STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135089	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Desert View	820 Sprague Avenue Buhl, ID 83316

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Grievances, Resident Council Meeting minutes, resident's interview, review of records, policy review, and staff interview, it was determined the facility failed to ensure grievances were responded to and investigated. This was true for 2 of 2 residents (#5 and #25) reviewed for grievances. This failure created the potential for psychosocial harm if residents' grievances were not acted upon. Findings include:The facility's Grievances policy dated 10/2024, documented the Administrator was the Grievance Officer. The Grievance Officer, with the assistance of social services, had the responsibility to oversee the grievance process, receive and track grievances through to their conclusion, lead any necessary investigation, maintain confidentiality, issue written grievance decisions and coordinate with state or federal officials as necessary. The facility also documented the Grievance Officer and/or Designee will make such reports available within five business days and a summary report of the investigation would be available to the residents.1. Resident #25 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (a group of lung disease characterized by increasing breathlessness), obesity, and insomnia.A Comprehensive MDS assessment dated [DATE], documented Resident #25 was cognitively intact.On 5/13/26 at 10:50 AM, Resident #25 stated within the last 30 days she had felt a CNA to be disrespectful three times to her and filed a grievance.2. Resident #5 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including quadriplegia (partial or total loss of motor and sensory function in all four limbs), schizoaffective disorder, bipolar type, dysphagia (difficulty swallowing), and hypotension.On 5/13/26 at 9:36 AM, LPN #2 stated some nurses would not catheterize Resident #5 due to his behavior. Resident #5 was scheduled to be catheterized at 9:00 AM, 3:00 PM, 9:00 PM, and 3:00 AM. LPN #2 stated Resident #5 likes to micro-manage everything, and if Resident #5 was not catheterized as scheduled, Resident #5 had to wait for another nurse. LPN #2 stated she had no problem dealing with Resident #5. LPN #2 stated a grievance had been filed on behalf of Resident #5. When asked who filed the grievance for Resident #5, LPN #2 did not provide an answer. Resident #5 always refused to be catheterized at 3:00 AM by the same nurse.A Grievance binder containing grievances from July 2025 to May 2026 was provided to the surveyor. Upon review of the grievances, grievance for the months of February, March, April and May 10, 2026, were not in the binder.On 5/13/26 at 11:38 AM, the Administrator provided the grievances received for February, March, April and May 2026 which were as follows:-February: one grievance-March: two grievances-April: one grievance-May: two grievancesResident #5 and #25's grievances were not included in the grievance file.The Administrator stated, These are the grievances that was written on the grievance form. When asked which grievances were written and which were not, the Administrator stated, Because the grievance was not written it does not mean we did not follow-up on the grievance. The goal is to follow up every grievance that comes to us. The Administrator stated if a grievance was brought to her attention, she would take it right away and make a follow up. She stated the best practice was to write every grievance.

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
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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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, policy review, and staff interview, it was determined the facility failed to ensure sufficient RN services at least eight consecutive hours per day, every 24 hours, seven days a week, as required. This failure had the potential to affect all residents in the facility who may require higher level of nursing assessment and intervention. Findings include: The facility policy titled Staffing, Sufficient and Competent Nursing, revised August 2022, documented, a registered nurse provides services at least eight consecutive hours every 24 hours, seven days a week. Review of the facility's three-week nursing schedule dated 4/19/26 through 5/10/26, documented the facility did not provide 8 consecutive hours of registered professional nursing coverage on: 5/9/26. On 5/14/26 at 11:47 AM, the HR Director stated there was no RN coverage for 24 hours on 5/9/26.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, FDA 2022 Food Code, and resident and staff interviews, it was determined the facility failed to ensure resident meals were palatable and maintained their correct temperature. This directly impacted all residents who dined in the facility. This failed practice had the potential to negatively affect residents' nutritional status and psychosocial well-being. Findings include:The FDA food Code Section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding documented bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature Danger Zone of 5 degrees C to 57 degrees C (41 degrees F to 135 degrees F) too long. Operations requiring heating or cooling of food should be performed as rapidly as possible to avoid the possibility of bacterial growth. Based on these data and conclusions from the risk assessment, FDA continues to recommend that food establishments limit the cold storage of time/temperature control for safety foods, ready to-eat foods to a maximum temperature of 41 F. On 5/11/26 at 11:45 AM, observed the following during a follow up visit to the kitchen for the lunch meal:- One scoop of potato salad was placed on small plates, one for each resident, and left on the kitchen counter until covered with plastic wrap and served to each resident. The remaining potato salad temperature was checked at 83.6 degrees F.- The peach cobbler fruit mixture was not temperature checked before being served to the residents.On 5/13/25 at 2:53 PM, the Dietary Supervisor stated the potatoes should have been cooked the day before and were not. The boiled potatoes did not have sufficient time to cool down before being combined into potato salad and served to residents.On 5/13/26 at 3:00 PM, the Dietary Supervisor stated the potato salad should not have been left on the counter and served at 83.6 degrees F but was.

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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, policy review, and review of the FDA 2022 Food Code, the facility failed to appropriately wear beard nets, clean kitchen surfaces, dishes and skillets, 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:a. The FDA Food Code Section 3-501.17 Ready-to-Eat, TCS (time/temperature control for safety) food, date marking, states marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded.The facility's Food Receiving and Storage policy dated 3/31/25, documented all food stored in the refrigerator or freezer are covered, labeled and dated (use by date). Refrigerated foods are labeled, dated and monitored so they are used by their use by date, frozen, or discarded.On 5/11/26 at 10:30 AM, observed the following during the kitchen tour. In the kitchen refrigerator- three bags of opened bread with no opened date documented- sliced cheese in a repackaged bag with one date only. - four-gallon containers of opened milk with no opened date documented.- opened 1/2 gallon container of half and half with no opened date documented.- plastic repackaged container of olives with no repackaged or use by dates documented.- repackaged container of chicken stock with prep date of 4-9-26, no used by date documented.- Opened plastic bag of hard boiled eggs with a used by date 5/6/26.In the kitchen pantry- four opened bags of elbow type noodles with no opened date documented.- one box of Ben original rice opened to the air with no opened date documented.- one opened bag of straight noodles with no opened date documented.On 5/11/26 at 10:38 AM, the Food [NAME] #1 stated she had been told that once a food package was opened, it should be documented at 7 days for use by dates and had not been. b. The FDA Code Section 4-602.12 Cooking and Baking Equipment documented, food-contact surfaces of cooking equipment must be cleaned to prevent encrustations that may impede heat transfer necessary to adequately cook food. Encrusted equipment may also serve as an insect attractant when not in use.- Observed on food plate covers, a black grease-like substance that staff thought was part of the plastic lid but when wiped with a fingertip it smeared. The dishwasher staff person stated, it comes from the dishwasher and does not know why.- Three skillets that had black encrusted food on the inside of the skillets which could be scratched off with a thumb nail.- Small white glass plates and bowls that were stored on a storage rack had spots of food on the edges.c. The FDA Food Code Section 4-302.12 Food Temperature Measuring Devices documented the presence and accessibility of food temperature measuring devices is critical to the effective monitoring of food temperatures. Proper use of such devices provides the operator or person in charge with important information with which to determine if temperatures should be adjusted or if foods should be discarded. On 5/11/26 at 10:42 AM, the surveyor observed the walk-in refrigerator temperature log was not posted or available to review. The Food [NAME] #1 stated the refrigerator temperature log was missing.On 5/12/26 at 8:23 AM, the surveyor observed the walk-in refrigerator temperature log was now posted to the front of the refrigerator and was missing temperature data on the following dates.- May 9, 2026, no AM or PM temperatures were logged.- May 10 and 11, 2026, the PM temperatures were not logged.On 5/12/26 at 8:24 AM, the Food [NAME] #1 stated the temperatures for May 9, 10, and 11, 2026 should have been logged in and were not.d. 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 5/14/26 at 9:30 AM, observed the Dietary Supervisor in the kitchen food prep area not wearing a beard net to cover is facial hair.On 5/14/26 at 9:39 AM, the Dietary Supervisor stated he was not aware of the need to (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	wear a beard net over his facial hair but would wear one from now on in the food prep area.e. The FDA Food Code Section 4-602.11 (Frequency) Equipment Food-Contact Surfaces and Utensils documented (A) Equipment food-contact surfaces and utensils shall be cleaned: (2) each time there is a change from working with raw foods to working with ready-to-eat food, (5) at any time during the operation when contamination may have occurred, (C) if used with time/temperature control for safety food, equipment food-contact surfaces and utensils shall be cleaned throughout the day at least every 4 hours. On 5/ 11/26 at 12:10 PM, when the surveyor inquired, the Food [NAME] #1 stated the sanitizer buckets were made fresh each morning and again when the evening crew came into work, a fresh batch was made.On 5/12/26 at 8:25 AM, the Administrator (who had the Food Service Manager certification) stated the sanitizer buckets should be changed every two hours.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, policy review, CDC Legionnella guidelines, OSHA Legionella guidelines, and staff interview, the facility failed to ensure adherence to infection control and prevention practices to provide a safe and sanitary environment when, 1. staff had not used barrier protection, 2. perform hand hygiene, 3. had not tested swamp cooler water. Findings include:1. CDC Controlling Legionella in other devices dated 1/3/25 obtained from https://www.cdc.gov/control-legionella/php/toolkit/other-devices-module.html documented the following. - Any system or equipment containing nonsterile water can grow Legionella. - Sediment and biofilm, temperature, water age, and disinfectant residual are the key factors that affect Legionella growth. - In the absence of control, Legionella can grow in almost any system or equipment containing nonsterile water at favorable temperatures. Tap water is an example of nonsterile water. - Equipment that may grow Legionella in the absence of control include the following: - Evaporative air coolers Regularly clean and maintain all water system components, such as - Hoses - Spray nozzles - Sprinkler heads Store and maintain water at temperatures outside the favorable growth range for Legionella (77–113 degrees F, 25–45 degrees C). Note that Legionella may grow at temperatures as low as 68 degrees F (20 degrees C). Clear components: Keep collection basins, condensate pans, cooling coils, and other components clean and free from - Biofilm - Corrosion - Debris - Dirt Maintain evaporative coolers to ensure they are functioning properly with managed airflow across condensate pans. Occupational Safety and Health Administration information obtained on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	https://www.osha.gov/legionnaires-disease/control-prevention on 5/21/26 documented water management programs that effectively prevent Legionella growth in water systems rely on control and prevention measures, including good system design, proper facility and equipment maintenance, and routine cleaning and disinfection. CDC Controlling Legionella in Cooling Towers on https://www.cdc.gov/control-legionella/php/toolkit/cooling-towers-module.html downloaded 5/21/26 documented Clean and disinfect as directed: Follow manufacturer recommendations - Prior to commissioning - Before startup - When idling - After shutdown Perform an offline disinfection and cleaning at least annually. Maintain paperwork: Keep site-specific log sheets, test procedures, service reports, and test results on site. The facility's water management plan (WMP) undated documented the effectiveness of the WMP in controlling Legionella will be validated as follows: by routinely testing certain building water systems for Legionella: sample cooling towers, decorative fountains, and whirlpools spas within two weeks of start-up following shutdown (whether shut down for the season or for maintenance) and at least once every 90 days during operation. On 5/13/26 at 12:47 PM, the Maintenance Director stated the facility has eight swamp type coolers on the roof. When the surveyor inquired when he last tested the swamp cooler water for Legionnaires disease, he stated he was up on the roof yesterday and looked at the coolers but has never tested them for Legionnaires disease. 2. The American Health Care Association webpage accessed on 5/19/26 titled: Tips for Meeting the Cleaning and Disinfection of Blood Glucose Meters Requirements in Skilled Nursing Facilities as follows: TIP: Place a clean and dry paper towel(s) under blood glucose meter before placing on resident table or on top of medication cart. TIP: Make sure blood glucose meter is cleaned and stored appropriately after each use. On 5/12/26 at 6:54 AM, a glucometer with test strip inserted on it, lancet and alcohol swab were observed on top of the medication cart while LPN #1 was looking at the computer. LPN #1 stated she would check the blood glucose of Resident #20. LPN #2 walked down to Resident #20's room with the glucometer and other supplies on her hand, placed them on top of the PPE cart, and donned gown and gloves without performing hand hygiene. Inside Resident #20's room LPN #1 put the glucometer on top (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of Resident #20's bedside table. LPN #1 was not observed to place a barrier before putting the glucometer on top of the bedside table. LPN #2 then took Resident #20's blood glucose, took off her gown and gloves, and returned to her medication cart. At 7:04 AM, LPN #1 was observed to place the glucometer on top of the medication cart and left the medication cart to wash her hand. After washing her hands, LPN #1 picked up the glucometer and placed the glucometer inside the zip-lock bag. LPN #1 was not observed to sanitize the glucometer before putting it back into the zip-lock bag. On 5/12/26 at 7:48 AM, LPN #1 donned gown and gloves before entering Resident #18's room without performing hand hygiene. LPN #1 then placed Fentanyl patch to Resident #18's right shoulder. LPN #1 removed her gown, gloves, and performed hand hygiene on her way to the medication cart. On 5/12/26 at 7:54 AM, LPN #1 stated she should have placed a paper towel on top of the bedside table before putting the glucometer. LPN #1 stated she did not sanitize the glucometer before putting it back inside the zip-lock bag. LPN #1 stated hand hygiene should be performed before and after donning PPE. On 5/12/26 at 9:23 AM, the DON stated there should be a barrier like paper towel before putting the glucometer on top of Resident #18's bedside table and should have been sanitized before putting it inside the zip-lock plastic bag. The DON also stated hand hygiene should be performed before and after donning on the PPE. 3.The facility's Handwashing/Hand Hygiene policy revised 11/17/25, documented hand hygiene should be performed before donning gloves and after removing gloves. On 5/14/26 at 11:09 AM, LPN #2 prepared the dressing supplies for Resident #22. LPN #2 opened the medication cart and took the Therablue (an antibacterial foam dressing) from Resident #5's dressing supplies and brought it into Resident #22's with the other dressing supplies. LPN #2 placed the Therablue on top of Resident #22's bedside table and dressing supplies on top of the bedside table. LPN #2 was not observed to put a barrier on the bedside table before putting the dressing supplies on it. LPN #2 donned gloves removed Resident #22's old dressing from his right lower leg and cleaned the wound. LPN #2 was about to cut the Therablue when she realized she did not bring an alcohol swab to sanitize the scissors. LPN #2 removed her gloves and walked back to the medication cart to get alcohol wipes. LPN #2 went back to Resident #22's room, put on gloves, sanitized the scissors, cut the Therablue, removed her gloves, put on another pair of gloves, applied collagen powder to Resident #22's wound, followed by the Therablue and covered it with gauze. LPN #2 was also observed applying lotion on Resident #22's back after changing her gloves. LPN #2 was not observed to perform hand hygiene before putting and after removing her gloves during the wound dressing of Resident #22. At the medication cart, LPN #2 stated she used Resident #5's Therablue because Resident #22 was out of Therablue dressing. On 5/14/26 11:30 AM, the IP stated hand hygiene should always be performed before and after changing gloves. She also stated dressing supplies should not be shared with other residents and taken into residents' room.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on interviews, the facility failed to employ a certified Activities Director. This failure had the potential to affect residents' quality of life when design of activities appropriate for residents was not implemented. Findings include:On 5/11/26 at 10:45 AM, the Administrator stated the facility's Activity Director had quit and the Activities Assistant was filling the position for now.On 5/13/26 at 2:10 PM, the acting Activities Director stated she was only in this position for a few weeks to see if she wanted to take the position. She stated she did not have the certification or license and was not in a training program to be licensed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure professional standards of practice were followed for 7 of 14 residents (#2, #4, #8, #10, #18, #23, and #38) reviewed for physician orders and bowel and bladder care, This failed practice created the potential for residents to experience discomfort when medications were not administered according to the physician's order. Findings include:a. The facility's Bowel Management - Clinical Protocol policy dated 4/2026, documented the facility shall assess, monitor, and manage bowel and bladder function for all residents according to individualized needs, physician/provider orders, and applicable regulations. Intervention Protocol documented as follows:- No bowel movement for 2 days: Senokot 8.6 mg PO BID/PRN; increase fluids, offer prunes or juice, and/or BAP from dietary, reduce for diarrhea.- No bowel movement for 3 days: give Mirlalax 17 gm PO BID/PRN (adminster in fluid of choice) plus day 2 bowel regime, increase fluids, offer prunes or juice, and/or BAP from dietary, reduce for diarrhea.- No bowel movement for 4 days: give lactulose 30 cc PO BID/PRN plus day 2 and day 3 bowel regime. Give Ducolax supp. PR before 0500. Notify MD if no BM by 1200 for further instructions1. Resident #2 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including chronic heart failure and chronic respiratory failure.On 5/11/26, Resident #2's bowel flowsheet documented he did not have a bowel movement as follows:- 4/17/26 until 4/21/26 (five days).- 5/3/26 until 5/11/26 (eight days).Resident #2's medical record has no documentation of nursing interventions with ordered BM medications from 4/16/26 through 5/11/26.2. Resident #4 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including Parkinson's disease (a progressive disease of the nervous system that affects movement), constipation, and diabetes.On 5/11/26, Resident #4's bowel flowsheet documented she did not have a bowel movement as follows:- 5/4/26 until 5/11/26 (seven days).Resident #4's care plan directed staff to monitor/document/report PRN s/sx of complications related to constipation: change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation, bradycardia (slow, low pulse), abdominal distension, vomiting, small loose stools, fecal smearing, bowel sounds, diaphoresis, abdomen: tenderness, guarding, rigidity, fecal compaction.Resident #4's medical record has no documentation of nursing interventions with ordered BM medications from 5/4/26 through 5/11/26.3. Resident #8 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including gastroparesis (the stomach cannot empty itself of food in a normal fashion) and diabetes.On 5/11/26, Resident #8's bowel flowsheet documented he did not have a bowel movement as follows: - 5/4/26 until 5/10/26 (six days).Resident #8's medical record has no documentation of nursing interventions with ordered BM medications from 5/4/26 through 5/10/26.4. Resident #10 was admitted to the facility on [DATE], with multiple diagnoses including multiple rib fractures and kidney failure.On 5/11/26, Resident #10's bowel flowsheet documented he did not have a bowel movement as follows:- 4/18/26 until 4/24/26 (six days). - 4/30/26 until 5/8/26 (eight days).Resident #10's medical record has no documentation of nursing interventions with ordered BM medications from 4/30/26 through 5/8/26.5. Resident #18 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including metabolic encephalopathy (a non-traumatic, reversible brain dysfunction caused by underlying systemic illnesses, chemical imbalances, or organ failure) and heart failure.On 5/12/26, Resident #18's bowel flowsheet documented she did not have a bowel movement as follows:- 5/3/26 until 5/8/26 (five days).Resident #18's medical record has no documentation of nursing interventions with ordered BM medications from 5/3/26 through 5/8/26.6. Resident #23 was admitted to the facility on [DATE], with multiple diagnoses including stroke with left side hemiparesis and diabetes.On 5/11/26, Resident #23's bowel flowsheet documented he did not have a bowel movement as follows:- 5/5/26 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	until 5/11/26 (six days).Resident #23's medical record has no documentation of nursing interventions with ordered BM medications from 5/5/26 through 5/11/26.7. Resident #38 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including stroke with left sided paralysis and diabetes. On 5/12/26, Resident #38's bowel flowsheet documented he did not have a bowel movement as follows:- 4/15/26 until 4/21/26 (six days).- 4/22/26 until 4/27/26 (four days).- 5/5/26 until 5/12/26 (seven days).Resident #38's medical record has no documentation of nursing interventions with ordered BM medications from 4/15/26 through 4/21/26, 4/22/26 through 4/27/26, and 5/5/26 through 5/12/26.On 5/13/26 at 2:35 PM, the CRN stated Residents #2, #4, #8, #10, #18, #23, and #38 did not have any nursing BM interventions documented in their medical record and should have.b. Resident #2 lack of CPAP orderResident #2 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including chronic heart failure and chronic respiratory failure.On 5/11/26 at 1:31 PM, Resident #2 was observed using oxygen at 5 LPM from his portable oxygen system and stated he was having issues using his CPAP device and mask. Resident #2 stated he had told numerous staff many times but nothing had been done about it so far.On 5/11/26 at 3:10 PM, Resident #2's medical record had not documented an active physician's order for CPAP use.Resident #2's medical record documented a physician order for Trilogy CPAP at bedside with a start date of 8/14/24 and with an end date of 11/4/24.A comprehensive encounter progress note dated 5/5/26 at 00:00 hours, documented Resident #2 needs a new CPAP mask and tubing. His mask is torn and obstructing airway.A psychiatric follow-up progress note dated 5/5/26 at 14:02 hours, documented Resident #2 did express ongoing difficulty adjusting to the CPAP machine. Staff and the medical team are aware of the concern and continue to monitor and address the issue.Resident #2's care plan had no documentation about CPAP usage.On 5/13/26 at 2:28 PM, the CRN stated Resident #2's CPAP should have had a physician's order and should have been care planned and was not.c. Resident #18 not notifying physicianResident #18 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including metabolic encephalopathy (a non-traumatic, reversible brain dysfunction caused by underlying systemic illnesses, chemical imbalances, or organ failure) and heart failure.On 5/12/26 at 3:04 PM, Resident #18's physician's order documented daily BP. If SBP <100, notify cardiology [PHONE NUMBER]. in the morning for taking midodrine.The following dates listed are those when Resident #18's blood pressure was below 100 and no documented notification to the cardiologist was found in Resident #18's medical record. - 3/1/26 90/58- 3/2/26 90/54- 3/6/26 88/68- 3/7/26 90/63- 3/8/26 98/60- 3/13/26 94/67- 3/20/26 93/57- 3/27/26 96/52- 3/28/26 95/67- 4/1/26 94/56- 4/2/26 98/56 - 4/3/26 97/62- 4/7/26 96/64- 4/8/26 90/59- 4/15/26 98/60- 4/19/26 96/65- 4/22/26 98/62- 4/24/26 98/69- 4/26/26 96/64- 4/27/26 96/64- 5/6/26 97/59- 5/7/26 98/59- 5/8/26 93/60Resident #18's medical record had no documentation of nursing intervention or that cardiology was notified during the times listed.On 5/12/26 at 1:35 PM, the CRN stated Resident #18's medical record had no notification documentation to cardiology during the times listed and should have.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Desert View	820 Sprague Avenue Buhl, ID 83316

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation 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 5/13/26 at 9:55 AM, during review of the daily staffing sheets from October 2025 through April 2026, the surveyor noted the actual hours worked had not been documented.The following documents those daily staffing sheets that were not completed correctly or were missing. - 2026- April 25, No RN scheduled or hours- [DATE], No evening nursing staff scheduled- [DATE], No RNs all three shifts, no nurses scheduled for evening shift- [DATE], No nurses scheduled for Day shift- [DATE], RN staffing for only 2 hours that day- [DATE], No RN's scheduled- [DATE], No RN's scheduled- [DATE], Missing the daily staffing sheet- [DATE], No RN's scheduled- [DATE], No RN's scheduled- [DATE], No nurses scheduled Days or evenings- [DATE], No RN's scheduled- [DATE], No nurses scheduled Day, evening, or nights- [DATE], No nurses scheduled for Day- [DATE], Missing the daily staffing sheet- [DATE], Missing the daily staffing sheet- [DATE], No nurses scheduled for Evening- 2025- [DATE], No nurses hours Day & evening- [DATE], No nurses scheduled Day & evening- [DATE], No RN hours listed all 3 shifts- [DATE], No RN hours listed all 3 shifts - [DATE], No nursing hours listed- [DATE], No nursing hours listed- [DATE], No RN scheduled- [DATE], No RN scheduled- [DATE], No RN scheduled- [DATE], No nursing hours listed- [DATE], No RNs scheduled- [DATE], No RNs scheduled On 5/13/26 at 2:38 PM, the ADON stated the daily staffing sheets should have been correctly completed and were not.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and interviews it was determined the facility failed to ensure residents were treated with dignity and respect. This was true for 2 of 14 Residents (#8 and #23) reviewed for respect and dignity issues. This deficient practice placed residents at risk of embarrassment and diminished sense of worth. Findings include: The facility's Dignity policy dated 2/2021, documented staff promote, maintain and protect resident privacy.demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents: for example, helping the resident to keep urinary catheter bag covered. 1. Resident #8 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including gastroparesis (the stomach cannot empty itself of food in a normal fashion) and diabetes. On 5/11/26 at 2:16 PM, Resident #8's catheter bag was observed hanging on the trash can in his room and had not been covered with a privacy bag. When the room door opens, the bag is visible to anyone in the hallway. Resident #8 stated the bag is always like that, never covered. On 5/13/26 at 2:16 PM, the CRN stated Resident #8's catheter bag should have been in a privacy cover and was not. 2. Resident #23 was admitted to the facility on [DATE], with multiple diagnoses including stroke with left side hemiparesis (muscle weakness or partial incomplete paralysis) and diabetes. On 5/11/26 at 10:35 AM, observed initially from the hallway through the open doorway, Resident #23's bed mattress with a large (24 inch) round area in the center of the mattress soaked with urine. The sheets had been removed but not the mattress itself. The soaked area was sunken due to the wet spot. When the surveyor entered Resident #23's room there as a very strong smell of urine and body odor. On 5/11/26 at 10:40 AM, the CRN stated the room, and mattress did have a strong urine smell and should have been removed once found and replaced with a new mattress but had not been.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **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 ensure residents and/or their representatives were informed in advance of the risks and benefits of psychotropic medications and alternative treatment options. This was true for 1 of 5 Residents (Resident #43) reviewed for unnecessary medications. This deficient practice created the potential for residents of receiving psychotropic medications without knowledge of the impact the medications could have on their physical and mental health. Findings include: The facility's Psychotropic Medication policy, dated 7/22, documented residents will not receive medications that are not clinically indicated to treat a specific condition, and in part 3, Residents, families, and/or the representative are involved in the medication management process. Resident #43 was admitted to the facility on [DATE], with multiple diagnoses including Alzheimer's Disease and depression. A physician's order documented Resident #43 was to receive the following medications:-Duloxetine (antidepressant) HCL, give 60 mg by mouth one time a day for depression-Quetiapine Fumarate (antipsychotic) oral tablet, give 25 mg by mouth every 6 hours as needed for dementia agitation for 14 days. Resident #43's record did not contain documentation she and/or her representative were informed of the risks and benefits of duloxetine and quetiapine fumarate and its adverse effects. On 5/14/26 at 9:41 AM, the CRN stated they do not have the consents for Resident #43's psychotropic medications.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, it was determined the facility failed to ensure that residents' drinking water was within their reach. This was true for 1 of 1 resident (Resident #28) reviewed for accommodation of needs. This deficient practice had the potential for residents to experience urinary tract infection, confusion and other health conditions if they were not able to maintain their hydration. Findings include:Resident #28 was admitted to the facility on [DATE], with multiple diagnoses including quadriplegia (partial or total loss of motor and sensory function in all four limbs) and diabetes.Resident #28 was observed in bed on the following days 5/11/26 at 2:50 PM, 5/12/26 at 3:59 PM, and 5/13/26 at 9:55 AM, lying in bed and watching the television. Drinking water was observed on top of his bedside table located on his right side by the head of his bed. Resident #28 was observed moving his left hand. There was no movement noted on Resident #28's arms. The drinking water was not within Resident #28 reach.On 5/13/26 at 10:21 AM, CNA #1 delivered Resident #28's drinking water and placed it on top of his bedside table. When asked if Resident#28 could reach the drinking water, CNA #1 stated Oh, you are right. CNA #1 looked around and moved an overbed table next to Resident #28. CNA #1 asked Resident #28 how he would like the table to be positioned. Resident #28 asked CNA #1 to move the overbed table closer to him. CNA #1 then positioned the overbed table directly in front of Resident #28 over his lap and placed the drinking water on the overbed table where Resident #28 could reach it.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **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 provide the Notice of Medicare Non-Coverage (NOMNC CMS-10123) within the CMS required timeframe to 1 of 3 residents (Resident #19) reviewed for beneficiary protection notification. This deficient practice had the potential to cause financial harm or distress for residents when they were not informed of their potential liability for payment when their Medicare Part A benefits ended. Findings include:The facility's Medicare Advance Beneficiary and Medicare Non-Coverage Notices policy dated 9/22, documented if the resident's Medicare covered Part A stay or when all of Part B therapies are ending, a Notice of Medicare Non-Coverage (CMS form 10123) is issued to the resident at least two calendar days before benefits end.Resident #19 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including acute respiratory failure with hypoxia (a critical condition where the lungs cannot adequately oxygenate the blood) and kidney disease.On 5/12/26 at 12:51PM, during review of beneficiary NOMNC notifications, the following was documented.- Resident #19 skilled part A nursing services ended 5/8/26 and he was not given the CMS required two-day notice when he signed the NOMNC document on 5/7/26.On 5/13/26 at 3:08 PM, the Administrator stated Resident #19 should have been given the skilled nursing services ending notice two days before 5/8/26 and had not been.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and policy review, and interview, it was determined the facility failed to ensure residents were monitored for the adverse effects of their psychotropic and opioid medications. This was true for 1 of 5 residents (Resident #43) reviewed for unnecessary medications. This deficient practice created the potential for harm if residents experienced side effects of the medication and were undetected due to lack of appropriate monitoring. Findings include: The facility's Pain Assessment and Management policy, dated 7/2022, Implementing Pain Management Strategies section 4, stated, when opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects, and potential overdose.The facility's Psychotropic Medication Use policy, dated 7/2022, Policy Interpretation and Implementation, section 13, stated, Residents receiving psychotropic medications are monitored for adverse consequences including: a. anticholinergics effects, flushing, blurred vision, dry mouth, altered mental status, difficulty urinating, falls, excessive, sedation and constipation; b. cardiovascular effects- irregular heart rate or pulse, palpitations, lightheadedness, shortness of breath, diaphoresis, chest/arm pain, increased blood pressure, orthostatic hypotension; c. metabolic effects- increased cholesterol,and triglycerides, poorly controlled or unstable blood sugar, weight gain; d. neurologic effects- agitation, distress, extrapyramidal symptoms, neuroleptic malignant syndrome, Parkinsonism, tardive dyskinesia, cerebrovascular events; and e. psychosocial effects- inability to perform ADLs or interact with others, withdrawal or decline from usual social patterns, decreased engagement in activities, diminished ability to think or concentrate,Resident #43 was admitted to the facility on [DATE], with multiple diagnoses including Alzheimer's Disease and depression.A physician's order documented Resident #43 was to receive the following medications:-Duloxetine (antidepressant) HCL, give 60 mg by mouth one time a day for depression-Quetiapine Fumarate (antipsychotic) oral tablet, give 25 mg by mouth every 6 hours as needed for dementia agitation for 14 days-Fentanyl (opioid pain medication) Transdermal Patch every 72 hours, 25 mcg/hour-Oxycodone HCL (opioid pain medication) oral tablet, give 5 mg by mouthReview of Resident #43's medical record did not include the side effects of her psychotropic and opioid medications being monitored.On 5/14/26 at 8:59 AM, the CRN confirmed there was no psychotropic and opioid side effect monitoring in place for Resident #43.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **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 1) ensure residents who were discharged home were provided with the necessary discharge information to ensure a smooth and safe transition of care. This was true for 1 of 1 resident (Resident #3) whose record was reviewed for planned discharge and 2) provide hospital transfer documents for 1 of 3 residents (Resident #5) whose records were reviewed for hospitalization. This deficient practice created the potential for residents to experience harm if they were not treated in a timely manner due to lack of information. Findings include: The facility's Transfer or Discharge policy date 10/2022, under Orientation for Transfer or Discharge (planned) documented, A post-discharge plan is developed for each resident prior to his or her transfer or discharge. This plan will be reviewed with the resident, and/or his or her family, at least twenty-four (24) hours before the resident's discharge or transfer from the facility. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including left below the knee amputation and diabetes. A Discharge note dated 5/1/26, documented Resident #3 was discharged to home. There was no documentation Resident #3 was provided with the necessary discharge documents such as medication list, recapitulation of her stay in the facility and any other discharge information. On 5/14/26 at 1:41 PM, CRN stated there was no documentation Resident #3 was provided with the necessary discharge documents. The facility's Transfer or Discharge policy dated 10/2022, documented should a resident be transferred or discharged for any reason, the following information was communicated to the receiving facility or provider: 1.The basis for the transfer or discharge. 2.Contact information of the practitioner responsible for the care of the resident. 3.Resident representative information including contact information. 4.Advance Directive information. 5.All special instructions or precautions for ongoing care, as appropriate. 6.Comprehensive care plan goals, and 7.All other information necessary to meet the resident's needs, including but not limited to: a. resident status, including baseline and current mental, behavioral, and functional status, b. recent vital signs, (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. diagnoses and allergies, d. medications (including when last received), e. most recent relevant labs[oratory], other diagnostic tests, and recent immunization, f. a copy of the resident's discharge summary, and g. any other documentation, as applicable to ensure a safe and effective transition of care. Resident #5 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including schizoaffective disorder, bipolar type, dysphagia (difficulty swallowing), and hypotension. A Nursing Note dated 12/23/26 at 12:58 PM, documented Resident #5 had few episodes of dark emesis (vomiting). The last two emesis contained coffee ground looking pieces. The provider was notified, and an order was received to transfer Resident #5 to the hospital for evaluation. EMS arrived and transferred Resident #5 to the hospital. There was no documentation in Resident #5's records, the hospital was provided with his current medical record when he was transferred to the hospital to ensure a safe and effective transition of care. On 5/13/26 at 1:13 PM, the CRN with the Administrator present stated face sheet, MAR. advance directive if available,and POST should be sent with the residents when they transferred to the hospital. The CRN stated there was no documentation in Resident #5's record that these documents were sent with him when he was transferred to the hospital.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review and staff interview, it was determined the facility failed to ensure a resident with positive PASARR Level 1 screening for mental illness was referred for further evaluation to the appropriate state-designated authority. This was true for 1 of 2 residents (Resident #5) whose PASARR I was reviewed. This deficient practice created the potential for harm if residents required but did not receive specialized services for mental health while residing in the facility. Findings include:The facility's Resident Assessments PASRR Screening Coordination policy dated 4/2025, documented the facility would refer to the appropriate state-designated authority any resident with newly evident or possible serious mental disorder, intellectual disability or related condition.Resident #5 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including schizoaffective disorder, bipolar type, dysphagia (difficulty swallowing), and hypotension.A PASRR Level 1 Screening dated 12/29/25, documented Resident #5 did not have major mental illness. Resident #5's record documented schizoaffective disorder was diagnosed on [DATE].On 5/14/26 at 1:25 PM, the CRN stated Resident #5 did not have PASARR Level II Screening and he should have one.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and interview, it was determined the facility failed to ensure a baseline care plan was developed within 48 hours of resident's admission. This was true for 1 of 3 residents (Resident #44) reviewed for baseline care plan. This failure created the potential for harm when the care plan failed to provide direction for care. Findings include:The facility's Care Plans - Baseline policy dated March 2024, documented a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission.Resident #44 was admitted to the facility on [DATE], with multiple diagnoses including unstageable pressure ulcer and severe sepsis (a life-threatening medical emergency occurring when an infection causes an overwhelming immune response, resulting in dysfunction or damage to one or more vital organs).Resident #44's baseline care plan was initiated on 9/16/25, and was not completed or signed until 9/22/25, six days after admission.On 5/13/26 at 3:35 PM, the CRN stated Resident #44's baseline care plan should have been completed within two days of being admitted and had not been.

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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 observation, policy review, record review, and staff interview, it was determined the facility failed to ensure comprehensive resident-centered care plans included the use of splint and RNA program of a resident. This was true for 1 of 14 residents (Resident #5) whose care plans were reviewed. This deficient practice created the potential for residents to receive inadequate or inappropriate care due to missing information in their care plan. Findings include:The facility's Care Plans Comprehensive Person-Centered policy revised 3/2022, documented the care plan Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.Resident #5 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including quadriplegia (partial or total loss of motor and sensory function in all four limbs), schizoaffective disorder, bipolar type, dysphagia (difficulty swallowing), and hypotension.Review of Resident #5's RNA flowsheet showed the following:a. BUE (bilateral upper extremities) PROM (Passive Range of Motion) dated 4/17/26 - 5/13/26, documented Not Applicable in 18 of 25 opportunities.b. Splint wearing tolerances with look back period of 30 days, no documentation Resident #5 had worn his splint.Review of Resident #5's care plan, did not document he was on RNA program and wore a splint as tolerated.On 5/12/26 at 10:30 AM, the ADON reviewed Resident #5's care plan and stated his splint and RNA program were not documented in the care plan. The ADON stated Resident #5's care plan should document he used a splint, and he was on RNA program.

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Cascades at Desert View	820 Sprague Avenue Buhl, ID 83316

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 policy review, observation, record review, and interview, it was determined the facility failed to ensure residents' comprehensive care plans were revised timely and as needed. This was true for 1 of 14 residents (Resident #5) whose care plans were reviewed. This deficient practice created the potential for residents to receive inappropriate care due to inaccurate information in their care plans. Finding include:The facility's Care Plans, Comprehensive Person-Centered policy revised March 2022, documented assessments of residents were ongoing and care plans were revised as information about the residents and the residents' condition changeResident #5 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including quadriplegia (partial or total loss of motor and sensory function in all four limbs), schizoaffective disorder, bipolar type, dysphagia (difficulty swallowing), and hypotension.A care plan initiated 12/2/25, documented Resident #5 used assistive devices halo bars for bed mobility.On 5/11/26 at 11:19 AM, and 5/12/26 at 9:45 AM, Resident #5 was observed lying in bed. There was no halo bar device attached to his bed.On 5/12/26 at 4:22 PM, the CRN stated Resident #5 was transferred to another room and he did not want the halo device installed to his bed. The CRN stated the care plan should have been updated to reflect Resident #5 did not have the halo device.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, Advair website, record review, and staff interview, it was determined the facility failed to ensure medication was administered according to professional standards of practice. This was true for 2 of 5 residents (#18 and #31) observed during medication administration. This created the potential for residents to develop yeast infection when they did not rinse their mouth with water after taking their inhaler medication. Findings include:The Advair website accessed on 5/19/26, documented after inhalation the patient should rinse his/her mouth with water without swallowing to help reduce the risk of oropharyngeal candidiasis (a fungal infection caused by an overgrowth of Candida [yeast]).1.Resident #31 was admitted to the facility on [DATE], with multiple diagnoses including asthma and acute and chronic respiratory failure with hypoxia (low levels of oxygen in the blood).A physician' order dated 2/23/26, documented Resident #31 was to receive Advair HFA Aerosol 115-21 mcg/act (Fluticasone [corticosteroid]-Salmeterol) two puffs inhale orally two times a day for Asthma wait one minute between puffs, rinse mouth after use.On 5/12/26 at 7:15 AM, Resident #31 was observed taking two puffs of Advair HFA through her mouth. LPN #1 was not observed to provide water to Resident #31 to rinse her mouth after taking the inhaler.2. Resident #18 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (COPD- a progressive lung disease characterized by increasing breathlessness) and diabetes.A physician's order dated 6/24/25, documented Resident #31 was to received Advair Diskus Inhalation Aerosol Powder Breath Activated 250-50 mcg/act (Fluticasone-Salmeterol) one puff inhale orally two times a day for COPD. Rinse mouth after use.On 5/12/26 at 7:42 AM, Resident #18 was observed taking one puff of Advair Inhalation through her mouth. LPN #1 was not observed to provide water to Resident #18 to rinse her mouth after taking the inhaler.On 5/12/26 at 9:17 AM, the DON with the CRN present stated, Resident #18 and #31 should have been provided with water to rinse their mouth after taking their inhaler.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, record review, and staff interview, it was determined the facility failed to ensure residents received treatment and services to prevent further decrease in range of motion (ROM). This was true for 3 of 3 residents (#5, #27 and #28) reviewed for treatment and services related to ROM. This failed practice placed residents at risk of harm when they did not receive their restorative program as care planned to prevent further deterioration of their existing ROM limitations. Findings include:The facility's Restorative Nursing Services policy revised 2024, documented that residents would receive restorative nursing care as needed to help promote safety and independence. 1. Resident #5 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including quadriplegia (partial or total loss of motor and sensory function in all four limbs), schizoaffective disorder, bipolar type, dysphagia (difficulty swallowing), and hypotension. On 5/11/26 at 10:52 AM, Resident #5 was observed in bed. Resident #5 was using a stylus with his mouth to navigate the cell phone. Resident #5's right fingers were observed to be curled inward. His left hand could not be visualized as it was under the sheet. Resident #5 stated he use the back of his head to push the touch button call light which was located behind his head to call for assistance. A hand brace/splint was observed on top of his chest drawers. On 5/12/26 at 10:39 AM, Resident #5's fingers on both hands were observed to be curled inward. Resident #5 stated he was not being assisted to put on the splint. Review of Resident #5's RNA flowsheet showed the following: a. BUE (bilateral upper extremities) PROM (Passive Range of Motion) dated 4/17/26 – 5/13/26, documented Not Applicable in 18 of 25 opportunities. b. Splint wearing tolerances with look back period of 30 days, no documentation Resident #5 had worn his splint. On 5/14/26 at 9:54 AM, RNA #1 stated it would require her to spend an hour with Resident #5 to do his RNA program and to put on his splint. Resident #5 was very specific on how he would like his splint to put on, it had never been right. RNA #1 stated, It's either I help him, or I will not be able to help two residents. When asked about the Not Applicable documentation on the flow sheets, RNA #1 stated it meant she was not able to provide the RNA program to the resident. 2. Resident #28 was admitted to the facility on [DATE], with multiple diagnoses including quadriplegia (partial or total loss of motor and sensory function in all four limbs) and diabetes. On 5/11/26 at 1:44 PM, Resident #28's was observed in bed. His right hand was observed to be closed in a fist. Two blue carrot splints were observed on top of his bedside table. Resident #28 stated the carrot splints were too big for his hands. Resident #28's carrot splint was observed on top of his bedside table on the following days: 5/11/26 at 2:50 PM, 5/12/26 at 3:59 PM, and 5/13/26 at 9:55 AM. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #28's RNA flowsheet showed the following: a. Passive ROM Bilateral Lower Extremities dated 4/13/26 – 5/12/26, documented Not Applicable in 18 of 28 opportunities. b. Assistance with Splint or Brace dated 4/13/26 – 5/12/26, documented Not Applicable in 18 of 28 opportunities. On 5/13/26 at 10:04 AM, RNA #1 stated Resident #28 was on RNA program. We are supposed to put the carrot splint on his hands, but I don't have time to get everybody to do their RNA program. RNA #1 stated she works 7.5 hours a day and had to provide RNA program to 26 residents. There was not enough time to provide RNA program to all the residents scheduled for the day. RNA #1 stated there are group exercise but not all residents could participate in the group exercise. Resident #28 required a one-on-one RNA program for his right hand. When asked about the Not Applicable documentation on the flow sheets, RNA #1 stated it meant she was not able to provide the RNA program to the resident. RNA #1 stated she also helps in the dining room and answers call lights as needed. 3. Resident #27 was admitted on [DATE] and again on 2/24/26 with multiple diagnoses including stroke, dementia, and left sided hemiplegia (paralysis on one side of the body). On 5/12/26 at 2:41 PM, Resident #27 observed with left hand curled while sitting in his room. On 5/13/26 at 2:55 PM, RNA stated Resident #27 is supposed to have Active ROM to maintain upper extremity mobility 7 days a week. She stated he only comes to therapy once a week to do the pulleys and walk while holding bars, he goes to group exercise during the week. She stated group exercise would not address his contracture to his left hand. On 5/13/26 3:00 PM, review of Therapy Referral Form dated 4/30/26, documented the following, Restorative Nursing Plan for Rehabilitation or Restorative Techniques marked Active ROM and Transfers with goal- 1. Maintain upper extremity and mobility, 5-10 minutes with pulleys 6-7/week2.Increase lower extremity strength, seated exercises-marching, ball squeezes, kicks, leg lifts 6-7/week 3.Increase ability to complete transfers safely, sit to stand transfers within 11 bars 6-7/week Review of RNA Flow Sheet- maintain upper extremity mobility dated 4/13/26-5/12/26 documented (NA) 8 out of 30 opportunities. RNA stated she works 4 days a week 7.5 hours and can be pulled to help the floor as needed and she did not have the time to see all the residents on her list. On 5/13/26 at 1:18 PM, the CRN stated there were two staff providing RNA programs to the residents. One RNA was scheduled each day. When asked about Not Applicable documentation in the RNA flowsheets, the CRN stated, I would assume the RNA was not completed. The CRN stated if the RNA program for the residents was written daily, then it should be completed daily. The CRN stated she would expect the RNA program to be reevaluated for appropriateness.

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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, 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 5 residents (#10 and #18) whose records were reviewed for respiratory services. This failure created the potential for residents to experience increased fatigue and low oxygen levels. Findings include:1. Resident #10 was admitted to the facility on [DATE], with multiple diagnoses including multiple rib fractures and kidney failure.On 5/11/26 at 1:55 PM, observed Resident #10 lying in his bed awake, getting oxygen via nasal cannula at 4 LPM.On 5/11/26 at 3:02 PM, Resident #10's physician oxygen order documented oxygen at 2 L/min via nasal cannula while sleeping.Resident #10's care plan documented he has oxygen therapy r/t nocturnal hypoxia. Oxygen use as needed and ordered, check Room air saturations as ordered, wean as able/ordered On 5/13/26 at 3:42 PM, the CRN stated Resident #10's oxygen should have been set at 2 LPM and was not. 2. Resident #18 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including metabolic encephalopathy (a non-traumatic, reversible brain dysfunction caused by underlying systemic illnesses, chemical imbalances, or organ failure) and heart failure.On 5/11/26 at 2:06 PM, observed an oxygen concentrator in Resident #18's room. Resident #18 was not wearing a nasal cannula and was not using the oxygen concentrator. Resident #18 stated she only uses it at night.Resident #18's physician oxygen order documented oxygen per nasal cannula at 3 l/min continuous. Check O2 sat qshift. Goal to maintain O2 sats >90%. On 5/12/26 at 8:25 AM, Resident #18's medical chart for SpO2 monitoring documented the following:- 3/14/26 at 10:21, 81.0% Room air- 4/17/26 at 07:29, 84.0% Room air- 4/17/26 at 11:24, 88.0% Room airOn 5/12/26 at 9:03 AM, Resident #18's medical record had no documentation of nursing interventions related to the documented low SpO2.On 5/13/26 at 2:37 PM, the CRN stated Resident #18's medical record should have had nursing intervention documentation notes and did not.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review, policy review, and interviews, it was determined the facility failed to ensure residents' identifiable information was not accessible to the public. This was true for 1 of 1 resident (Resident #16) whose care plan was found to be in the Resident Council Meeting minutes. This deficient practice created the potential for residents to experience psychosocial harm due to loss of dignity and emotional distress. Findings include: The facility's policy titled Protected Health Information Uses and Disclosures of, dated 2001, policy stated, Protected health information will not be used or disclosed except as permitted by law. On 5/12/26 at 4:10 PM, the Resident Council Meeting minutes were reviewed. The Resident Council Meeting minutes included Resident #16's partial care plan with the focus on behavior goals and interventions, and a nursing department note with medical information about his feet, medication, and treatment refusals.On 5/12/26 at 4:18 PM, the Administer stated the Resident Council Meeting minutes binder was available to the public when they asked for it.On 5/12/26 at 4:30 PM, the Acting Director stated the Resident Council Meeting minutes binder was in her office and would be available to the public and who wanted to view it.