STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135090	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shaw Mountain of Cascadia	909 Reserve Street Boise, ID 83712

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 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 and staff interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person centered care plan, and the residents' choices. This was true for 3 of 8 residents (Resident #1, #2, and #4,) whose records were reviewed for quality of care. This failure created the potential for harm when residents were not reassessed to ensure the plan of care was effective, when physician orders were conflicting, and physician orders were not implemented or followed when ordered. Findings include:1.The American Heart Association website accessed 12/30/25, documented the following blood pressure categories: Normal: less than 120/ less than 80 Elevated: 120-129/ less than 80 Stage 1 hypertension: 130-139/ 80-89 Stage 2 hypertension: 140 or higher / 90 or higher Severe hypertension: Higher than 180 / higher than 120 Hypertensive emergency Higher than 180/ higher than 120 a) Resident #1 was admitted on [DATE] with multiple diagnoses including congestive heart failure and hypertension. Review of Resident #1's care plan, revised 11/26/25, directed staff to monitor and report to the physician any adverse changes in cardiac status, including: Chest pain or pressure Heartburn Nausea or vomiting Shortness of breath Excessive sweating (continued on next page)

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dependent edema Lung congestion Changes in capillary refill Abnormal vital signs Review of Resident #1's record documented the following blood pressure readings: 12/1/25: 187/75 12/2/25: 179/60 12/5/25: 148/74 12/13/25: 143/83 12/14/25: 194/89 b) Med-Health.net accessed 12/31/25 documented the following edema levels: 1+ 2mm or less: slight pitting, no visible distortion, disappears rapidly. 2+ 2-4mm indent: somewhat deeper pit, no readably detectable distortion, disappears in 10-25 seconds. 3+ 4-6mm: pit is noticeably deep. May last more than a minute. Dependent extremity looks swollen and fuller. 4+ 6-8mm: pit is very deep. Lasts for 2-5 minutes. Dependent extremity is grossly distorted. Review of Resident #1's MAR dated 12/1/25–12/22/25 documented 3+ edema on the following dates: 12/8/25 12/9/25 12/15/25 12/21/25 On 12/29/25 at 4:28 PM, a request for edema notification to provider was made and not provided. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/30/25 at 4:38 PM, the Director of Nursing (DON) confirmed that blood pressures above 180 are considered severely elevated. After reviewing Resident #1's record, the DON stated she was unable to locate documentation of reassessment related to the elevated blood pressures. She also confirmed the record did not include documentation of provider notification regarding the increased edema. The DON stated staff provided verbal notifications to the provider; however, this was not documented in the medical record. 2.The National Library of Medicine, accessed 12/31/25, documented that absent bowel sounds may be associated with serious complications including bowel obstruction, intestinal ischemia, paralytic ileus, or peritonitis, all of which require further clinical intervention. Resident #2 was admitted on [DATE] with multiple diagnoses including muscle weakness, retention of urine, and cognitive communication deficit. A nursing progress note dated 11/8/25 documented Resident #2 had a distended abdomen with absent bowel sounds and was administered Milk of Magnesia. On 12/29/25 at 5:09 PM, the survey team requested documentation of physician notification regarding Resident #2's condition. On 12/29/25 at 6:33 PM, the DON provided a nursing progress note dated 11/9/25, documenting Resident #2 had not had a bowel movement in over 72 hours and continued to have abdominal distention. The note documented the physician was notified, with no new orders received. On 12/30/25 at 4:50 PM, the DON stated that absent bowel sounds are considered an emergency. She confirmed the provider was not notified of the absent bowel sounds assessed on 11/8/25 until 11/9/25. 3. Resident #4 was admitted to the facility on [DATE] for care following sepsis (a life-threatening, extreme response to an infection that causes the immune system to damage the body's own organs and tissues) and multiple abscesses (pus-filled infected pockets of fluid) of of his liver. Upon his admission, Resident #4 had 3 drain tubes surgically placed in his abdomen to drain waste from the liver abscesses into collection bags outside his body. On 3/14/25, a drain check note from Interventional Radiology documented: Drain #1 was removed, drain #2 and #3 remain in place, re-check tubes in 7 to 10 days Empty drain bags daily and record output on each drain On 3/21/25, a drain check note from Interventional Radiology documented: Drain #2 removed, drain #3 remains, re-check tubes in 2 weeks If output is less than 10 ml for two consecutive days call interventional radiology to schedule a sooner check Flush with 5 ml sterile saline once daily (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #4's treatment administration record documented the following physician orders: Flush each drain daily with 10 ml of sterile saline up into the drain, release and let flow back out at bedtime, start date 3/13/25, discontinue date 3/24/25. Drain #2 and #3 remain in place. Empty drain bags daily and record output every day during day shift, start date 3/15/25, discontinue date 3/24/25. Drain tube check in 2 weeks, if output is less than 10 ml for two consecutive days call IR to schedule check sooner. Flush with 5 ml once daily, start date 3/22/25, discontinue date 3/24/25. a. On 1/30/25 at 5:03 PM, the DON stated, Resident #4's TAR had two conflicting orders, one to flush the drains with 10 ml of sterile saline, and one to flush the drains with 5 ml of sterile saline. She stated, the order to flush with 10 ml should have been discontinued on 3/21/25 when new orders were received. b. On 1/30/25 at 5:04 PM, the DON stated Resident #4 received new orders for his drain tubes on 3/14/25 and 3/21/25, and those orders were not implemented on the TAR until 3/15/25 and 3/22/25 respectively. She stated, the new orders should have been implemented the same day they were received, not the following day. c. On 1/30/25 at 5:06 PM, the DON stated Resident #4's record did not document the amount of fluid drained from his collection bags on 3/14/25, 3/16/25, and 3/17/25, and the nurses did not follow the physician order to record output.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on record review and staff interview, it was determined the facility failed to ensure sufficient staff were on-site to provide nursing services. This failure had the potential to affect all residents living in the facility and placed them at risk for harm if their call lights were not able to be answered in a timely manner or care was not provided due to not having adequate numbers of staff. Findings include:The facility Grievance Log was reviewed for July-December 2025, and documented the following:On 8/8/25, a resident reported long call light wait times. The facility completed call light audits and staff were provided education to answer call lights in a timely manner. On 8/15/25, a resident reported they were left soiled for 2 hours while their call light was on, once staff responded they seemed hurried. The facility provided one to one training to the CNA for answering call lights.On 8/22/25, a resident reported they used their call light for incontinence care, a CNA responded and turned off the call light, then said they would come help them with a shower, then did not return for 1 hour 15 minutes. The facility provided one to one education for the CNA and the CNA would not be assigned to work with that resident in the future. On 9/19/25, a resident representative reported their loved one had been wearing the same clothes all weekend. The facility provided education to staff for providing care and activities of daily living. On 11/3/25, a resident representative reported their loved one was observed to be in their recliner in their bedroom soiled with urine and stool. The facility provided education to staff to provide incontinence care every two hours. On 11/14/25, a resident representative reported their loved ones call lights were not being responded to. The facility provided education to all staff about answering call lights. On 12/10/25, a resident reported they waited 2 hours and 30 minutes to use the restroom because no staff were available to answer their call light. The facility did not address this concern. On 1/30/25 at 5:25 PM, the DON stated, call lights are a constant problem. She stated they do call light audits and education with the staff when concerns were brought to their attention. The DON stated the administrative staff were encouraged to answer call lights when they notice them. She added, the administration was struggling to find a solution to long call light wait times.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure resident records were accurately documented in accordance with professional standards of practice. This was true for 1 of 8 residents (Resident #4) whose records were reviewed for accuracy of resident records. This failure resulted in inaccurate clinical documentation. Findings include:Resident #4 was admitted to the facility on [DATE], for care following sepsis (a life-threatening, extreme response to an infection that causes the immune system to damage the body's own organs and tissues) and multiple abscesses (pus-filled infected pockets of fluid) of his liver. Upon his admission, Resident #4 had 3 drain tubes surgically placed in his abdomen to drain waste from the liver abscesses into collection bags outside his body. On 3/14/25, a drain check note from Interventional Radiology documented: Drain #1 was removed, drain #2 and #3 remain in place, re-check tubes in 7 to 10 days On 3/21/25, a drain check note from Interventional Radiology documented: Drain #2 removed, drain #3 remains, re-check tubes in 2 weeks Resident #4's progress notes from 3/11/25 through 3/24/25, documented the following: On 3/11/25 at 1:58 PM, in a Clinical Evaluation Summary note, Resident #4 had 3 drains to his liver. On 3/11/25 at 1:59 PM, in a Skin Inspection Note, Resident #4 had 3 drains to his liver in his left upper abdomen, On 3/13/25 at 1:01 AM, in a Health Status Note, Resident #4 had 3 drains to his liver. On 3/13/25 at 11:21 PM, in a Health Status Note, Resident #4 had 3 drains to his liver. On 3/14/25 at 10:07 AM, in a Health Status Note, Resident #4 had 3 drains to his liver and went to an appointment that day to check his drains. On 3/15/25 at 12:31 AM, in a Health Status Note, Resident #4 had 3 drains to his liver. On 3/17/25 at 4:49 AM, in a Health Status Note, Resident #4 had 3 drains to his liver. On 3/17/25 at 11:54 PM, in a Health Status Note, Resident #4 had 3 drains to his liver, both drains were flushed during the night shift. On 3/18/25 at 11:00 PM, in a Skilled Charting Note, Resident #4 had 3 drains to his liver that were drained in the evening (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/25 at 11:34 PM, in a Health Status Note, Resident #4 had 3 drains to his liver that are drained and flushed every evening, draining serous-bloody drainage, 25 ml from one drain, and 15 ml from the other. On 3/20/25 at 11:00 PM, in a Health Status Note, Resident #4 had 2 drains to his liver that were drained in the evening On 3/21/25 at 7:07 PM, in a Health Status Note, Resident #4 had an appointment that day for a drain check, drain #2 was removed and drain #3 remained. On 3/21/25 at 11:00 PM, in a Skilled Charting Note, Resident #4 had 2 drains to his liver, and one drain attached and patent, measured and recorded. On 3/22/25 at 8:49 PM, in a Health Status Note, Resident #4 had 2 drains to his liver, and one drain attached and patent, measured and recorded. On 3/23/25 at 5:09 AM, in a Health Status Note, Resident #4 had 2 drains to his liver, and one drain attached and patent, measured and recorded. On 3/24/25 at 11:26 AM, in a Health Status Note, Resident #4 had 1 drain to his liver and was preparing to discharge home. On 1/30/25 at 5:12 PM, the DON stated multiple progress notes documented the wrong number of drains and Resident #4's medical record documents were not accurate. She added, the nurses may have been copying and pasting their progress notes.