STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135067	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradise Creek Health and Rehab of Cascadia	640 North Eisenhower Street Moscow, ID 83843

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 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 observations, interviews, and policy review, the facility failed to maintain sanitary conditions in the walk-in freezer and in the ice scoop holder on the side of the ice machine. These failures had the potential to cause contamination which could affect 46 residents who consumed food from the kitchen. Findings include:During the initial tour of the kitchen on 05/04/26 at 9:20AM, an observation in the walk-in freezer identified that ice had built up on the freezer lines. The ice extended far enough to encroach on the upper stacked box of burritos. An interview during the tour at 9:45 AM with the Dietary Manager (DM) identified that the ice buildup had happened before. At the end of the initial tour at 9:50 AM, inspection of the ice machine identified an ice scoop holder mounted on the side of the machine. Two ice scoops were stored in the holder. Approximately 20 milliliters of standing water was present in the bottom of the holder, and the scoops were in contact with the standing water. There was no visible way to allow the water to drain. An interview on 05/04/26 at 09:55AM with the DM identified that, No one has ever mentioned that before in regard to the standing water in the scoop holder. Review of the facility's policy titled, Food Safety & Storage, dated 11/28/17, revealed, The facility stores and handles all food, non-food items, and food preparation supplies in a manner that ensures safety, sanitation, and compliance with federal, state and local regulations. Review of the facility's policy titled, Ice Machines Preventative Maintenance program dated 10/6/25, revealed Wipe down the exterior surfaces, including the catch basin, using a clean cloth and food safe sanitizer.

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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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure recommendations to address gradual weight loss were implemented for one of four residents (Resident (R) 2) reviewed for nutrition out of a total sample of 18 residents. This failure had the potential to contribute to continued weight loss, skin breakdown, or malnutrition for R2. Findings include:Review of R2's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, malnutrition, anemia, and osteoporosis. Review of R2's Care Plan, dated 01/05/26 and located under the Care Plan tab of the EMR revealed, [R2] is at risk for nutritional decline r/t [related to] dementia, B vitamin deficiency, hx [history of] ETOH [alcohol] abuse, PVD [peripheral vascular disease], HTN [hypertension], CKD3 [chronic kidney disease stage 3], anemia. The approaches included: Obtain weights weekly and record . Complete Mini Nutritional Assessment and alert dietician that resident triggers as . at risk for malnutrition, [and] . Provide meals per physician diet order and record intakes. Dietician to review as indicated. Review of R2's Care Plan, dated 01/06/26 and located under the Care Plan tab of the EMR revealed, [R2] has dehydration or potential fluid deficit r/t dementia, electrolyte disturbances, [and] diuretic use. Review of R2's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/10/26 and located under the MDS tab of the EMR, revealed she scored a three out of 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognition. She was at risk for pressure ulcers and received a therapeutic diet. She required set-up or clean-up assistance with eating. Review of R2's Nutritional Review note, dated 04/15/26 and located under the Progress Notes tab of the EMR, revealed, Intakes are poor, avg [average] ~ [about] 31%. Fluids with meals, avg ~612ml. No routine supplements are in place, although do feel she would benefit from additional support. Will request. She has been followed for weight loss from admit, more stable over the month . Potential for further weight loss r/t intakes . Initiate 2 oz. [ounces] Med Pass [nutritional supplement] BID [twice a day] between meals for additional support. Nursing to document the amount consumed. Review of R2's EMR under the Orders tab revealed there was no order for Med Pass supplement. Review of R2's EMR under the Vitals tab revealed a ten-pound weight loss since admission. On 01/03/26, R2 weighed 141 pounds (lbs) and on 05/02/26, R2 weighed 131.4 lbs. This represented a 6.8% weight loss in four months. R2's lowest weight was 128.4 lbs on 03/28/26. During a telephone interview on 05/06/26 at 12:00 PM, the Registered Dietician (RD) stated she and another consultant were filling the position temporarily while a new facility RD was being hired. She stated the typical process for communicating recommendations for supplements would be to send an email to the nursing staff at the facility, who would enter the order into the system, notify the physician, and implement the order. The RD stated her expectation was that new recommendations were implemented within 48 hours if there was weight loss involved. She stated she would then follow up with the nursing staff the following week to ensure the recommendations were followed (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	through. The RD stated she did not know why the Med Pass recommendation was not implemented for R2. During an interview on 05/06/26 at 12:07 PM, the Resident Care Manager (RCM) confirmed R2 was not receiving Med Pass as recommended by the RD and stated he did not know why this was not implemented. RCM explained that he was not aware of the recommendation, as the recommendations were typically sent via email by the RD and communicated in the Nutrition At Risk (NAR) committee meetings; however, without a steady facility RD in place, the meetings had not been held consistently since December. The RCM was unable to find any email communication related to R2's RD recommendations. The RCM stated there was no system in place so that he could be aware of new recommendations from the RDs if they were not emailed to the NAR committee. During an interview on 05/06/26 at 1:29 PM, the Clinical Resource Consultant (CRC) stated the RD's recommendation for Med Pass twice daily for R2 was not communicated to the facility staff and therefore had not been implemented. A policy addressing RD recommendations and/or supplement orders was requested on 05/06/26 but was not provided prior to facility exit. A policy on weight loss was requested on 05/07/26 but was not provided prior to facility exit.

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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 observation, interview, record review, and facility policy review, the facility failed to obtain a physician's order, in accordance with professional standards of practice, prior to administering oxygen to one of two residents reviewed for respiratory care (Resident (R) 8) out of a sample of 18 residents. This failure had the potential to result in unsafe or inappropriate oxygen administration and inadequate monitoring of the resident's respiratory treatment. Findings include:Review of R8's admission Record located under the Profile tab of the electronic medical record (EMR) revealed R8 was admitted to the facility on [DATE] with diagnoses of pulmonary hypertension, malignant neoplasm of cardia, malignant neoplasm of lower third of esophagus, abnormal findings in the lung fields, and chronic systolic (congestive) heart failure. Review of R8's Care Plan located under the Care Plan tab of the EMR revealed R8 had the potential for altered respiratory status with nursing pulmonary services for pulmonary hygiene related to shortness of breath while lying flat and need for oxygen. O2 [oxygen] therapy as ordered through nasal canula, date initiated 04/02/26. Review of R8's admission Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 04/08/26 revealed that R8 received oxygen while a resident. Review of R8's Order Recap Report located under the Orders tab of the EMR, dated 04/01/26 through 05/05/26, revealed no physician order for oxygen. Review of R8's Medication Administration Record (MAR) located under the Orders tab of the EMR, dated 04/02/26 through 05/05/26, did not indicate the resident received oxygen. Review of R8's Progress Notes located under the Progress Notes tab of the EMR, dated 04/02/26 through 05/05/26, did not reveal a physician's order for oxygen. During an observation on 05/04/26 at 10:01 AM, R8 was in his room receiving oxygen through a nasal cannula at 1.5 liters per minute (LPM) with no humidification present. During an observation on 05/05/26 at 12:28 PM, R8 was in his room receiving oxygen through a nasal cannula at 1.5 LPM with no humidification present. During an observation on 05/06/26 at 11:33 PM, R8 was in his room receiving oxygen through a nasal cannula at 1.5 LPM with humidification present. During an interview on 05/06/26 at 1:31 PM, Licensed Practical Nurse (LPN) 1, at R8's bedside, confirmed the resident was receiving oxygen at 1.5 LPM through a nasal cannula. LPN1 confirmed R8 did not have a physician's order for oxygen and that there should be an order. LPN1 confirmed there was no documentation in R8's MAR indicating the resident was being monitored while receiving oxygen. LPN1 also revealed R8 had been receiving oxygen since he was admitted to the facility on [DATE]. During an interview on 05/06/26 at 1:40 PM, the Director of Nursing (DON), at R8's bedside, confirmed the resident was receiving oxygen at 1.5 LPM through a nasal cannula. The DON confirmed that R8 did not have a physician's order for oxygen and that R8 should have had an order before the oxygen was (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered. The DON revealed there was no documentation in R8's MAR that he was receiving oxygen because there was no physician's order. Review of the facility's policy titled, Oxygen Administration, Safety, Storage & Maintenance, with a revision date of 10/10/25, indicated, the facility will administer, store, and maintain supplemental oxygen safely in accordance with current standards of practice and licensed practitioner orders . Procedure- General Guidelines . 6. Verify provider order prior to initiating/ changes oxygen therapy .