

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Aspen Park of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 420 Rowe 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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews it was determined the facility failed to ensure residents were able to use their personal property as needed. This was true for one of one resident (Resident #35) reviewed for residents' rights. This deficient practice created the potential for Resident #35 to experience a violation of her right to use her personal property, loss of trust in staff, and emotional distress when staff changed the orientation of the batteries in her remote control. Findings include: The facility's Quality of Life policy revised 6/4/25 documented The Resident has the right to retain and use personal possessions, including furnishings and clothing, as space permits, to promote homelike environment, unless to do so would infringe upon rights, health and/or safety of others. The Resident's personal property will be treated with respect.1. Resident #35 was admitted to the facility on [DATE] with multiple diagnoses including hypertension, hemiplegia and hemiparesis (paralysis and weakness on one side of the body) and aphasia (inability or impaired ability to understand or produce speech) following stroke.Resident #35's Quarterly MDS Assessment documented she was severely cognitively impaired.2. Resident #10 was admitted to the facility on [DATE] with multiple diagnoses including diabetes, congestive heart failure and hypertension.A Quarterly MDS assessment dated [DATE] documented Resident #10 was moderately cognitively impaired.Resident #35 and Resident #10 were roommates.On 7/21/26 at 9:21 AM, Resident #10 stated Resident #35's TV's volume was loud and kept her awake at night. Resident #10 stated she reported it to the nurse; the nurse turned the volume down but after a while her roommate would turn the TV's volume up. Resident #10 stated this happened every night and she kept calling the nurse to turn her roommate's TV's volume down.The following staff were interviewed on 7/22/26 via telephone:At 5:35 PM, CNA #2 stated Resident #10 would call a few times during her shift because Resident #35's TV was loud. CNA #2 stated she would come into their room and would turn the TV's volume down, Resident #35 would turn it up again, and Resident #10 would press her call light again for staff to lower the volume. CNA #2 stated sometimes she would flip Resident #35's TV batteries so Resident #35 would not be able to turn volume up. When asked what she meant by flipping the batteries, CNA #2 stated it was changing the orientation of the positive and negative ends of one of the batteries.At 5:46 PM, CNA #3 stated Resident #10 would press her call light because Resident #35's TV volume was loud. CNA #3 stated she would ask Resident #35 to use her headphones and explained that she needed to keep her TV volume down. CNA #3 stated Resident #35 did not like using her headphones. CNA #3 stated that she would flip Resident #35's remote batteries as the last resort.At 7:00 PM, CNA #4 stated Resident #10 was recently moved to her current room. CNA #4 stated Resident #10 slept at night but probably did not get the best sleep. When asked why Resident #10 was not getting the best sleep, CNA #4 stated because Resident #35's TV volume was loud at night. She stated Resident #10 would press her call (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, it was determined the facility failed to ensure residents were provided with a safe, comfortable, and homelike environment. This was true for one of one resident (Resident #10) reviewed for quality of life, whose sleep was affected by her roommate's loud television (TV) volume. This failure created the potential for Resident #10 to be deprived of sleep, affecting comfort and overall well-being. Findings include: The facility's policy titled, Homelike Environment, revised 9/17/25, described Comfortable Sound Levels as Noise levels that do not interfere with hearing, enhance privacy when desired, and encourage interaction during social activities. The facility's policy titled, Quality of Life, revised 6/4/25, documented the facility was committed to providing a safe, comfortable, and enriching environment that supports the physical, mental, and psychosocial health of each resident. Resident #10 was admitted to the facility on [DATE] with multiple diagnoses including diabetes, congestive heart failure and hypertension. A Quarterly MDS assessment dated [DATE], documented Resident #10 was moderately cognitively impaired. On 7/21/26 at 9:21 AM, Resident #10 stated her roommate's television was loud and kept her awake at night. Resident #10 stated she reported it to the nurse; the nurse turned the volume down but after a while Resident #35 (her roommate) would turn the TV's volume up. Resident #10 stated this happened every night and she kept calling the nurse to turn Resident #35 TV's volume down. On 7/22/26 at 3:56 PM, Resident #10 stated she pressed her call light about 3-4x to ask the nurse to turn Resident #35's TV volume down. Resident #10 stated she heard the nurse saying that they were tired of coming back and forth to their room, so the nurse turned the TV off. On 7/23/26 at 8:44 AM, the Surveyor informed the LMSW regarding Resident #10's ongoing concern with Resident #35's TV volume being loud at night and disturbing her sleep. The LMSW stated she was not aware of Resident #10's concern and was only made aware of it that morning when LPN #3 reported it to her. The LMSW further stated staff should have completed a grievance form regardless of whether the resident requested to fill one out, and should have notified management of Resident #10's concern. She also stated the facility maintains a communication board where staff may enter residents' concern, which they review before their morning meeting/huddle.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 records, policy review, and resident and staff interviews, it was determined the facility failed to ensure an ongoing resident's concern was recognized and addressed as a grievance. This was true for one of one resident (Resident #10) whose ongoing concern regarding her roommate's TV volume was not addressed. This deficient practice had the potential to negatively affect Resident #10's quality of life and satisfaction with care. Findings include: The facility's policy titled, Grievance Process, revised 8/29/25, documented the Grievance program was utilized to address the concerns of residents, family members and visitors, and the facility should make prompt efforts to resolve grievances. Any associate can assist in the completion of a Grievance form if a resident, family member, or guest expresses concern or comment. 1. Resident #10 was admitted to the facility on [DATE], with multiple diagnoses including diabetes, congestive heart failure and hypertension. A Quarterly MDS assessment dated [DATE], documented Resident #10 was moderately cognitively impaired. 2. Resident #35 was admitted to the facility on [DATE] with multiple diagnoses hypertension, hemiplegia and hemiparesis (paralysis and weakness on one side of the body) and aphasia (inability or impaired ability to understand or produce speech) following stroke. Resident #35's Quarterly MDS Assessment documented she was severely cognitively impaired. Resident #10 and Resident #35 were roommates. On 7/21/26 at 9:21 AM, Resident #10 stated Resident #35's TV volume was loud and kept her awake at night. Resident #10 stated she reported it to the nurse; the nurse turned the volume down but after a while Resident #35 would turn the TV's volume up. Resident #10 stated this happened every night and she kept calling the nurse to turn Resident #35 TV volume down. On 7/22/26 at 3:56 PM, Resident #10 stated she pressed her call light about 3-4x to ask the nurse to turn Resident #35's TV volume down. Resident #10 stated she heard the nurse saying that they were tired of coming back and forth to their room, so the nurse turned the TV off. The following staff were interviewed on 7/22/26 via telephone: At 5:18 PM, LPN #2 stated Resident #10 was normally awake at night, and that sometimes she slept and sometimes did not because Resident #35 TV volume was a little loud. LPN #2 stated they had spoken to Resident #35 to keep her TV volume down. LPN #2 further stated Resident #10 would complain about Resident #10's TV volume being loud once or twice during her night shift. LPN #2 stated she would normally enter the resident's concern on their communication board, but probably she did not enter Resident #10's concern because she was able to address and resolve it during her shift. When asked what the communication board was, LPN #2 stated it was an entry the nurses made into their electronic health record system that would be reviewed every morning during the management meeting. At 5:35 PM, CNA #2 stated Resident #10 would call a few times during her shift because Resident #35's TV was loud. CNA #2 stated she would come into their room and would turn the TV's volume down, Resident #35 would turn it up again, and Resident #10 would press her call light again for staff to lower the volume. CNA #2 stated sometimes she would flip Resident #35's TV batteries so Resident #35 would not be able to turn volume up. When asked what she meant by flipping the batteries, CNA #2 stated it was changing the orientation of the positive and negative ends of one of the batteries, so even though she press the remote control the volume would be the same. CNA #2 stated she usually informed the nurse about Resident #10's concern with Resident #35's TV being loud at night. CNA #2 also stated if she was assigned to 300 Hall, Resident #10 would press her call light 90 percent of the time to ask staff to turn down Resident #35's TV volume down. At 5:46 PM, CNA #3 Resident #10 would press her call light because Resident (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	35's TV volume was loud. CNA #3 stated she would ask Resident #35 to use her headphones and explained that she needed to keep her TV volume down. CNA #3 stated Resident #35 did not like using her headphones. CNA #3 further stated Resident #35 liked the remote control within her reach, so she would flipped the batteries as the last resort and the TV's volume could not be changed. At 7:00 PM, CNA #4 stated Resident #10 was recently moved to her current room. CNA #4 stated Resident #10 slept at night but probably did not get the best sleep. When asked why Resident #10 was not getting the best sleep, CNA #4 stated because Resident #35's TV volume was loud at night. She stated Resident #10 would press her call light and she would speak with Resident #35 and explain that she needed to turn the TV volume down. CNA #4 stated that Resident #35 would turn up the volume back up again, causing Resident #10 press her call light again. When asked if she reported Resident #10 to the nurse, CNA #4 stated Yes, I did. CNA #4 stated the nurse ask her to talk to Resident #35 that after 10:00 PM it was a quiet time. CNA #4 stated the last resort was to flip the batteries in the remote control so that the volume could not be increased, even if Resident #35 pressed the volume. At 8:05 PM, RN #1 stated Resident #10 told her about Resident #35's TV volume being loud when she came to work in the morning. RN #1 stated Resident #10 told her the nurse would come in and turn Resident #35's TV volume down, but Resident #35 would turn it up again once the nurse left the room. RN #1 stated she would enter Resident #10's concern in their communication board if it was an ongoing concern. On 7/23/26 at 8:33 AM, LPN #3 stated she was on duty the night before. LPN #3 stated Resident #10 expressed concern regarding Resident #35's TV volume being loud. She stated a CNA would come to turn the volume down, but Resident #35 would turn it up again. LPN #3 stated she went to the room and explained to Resident #35 the quiet time was after 10:00 PM. When asked what time it was when she spoke to Resident #35, LPN #3 stated it was probably between midnight and 1:00 AM, and Resident #10 did not press her call light again after that. When asked if this was a grievance, LPN #3 stated she did not think it was a grievance because the concern was addressed and resolved during her shift. LPN #3 stated if it was an ongoing concern, she would inform the management. On 7/23/26 at 8:44 AM the Surveyor informed the LMSW regarding Resident #10's ongoing concern with Resident #35's TV volume being loud at night and disturbing her sleep. The LMSW stated she was not aware of Resident #10's concern and was only made aware of it that morning when LPN #3 reported it to her. The LMSW stated, LPN #3 had addressed and resolved the issue the previous night. When asked whether Resident #10's concern constituted a grievance, the LMSW stated yes, it was grievance. When asked why the staff had not considered Resident #10's concern as a grievance, the LMSW stated probably because it was resolved at the time it occurred. She stated if it was an ongoing issue, it would be considered a grievance. The LMSW further stated staff should have completed a grievance form regardless of whether the resident requested one and should have notified management of Resident #10's concern. She also stated the facility maintained a communication board where staff may enter residents' concerns, which they review before their morning meeting/huddle.		

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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 policy review, record review, and interviews, it was determined the facility failed to ensure residents' care plan interventions were implemented as written. Specifically, staff did not follow the resident's care plan regarding the management of his hearing aid and the required storage of his smoking paraphernalia. This was true for 1 of 1 resident (Resident #36) whose care plan was reviewed. This failure created the potential for unmet needs, safety concerns, and a decline in Resident #36's physical and psychosocial well-being. a. Resident #36 was admitted to the facility on [DATE], with multiple diagnoses including unspecified hearing loss, stroke, and hypertension. Resident #36's Quarterly MDS assessment dated [DATE], documented, in Section B- Hearing, Speech, and Vision, regarding Resident #36's hearing, had moderate difficulty -speaker has to increase volume and speak distinctly. It also documented there was no hearing or other hearing appliance used in completing the assessment. Resident #36's care plan, initiated 2/20/26, documented she had hearing impairment related to bilateral moderate to severe sensorineural hearing loss. The intervention included Offer [Resident #36] adaptive equipment of headset/amplifier as she accepts. On 7/21/26 at 9:16 AM, Resident #36 was lying in bed and awake. Resident #36 was asked two times how she was doing, Resident #36 replied, I can't hear you. The Surveyor then typed on the laptop in bold, size-28 font: Have you eaten your breakfast? Resident #36 looked at the computer screen but did not respond. The Surveyor typed Do you have a hearing aid? and asked the question while showing Resident #36 the screen. Resident #36 again stated I can't hear you. No headset/amplifier was observed in Resident #36's room. On 7/21/26 at 9:35 AM, the CNO stated Resident #36 had an audiology appointment in 2/2025 and she was not a candidate to use hearing aid. An Audiologist Comprehensive Hearing Evaluation dated 3/27/25, documented Resident #36 had bilateral moderate to severe sensorineural hearing loss between 250Hz - 8000Hz with poor word recognition ability. The Audiologist recommended that Resident #36 use an assistive device, such as a Pocket Talker, to help improve her communication ability. The Audiologist also recommended that Resident #36 use Caption Call Phone which would allow her to read the conversation on a screen when conversing over the phone. A Nursing Note dated 6/25/26 documented Spoke with [Resident #36] regarding [Resident #36's son] concern for her hearing and dentures. Reminded [Resident #36] of a previous audiologist appointment where they stated hearing aides would not be beneficial at this time and stated they suggested hearing amplifiers which [Resident #36] previously declined to use. On 7/22/26 at 10:03 AM, the Activity Director (AD) with the MDS Nurse present, showed the Personal Sound Amplifier, which the MDS Nurse stated was the Pocket Talker. The AD stated Resident #36 tried it about nine months ago and again on 6/30/26, but she refused to use it. The AD also stated Resident #36 tried to use the headphones but did not like them due to too much background noise. When asked about the documentation that Resident #36 tried the Pocket Talker and headphones, the AD stated, Unfortunately I did not document a progress note. On 7/23/26 at 9:33 AM the MDS Nurse, in the presence of the CNO and CEO, stated the Pocket Talker and headphones were not in Resident #36's room due to her refusal to use them. b. A care plan initiated 4/13/22 documented Resident #36 had been assessed as an independent smoker, and her smoking paraphernalia were stored in a lock box in her room. A Smoking Evaluation dated 5/4/26 documented Resident #36 was an independent smoker/nicotine user. Her smoking paraphernalia were stored in a lock box in her room. On 7/21/26 at 3:38 PM, CNA #5 was observed wheeling Resident #36 to the smoking area. Resident #36 had a small (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	black shoulder bag with her. At the smoking area Resident #36 was observed taking a cigarette from the bag. She then took a lighter from the bag and lit the cigarette. On 7/22/26 at 8:42 AM Resident #36 was sleeping. The small black bag was observed hanging on the side of her overbed table. On 7/22/26 at 9:10 AM the MDS Nurse stated residents assessed as independent smokers were provided with a lock box to store their smoking paraphernalia and were given a code to open the box. The Surveyor asked the MDS Nurse to verify where Resident #36 was storing her smoking paraphernalia. In Resident #36's room, the MDS Nurse asked Resident #36 Where is your lock box? Resident #36 replied, What? The MDS Nurse repeated the question, Where is your lock box for your cigarettes? Resident #36 then retrieved a small bag hanging from the side of her overbed table and took a cigarette from the bag. The Surveyor asked the MDS Nurse to ask Resident #36 where her lighter was. The MDS Nurse asked Resident #36 Is the lighter in your purse? Resident #36 took the lighter from the same bag and showed it to the MDS Nurse. The MDS Nurse stated she would provide Resident #36 a lock box to store her smoking paraphernalia. On 7/22/26 at 9:26 AM, the MDS Nurse stated it was appropriate for Resident #36 to store her smoking paraphernalia in a lock box to keep it safe from other residents.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, observations, and staff interviews, the facility failed to ensure indwelling catheter care was implemented for 1 of 1 resident (Resident #19) whose records were reviewed for catheter care. This failure created the potential for Resident #19 to not receive appropriate catheter care to his suprapubic catheter. Findings include: Review of the facility policy titled, Indwelling Catheters, revised 9/25/25 documented, 1. An indwelling catheter is used only when a resident's clinical condition demonstrates that catheterization is necessary. Care and treatment are provided to help the resident restore their highest level of normal bladder function as possible and to reduce catheter associated complications such as a urinary tract infection .andf. Unobstructed urine flow and drainage bag positioning below the level of the bladder is maintained with drainage bag and tubing off the floor. Resident #19 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses that included heart attack, benign prostatic hyperplasia (BPH is a non-cancerous enlargement of the prostate gland) without lower urinary tract symptoms, and presence of urogenital (referring to the urinary and reproductive organs) implants. An admission MDS assessment dated [DATE] documented Resident #19 was assessed to be cognitively intact. The Comprehensive Care Plan dated 7/7/26 documented Resident #19 had a chronic suprapubic catheter with interventions to secure the catheter bag and tubing with a leg strap and to follow physician orders. On 7/20/26 at 12:40 PM, an observation was made during lunchtime meal service in the dining room. Resident #19 was observed to be sitting at the table in a wheelchair where his catheter bag with a privacy cover was affixed to the left side. The catheter tubing was observed to be draped on the ground under the wheelchair. On 7/21/26 at 9:06 AM, an observation was made of Resident #19 receiving in-room therapy services. The therapy staff member was observed holding his catheter bag in an ungloved hand and the catheter tubing was draped on the ground when assisting Resident #19 back into bed. On 7/22/26 at 12:03 PM, the CNO stated indwelling devices, including catheters, require Enhanced Barrier Precautions (EBP) in which staff use gown and gloves for high contact care and expects staff to adhere to the isolation precautions. The CNO stated she expects staff to ensure catheter bags and tubing to not touch the floor because the system could become contaminated. The CNO further stated there are typically as needed orders to change an indwelling catheter for various reasons including breaks in infection control and would have Resident #19's catheter changed.		

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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, resident and staff interviews, and record review, it was determined the facility failed to ensure 1 of 2 residents (Resident #44) received oxygen via nasal cannula as prescribed by the physician. This deficient practice created the potential for Resident #44 to experience respiratory difficulties or impaired breathing. Findings include: The facility's policy titled, Oxygen Administration, Safety, Storage & Maintenance, revised 10/10/25, documented, The facility will administer, store, and maintain supplemental oxygen safely in accordance with current standards of practice and licensed practitioner orders. Resident #44 was admitted on [DATE] with multiple diagnoses including COPD, respiratory failure (a life-threatening medical condition where your lungs cannot pass enough oxygen into your blood, or they cannot remove enough carbon dioxide from your body), and dependence on supplemental oxygen. An admission MDS assessment dated [DATE], documented Resident #44 was cognitively intact. Resident #44 physician's orders included the following: -Oxygen at 2 LPM via nasal cannula as needed, dated 5/15/26. On 7/20/26 at 4:30 PM, observed nasal cannula in Resident #44's nares, and the oxygen concentrator was turned off. On 7/20/26 at 4:33 PM, CNA #1 confirmed the concentrator was turned off, and then turned it on. Resident #44 told LPN #1 and the Surveyor she had checked her oxygen saturation with her own personal pulse/oximeter monitor and her oxygen saturation was 82% immediately after the oxygen concentrator had been turned on. On 7/20/26 at 4:37 PM, the Surveyor asked LPN #1 to check Resident #44's oxygen concentrator, she stated it was on and delivering oxygen at 2 LPM. Resident #44 stated right before surveyor and LPN #1 returned to the room to check the oxygen concentrator, she had checked her oxygen saturation again and it had risen to 90%. PubMed Central, accessed 7/28/26, documented, For patients with chronic obstructive pulmonary disease (COPD), the recommended target oxygen saturation range is 88% to 92%. On 7/20/26 at 4:37 PM LPN #1 stated, Resident #44 had a medical appointment earlier in the day and whoever brought her back to her room probably forgot to turn the concentrator on. On 7/23/26 at 10:48 AM, the CNO stated when a resident who requires oxygen is brought back to the room, the CNA is allowed to put the nasal cannula on the resident and turn on the concentrator. She further stated, the CNA who brought Resident #44 back to the room should have put the nasal cannula on her and turned on the concentrator.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Aspen Park of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 420 Rowe 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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure a resident was adequately monitored for medication side-effects. This was true for 1 of 6 residents (Resident #37) whose records were reviewed for unnecessary medications. This failure placed Resident #37 at risk for harm if they were to suffer from side-effects of a medication due to a lack of monitoring. Findings include: Resident #37 was admitted to the facility on [DATE] with multiple diagnoses including dementia and heart failure. Resident #37's record included the following physicians' orders: -Mirtazapine oral tablet, (an antidepressant frequently prescribed for appetite stimulation) Give 7.5 MG by mouth one time a day for appetite, start date: 5/19/26 -Hydrocodone-Acetaminophen oral tablet 7.5-325 MG (an opioid pain medication) Give 1 tablet by mouth two times a day for pain, start date: 5/28/25 Resident #37's care plan directed staff to monitor for the following side effects: -Monitor/document effectiveness and potential side effects. Opioid/Narcotic Side-Effects: over-sedation/lethargy, constipation, respiratory depression, nausea and/or vomiting, increased depressed mood, restless agitation, itching/sweating/shaking, change in gait, increased tolerance/pain sensitivity, vital sign changes, headache, date initiated: 2/25/25 -Monitor/document effectiveness and potential side effects. Antidepressant Side-Effects: over-sedation/lethargy, restless agitation, increased confusion/poor concentration, mental status changes, visual disturbances, change in gait/extrapyramidal symptoms (involuntary movements), nausea and/or vomiting, vital signs changes, constipation, urinary retention, headache, weight change, date initiated: 5/18/26 Resident #37's record did not include documentation side effects were being monitored for the use of an antidepressant and an opioid medication. On 7/22/26 at 12:05 PM, the CNO stated, there were not side effect monitors in place for Resident #37's opioid and antidepressant medications and there should have been.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Aspen Park of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 420 Rowe 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, observations, and staff interviews it was determined that the facility failed to ensure completed medications were properly discarded for 1 of 2 medication carts reviewed. This failure created the potential for medication errors to occur. Findings include: Review of the facility policy titled, Medication Storage and Labeling, revised 10/13/25 documented that, expired or discontinued medications must be removed promptly and disposed of per facility policy. Resident #23 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses which included unspecified depression and unspecified anxiety disorder. A completed physician's order for sertraline hydrochloride (HCl) oral tablet (antidepressant) with a start date of 4/18/26 and end date of 5/18/26 documented to administer 25 mg by mouth 1 time a day related to depression for 30 days. A Quarterly MDS assessment dated [DATE] documented Resident #23 was assessed to be cognitively intact. The MDS further documented in Section I - Active Diagnoses, that Resident #23 had depression and anxiety. Further review of the MDS, Section N - Medications, Resident #23 was not being treated with antidepressant or anti-anxiety medications. On 7/23/26 at 11:39 AM an interview and observation of the 300-Hall medication cart was conducted with RN #1. RN #1 pulled Resident #23's medications for review, where one blister package of sertraline HCl 25 mg oral tablet was observed in the medication cart. The blister package had nine green tablets left in the package and an order date of 4/17/26 with orders to administer one 25 mg tablet by mouth one time a day for 30 days. RN #1 stated Resident #23's sertraline HCl 25 mg should have been removed from the medication cart after the last dose. RN #1 stated it is the nurse on the medication cart's responsibility to discard any discontinued or expired medications as soon as they are made aware but stated that medications are not always removed timely. RN #1 further stated that after orders are discontinued or completed the medications should be removed from the medication cart to prevent potential medication errors. On 7/23/26 at 3:37 PM, an interview was conducted with the CNO, and the CEO, CRN, and Administrator-in-Training (AIT) were present. The CNO stated that medications should be immediately removed from the medication cart when they are expired, discontinued, or completed. The CNO further stated it is the nurse on the medication cart's responsibility to remove old or expired medications. The CNO stated removing discontinued or completed medications from the carts is to reduce the risk of medication errors. The CNO stated that completed medications being left in the cart for over two months past the order completion date was not acceptable.		