medical, physical, mental and psychosocial needs.</p> <p>1. Resident #11 was initially admitted to the facility on [DATE] with multiple diagnoses including dementia, heart failure, and muscle weakness.</p> <p>An Annual MDS Assessment, dated 12/4/24, documented resident #11 was observed wandering daily.</p> <p>Resident #11's care plan, last reviewed 12/4/24, did not include directions to care for her daily wandering.</p> <p>Resident #11 was observed wandering into resident rooms on the following dates:</p> <ul style="list-style-type: none"> <li>- On 4/29/25 at 2:15 PM, Resident #11 was room [ROOM NUMBER], a male resident's bathroom.</li> <li>- On 4/30/25 at 11:00 AM, Resident #11 was observed in the doorway of room [ROOM NUMBER].</li> <li>- On 5/1/25 in the morning, Resident #11 was observed at an exit doorway with her hand on the door.</li> </ul> <p>On 4/29/25 at 2:00 PM, the DON stated, Resident #11's care plan should have included directions to care for her wandering behavior.</p> <p>36193</p> <p>2. Resident #48 was admitted to the facility on [DATE] with multiple diagnoses including Parkinson's disease and dysphagia (difficulty swallowing).</p> <p>A physician's progress notes, dated 1/8/25 documented Resident #48 had significant difficulty with dysarthria (a motor speech disorder that occurs when the muscles used for speech are weak or difficult to control. It often results in slurred or slow speech that can be hard to understand).</p> <p>Resident #48's care plan did not document he had difficulty with speech.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A document titled Communications, dated 7/27/24 documented Resident #48 was hard to understand, and he had a communication board that he was taught to use. The staff were to encourage Resident #48 to speak slower and use his board for better assistance with communicating.</p> <p>Resident #48's care plan did not address he had difficulty with speech and uses a communication board.</p> <p>On 4/30/25 at 3:26 PM, the DON reviewed Resident #48's care plan and stated she did not see Resident #48's difficulty with speech was included in his care plan. The DON stated, Yes, it should have been in the care plan.</p>		

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<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36193</p> <p>Based on record review, policy review and staff interview, it was determined the facility failed to ensure residents' care plan were revised and updated. This was true for 1 of 16 residents (Resident #40) whose care plans were reviewed. This deficient practice created the potential for harm if cares and services were not provided due to inaccurate information on the care plan. Findings include:</p> <p>The facility's Care Plan policy, revised 10/15/22, documented the care plan would be reviewed and revised by the interdisciplinary team as necessary to reflect the individual's current status.</p> <p>Resident #40 was admitted to the facility on [DATE] with multiple diagnoses including dementia and diabetes.</p> <p>A care plan, initiated 1/26/24, documented Resident #40 was on hypnotic therapy Trazodone (antidepressant) as needed related to inability to sleep.</p> <p>Resident #40's physician's order did not include an order for Trazodone.</p> <p>On 4/30/25 at 9:33 AM, the DON stated Resident #40's Trazodone was discontinued by his physician. The DON stated residents' care plans were updated quarterly and as needed, and Resident #40's care plan should have been updated when the Trazodone was discontinued, and it was not.</p>		

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<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>50603</p> <p>Based on observation, FDA Food Code, and staff interview, it was determined the facility failed to ensure kitchen equipment was cleaned. These deficiencies had the potential to affect the 57 residents who consumed food prepared by the facility. This placed residents at risk for potential foodborne illnesses and adverse health outcomes. Findings include:</p> <p>The FDA Code Section 4-602.12 Cooking and Baking Equipment documented food-contact surfaces of cooking equipment must be cleaned to prevent encrustation's 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 4/30/25 at 3:05 PM, during a kitchen inspection, pots and pans located on the clean dish drying rack were observed with the following:</p> <p>-A stainless steel pot had a red ring around the middle interior of the pot.</p> <p>On 4/30/25 at 3:26 PM, the Registered Dietitian (RD) stated the pot with the red ring was visibly dirty and removed it from the clean drying rack.</p> <p>On 5/1/25 at 7:05 AM during a follow-up kitchen inspection, a baking sheet pan, and cooking pots had a ring of dark residue around the upper areas and underside lip of the pots and pans.</p> <p>On 5/1/25 at 8:00 AM, Kitchen Staff: Culinary Aide #1, Culinary Aide #2, and Medical Records Manager helping as Culinary Aide #3, stated the pans and pots with the dark, encrusted residue were cleaned and sanitized as they had been washed in the high temperature dish machine. However, Kitchen Staff all agreed the dark residue should not scratch off if the pans and pots were cleaned. They were unaware the pans were not supposed to have encrusted dark residue.</p>

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<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>36193</p> <p>Based on observation, staff interview, and CDC guidance it was determined the facility failed to ensure glucometer (used to check the blood glucose levels) was cleaned/sanitized after being use. This was true for 2 of 2 residents (#32 and #47) observed for blood glucose level testing. This deficient practice created the potential for the spread of infectious organism from cross contamination which could harm Resident #32 and #47. Findings include:</p> <p>The CDC website <a href="https://www.cdc.gov/infection-control/hcp/environmental-control/index.html">https://www.cdc.gov/infection-control/hcp/environmental-control/index.html</a>, article titled Guidelines for Environmental Infection Control in Health-Care Facilities (2003) Nursing Homes, accessed on 5/5/25, updated July 2019 documented use barrier protective coverings as appropriate for non-critical equipment surfaces that are touched frequently with gloved hands during delivery of patient care, likely to become contaminated with blood or body substances .</p> <p>On 4/30/25 at 11:56 AM, MAC #1 entered Resident #47's room with a glucometer, cotton balls, alcohol wipes and lancet in hand. MAC #1 placed the glucometer on top of Resident #47's overboard table with no barrier between the glucometer and the overbed table, and checked his blood glucose. After the completion of blood glucose test, MAC #1 went to the sink, placed the glucometer on top of the sink counter with no barrier between the sink and the glucometer, removed her gloves and washed her hands. MAC #1 picked up glucometer, returned to the medication cart, placed the glucometer on top of the medication cart, and recorded the blood glucose to her computer. MAC #1 then placed the glucometer inside the storage box without cleaning/sanitizing the glucometer.</p> <p>On 4/30/25 at 12:02 PM, MAC #1 entered Resident #31's room with a glucometer, cotton balls, alcohol wipes and lancet in hand. MAC #1 placed the glucometer on top of Resident #31's overboard table with no barrier between the glucometer and the overbed table, and checked his blood glucose. After the completion of blood glucose test, MAC #1 went to the sink, placed the glucometer on top of the sink counter with no barrier between the sink and the glucometer, removed her gloves and washed her hands. MAC #1 picked up the glucometer, returned to the medication cart, placed the glucometer on top of the medication cart, and recorded the blood glucose to her computer. MAC #1 then placed the glucometer inside the storage box without cleaning/sanitizing the glucometer.</p> <p>The storage container has the following inside: glucometer, cotton balls, alcohol wipes, lancet and test strips.</p> <p>On 4/30/25 at 12:08 PM, MAC #1 stated she did not clean/sanitize the glucometer before placing them in their individual container. MAC #1 stated she was not sure if the glucometer was needed to be clean since they have their individual container.</p> <p>On 4/30/25 at 2:34 PM, the IP stated there should be a barrier like a paper towel between the glucometer and surfaces such as the overbed table or sink counter. The IP stated the glucometer should be cleaned before placing them in their container.</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36193</p> <p>Based on record review, policy review, CDC guidelines, and staff interview it was determined the facility failed to ensure antibiotic stewardship program was implemented and resident had appropriate clinical indications for the use of an antibiotic. This was true for 1 of 4 residents (Resident #49) whose records were reviewed for antibiotic use. This deficient practice created the potential for Resident #49 to develop resistance to antibiotics resulting ineffective or difficult treatment for infections. Findings include:</p> <p>The CDC website <a href="https://www.cdc.gov/antibiotic-use/hcp/core-elements/nursing-homes-antibiotic-stewardship.html">https://www.cdc.gov/antibiotic-use/hcp/core-elements/nursing-homes-antibiotic-stewardship.html</a>, article titled Core Elements of Antibiotic Stewardship for Nursing Homes, accessed on 5/5/25, documented Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority. Antibiotic Stewardship refers to a set of commitments and actions designed to 'optimize the treatment of infections while reducing the adverse events associated with antibiotic use.' The article also recommended that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use.</p> <p>The facility's Antibiotic Stewardship policy, revised 10/15/22 documented the facility focused on improving antibiotic use through an Antibiotic Stewardship program to ensure appropriate antibiotic usage practices are in place, to promote optimal therapeutic and cost-effective care for their residents, and reduce the likelihood of developing multi-drug resistant organisms. The policy also documented the facility's pharmacy consultant reviews the antibiotic therapy as part of the Medication Regimen Review and makes recommendation to improve antibiotic use as needed, which may include the review of indications, assignment of antibiotic stop dates and etc.</p> <p>Resident #49 was admitted to the facility on [DATE] with multiple diagnoses including Methicillin Susceptible Staphylococcus Aureus (MSSA - bacterial infection) and Intentional Self-Harm by unspecified firearm discharge.</p> <p>A physician's order, dated 11/7/24, documented Resident #49 was to receive Amoxicillin-Pot Clavulanate (antibiotic) Oral tablet 875-125 milligrams, one tablet by mouth two times a day related to sepsis (a serious condition that can cause extensive inflammation throughout the body and can lead to tissue damage, organ failure and even death) due to Methicillin Susceptible Staphylococcus Aureus. The physician's order documented no stop date at this time.</p> <p>On 4/30/25 at 2:46 PM, the IP stated Resident #49 had sepsis when he was prescribed the antibiotic in November 2024. When asked if Resident #49 still had an infection, the IP stated Resident #49 had no more infection. When asked why Resident #49 was still taking the antibiotic, the IP stated she would ask the physician for the indication of Resident #49's antibiotic.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/1/25 at 9:53 AM, the Pharmacist stated Resident #49's antibiotic was reviewed in November 2024 during their Antibiotic Stewardship meeting. The Pharmacist stated the Infectious Disease Physician ordered the Amoxicillin-Pot[assium] Clavulanate for Resident #49 with no stop date, and he did not include Resident #49 on his succeeding review of residents' antibiotic in the facility. When asked if the continued use of the antibiotic was needed when Resident #49 did not have an infection anymore, the Pharmacist stated, I agree they [facility] should have reviewed the indication for the antibiotic.</p> <p>On 5/1/25 at 10:58 AM, during the follow-up interview, the IP stated she did not ask the infectious disease physician's indication for the continued use of Resident #49's antibiotic when he was no longer had an infection. The IP stated, Yes, I should have asked the physician for the indication of the antibiotic.</p>