STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135095	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherry Ridge of Cascadia	501 West Idaho Boulevard Emmett, ID 83617

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of The Long-Term Care Agency reporting portal, facility's incident report, record review and staff interview it was determined the facility failed to conduct a thorough investigation into an allegation of abuse. This was true for 1 of 3 residents (Resident #7) whose record was reviewed for Abuse and Neglect. This failure created the potential for undetected harm due to incomplete investigative procedures. Findings include:Resident #7 was admitted to the facility on [DATE], with multiple diagnoses including schizophrenia, auditory hallucinations, and chronic pain syndrome.On review of The Long-Term Care Agency reporting portal an incident dated 1/3/25 was reported. The incident documented Dietary Aide #1 and Dietary Aide #2 provided Resident #7 with THC (tetrahydrocannabinol) gummies; a psychoactive substance derived from cannabis. On review of the facility's incidents and accidents, a report initiated on 1/3/25 was located documenting the following investigation:On 1/3/25, the previous CEO was informed Dietary Aide #1 and Dietary Aide #2 had provided Resident #7 with THC gummies. The investigation included an interview from Resident #7 stating he had jokingly asked the staff if they could get him THC gummies to help him sleep. Later, Dietary Aide #1 and Dietary Aide #2 provided Resident #7 with 1 gummy on 2 separate occasions. The investigation included two dietary unidentified staff interviews both concluding Dietary Aide #1 and Dietary Aide #2 had provided THC gummies to Resident #7. The investigation also included 3 resident interviews; all residents were asked the following questions: Do you feel safe in the facility? Do you have concerns regarding the safety of other residents? Do you have any concerns with staff or visitors?However, none of the residents were asked questions specifically related to the incident involving THC or other drug-related concerns.On further review of the investigation, it was identified the facility terminated Dietary Aide #1 and Dietary Aide #2 as a result of the investigation. Therefore, substantiating the allegation.On 8/5/25 at 3:06 PM, on review of the abuse and neglect investigation dated 1/3/25, the CEO stated if she was the one conducting the interview she would have interviewed residents with questions that addressed the issue instead of using generic safety questions.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of the Resident Assessment Instrument (RAI) Manual, record review, and staff interview, it was determined the facility failed to ensure a residents Minimum Data Set assessment included correct information. This was true for 1 of 3 residents (Resident #6) whose records were reviewed for accuracy of assessments. This deficient practice had the potential for negative consequences if residents were not monitored due to inaccurate assessments. Findings include: The RAI Manual, revised 10/1/24, documented section A1500, PASRR (Preadmission Screening and Resident Review), was to be coded yes when a PASRR level II screening determined a resident had a serious mental illness and/or intellectual disability, or related condition.Resident # 6 was admitted to the facility on [DATE], with multiple diagnoses including major depressive disorder, anxiety disorder, and alcohol dependance. Resident #6's admission MDS Assessment, dated 10/21/24, documented under A1500 in Section A, no for the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?However, there was a PASRR Level II observed in his electronic medical record, dated 10/18/24.On 8/6/25 at 5:26 PM, the Director of Clinical Services stated, Yes, the MDS was coded inaccurately.

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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 record review and staff interview, it was determined the facility failed to refer residents with a diagnosed mental disorder to the appropriate state-designated authority for an evaluation and determination. This was true for 3 of 3 residents (#5, #6, and #8), reviewed for PASRR level I evaluations. This deficient practice had the potential to cause harm if resident's specialized services for mental health needs were not evaluated by an appropriate state-designated authority. Findings include: 1. Resident #5 was admitted to the facility on [DATE], with multiple diagnoses including multiple sclerosis, Alzheimer’s disease, and depression. The Change in Status MDS Assessment, dated 6/30/25, did not document Resident #5 had a PASRR level II. Resident #5’s PASRR level 1, dated 1/15/24, did not include documentation of Resident #5's depressive disorder, although it did document Resident #5 was taking Trazadone (an antidepressant) 50 milligrams at bedtime. On 8/6/25 at 5:15 PM, the Social Services Director stated Resident #5 did not have a PASRR level II, and there should have been one. 2. Resident #8 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including quadriplegia, depression, and anxiety. The admission MDS Assessment, dated 6/30/25, did not document Resident #8 had a PASRR level II. Resident #8’s PASRR level 1, dated 1/7/25, did not include documentation of Resident #8's diagnoses of depression and anxiety. A PASRR level 1, dated prior to readmission on [DATE] was not provided by the facility. On 8/5/25 at 9:31 AM, the Social Services Director stated Resident #8's PASRR level 1 should have been reviewed for accuracy, and a PASRR level II completed, and it was not. 3. Resident #6 was admitted to the facility on [DATE], with multiple diagnoses including major depressive disorder, anxiety disorder, and alcohol dependance. A PASRR Level 1 pre-admission screening, dated 10/17/24, documented Resident #6 had a mild or situational depression. However, the assessment did not include documentation of Resident #6 having a major depression disorder or anxiety. On 8/6/25 at 5:01 PM, the Social Services Director stated Resident #6’s PASRR Level 1 pre-admission screening should have been completed to accurately reflect his diagnosis of major depression and anxiety disorder.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, record review and staff interview, it was determined the facility failed to ensure nurse staffing information was accurate with hours 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:From 8/4/25 through 8/6/25 it was observed the nurse staffing information did not include the number of hours worked per shift for registered nurses, licensed practical nurses, and certified nursing assistants.On 8/6/25 at 10:30 AM, the Staffing Coordinator stated the hours worked for nursing staff were not posted for the number of covered positions on the daily staff postings. The hours should have been posted.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, record review, and staff interview it was determined the facility failed to ensure significant medication errors were prevented. This was true for 3 of 3 residents (#2, #3, and #17) whose records were reviewed for significant medication errors. These findings created the potential for increased pain and adverse outcomes when medication was not administered according to the resident's physician order. Findings include:The facility’s Medication Errors policy, revised on 8/1/23, documented the following: A medication error is observed or identified when the observation or administration of drugs are not in accordance with: Prescriber’s Orders Manufacture’s specification regarding the preparation and administration of the drug or biological. Accepted professional standards and principles that apply to the professional providing services. 1. Resident #2 was admitted to the facility on [DATE], with multiple diagnoses including chronic pain, absence of left hip joint, and flexion deformity of left shoulder. A physician’s order dated 6/18/25, directed staff to administer Morphine sulfate concentrate (an opioid pain medication) give 0.4 milliliters by mouth every 6 hours for chronic pain. An incident report dated 6/6/25, documented Resident #2 did not receive his bedtime morphine medication because LPN #2 forgot to get the medication out of the narcotic drawer. The report documented LPN #2 was assisting another resident and forgot it get it. It also documented Resident #2 was alert and oriented and was able to verbalize a pain level of a 4 out of 10. A nurse’s progress note dated 6/6/25, documented Resident #2 was monitored for adverse side effects of missing medication. The note included documentation Resident #2 stated he was not in pain. The investigation included a statement dated 6/9/25, documenting LPN #2 stated he forgot to pull the medication for Resident #2 when he got busy with another resident. On 8/5/25 at 6:00 PM, the DON stated LPN #2 identified the medication error at the end of shift during a narcotic count with another nurse. She also stated LPN #2 was not provided with any training as this was his first offence. 2. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including back pain, osteoarthritis (a type of degenerative joint disease that results from breakdown of joint cartilage and underlying bone) of the left and right shoulder, and age-related osteoporosis(a progressive bone disease characterized by decreased bone density and increased fragility, leading to a higher risk of fractures.) (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician’s order dated 4/29/25, directed staff to administer Oxycodone (an opioid pain medication) 10 milligrams; give 1 tablet by mouth every 4 hours for chronic pain. An incident report dated 7/1/25, documented Resident #3 did not get her oxycodone during the 7:00 PM medication pass because LPN #2 forgot to administer it. The incident report documented Resident #3’s first pain level was a 6 out of 10. The second pain level was documented as 7 out of 10. The investigation included the following immediate action taken: Resident #3 was monitored for adverse side effects and monitored for signs and symptoms of withdrawal. No adverse findings were identified. Documentation of LPN #2’s competencies were requested and a check list titled “Medication Administration Oral” was provided. The list included procedure steps on the following topics: Medication preparation rights, medication administration, medication documentation rights, and medication refusal. The training was noted to have LPN #2’s name written in with “-phone” next to it. It was unclear if the training was provided over the phone. On 8/4/25 at 3:50 PM, the DON stated LPN #2 was overwhelmed because so many residents were waiting around the medication cart that he forgot to give Resident #3 her oxycodone. 3. Resident #17 was admitted to the facility on [DATE], with multiple diagnoses including type 2 diabetes and morbid obesity. A physician’s order, dated 6/6/25, documented Resident #17 was to receive Insulin Aspart subcutaneous solution pen-injector 100 unit/milliliters. Inject as per sliding scale: 0-150 = 0 units 151 – 200 = 2 units 201 – 250 = 4 units 251 – 300 = 6 units 301 – 350 = 8 units 351 – 400 = 10 units 401 + = 12 units *Call physician for further directions, subcutaneously two times a day for type 2 diabetes. On 7/2/25, Resident #17's blood sugar measured 159 at 8:00 PM. On review of the Medication Administration Record (MAR) dated 7/2/25, Resident #17's record did not include documentation of insulin given by LPN #2. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/5/25 at 3:11 PM, during a review of Resident #17's MAR with the CEO and CNO, it was determined there was no documentation Resident #17 had received her sliding scale insulin as ordered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 observation and staff interview it was determined the facility failed to ensure medications available for residents were labeled and dated. This was true for 1 of 2 medication carts inspected. This failure created the potential to receive expired medication with decreased efficacy. Findings include:On [DATE] at 9:03 AM, during a medication cart inspection the following medication was located with no open date or date of discard: Erythromycin ophthalmic ointment 5 milligram Trelegy Ellipta inhaler 62.5 microgramOn [DATE] at 09:06 AM, LPN #1 stated she was not sure how long the ophthalmic ointment was good for. She also stated both medications should have been labeled with the open date.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, record review, and staff interview, it was determined the facility failed to ensure food was stored appropriately, dated, and not contaminated by ice, and the kitchen was clean and free of pests. These deficiencies had the potential to affect the 31 residents who consumed food prepared by the facility. This placed residents at risk for potential contamination of food and adverse health outcomes, including food-borne illnesses. Findings include: 1. The FDA Food Code Section 3-303.12 documented packaged food may not be stored in direct contact with ice or water if the food is subject to the entry of water because of the nature of its packaging, wrapping, or container or its positioning in the ice or water. On 8/4/25 at 8:20 AM, and on 8/7/25 at 11:15 AM, freezer icicles were observed in the vegetable and dough freezer stuck to the back of the fridge. Ice was stuck to the shelves containing boxes of food, opened and unopened, with ice dripping down through the shelves onto additional boxes of opened and unopened food. On 8/7/25 at 11:17 AM, the Dietary Manager stated the issue with the dripping water had been looked at by a third-party vendor two weeks prior. She did not provide an answer why the food continued to have ice build-up or why the freezer was still in use. 2. The FDA Food Code Section 3-305.11 Food Storage documented, food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. On 8/4/25 at 8:25 AM, and on 8/5/25 at 11:00 AM, the following was observed in the dry-food pantry: -A bag of flour was stored under the shelves.-Large cans of butterscotch pudding were stored on the floor. -Large cans of diced, red pimientos, and diced green chili peppers were stored on the floor. On 8/5/25 at 11:05 AM, the Regional CDM stated the flour and canned food should not be stored on the floor of the pantry; it should be stored at least 6 inches off the floor. 3. The FDA Food Code Section 3-501.17 Ready-to-Eat, TCS (time/temperature control for safety) Food documented, date marking, should be done on 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. On 8/4/25 at 8:15 AM, during the initial kitchen walk-through, the following was observed:-In the dough/fry freezer multiple packages of undated cookies, undated and open egg omelets, and husked corn cobs were exposed. -In the meat freezer a Core water bottle was stored on its side and had been opened, undated, and not identified as staff or resident water. On 8/7/25 at 11:25 AM, the Dietary Manager stated she did not know why Core water was stored in the resident's refrigerator. She was unaware there was undated food in the dough/fry freezer. 4. The FDA Food Code Section 4-602.11 Equipment Food-Contact Surfaces and Utensils documented: (E) Surfaces of utensils and equipment contacting food that is not time/temperature control for food shall be cleaned: On 8/5/25 at 12:50 PM, a layer of dust was found on the wall mounted knife rack located on the hallway wall outside of the dishwashing room. On 8/5/25 at 12:52 PM, the Dietary Manager stated she did have a cleaning schedule for the kitchen, but the knife rack was not listed on it, and it should have been added to it as it was visibly dusty. 5. 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. On 8/4/25 at 8:35 AM, and 8/5/25 at 12:15 PM, 3 skillets and 4 baking sheets were observed with black encrusted residue. On 8/5/25 at 12:45 AM, the Dietary Manager stated she was aware there were encrusted pans in the kitchen, but she had not been directed to remove them or order replacements. When she was asked who would have directed her, the Dietary Manager stated in February or March 2025, the Administrator was informed, and she was still waiting for new pans. 6. The FDA Food Code Section 4-803.11 Storage of Soiled Linens documented, soiled linens shall be kept in clean, nonabsorbent receptacles or clean, washable laundry bags and stored and transported to prevent contamination of food, clean equipment, clean utensils, and single-service and single-use articles. On 8/7/25 at 11:35 PM, it was observed in the dishing washing area 2 aprons used for washing dishes were covered with food particle residue and hanging on the wall inside the dishroom. On 8/7/25 at 11:40 AM, the Dietary Manager stated she was not aware her dishwasher was using the aprons, nor had she had them washed as there were disposable aprons the staff were supposed to be using. 7. The FDA Food Code Section 6-501.111 Controlling Pests documented, the premises shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the premises by: (A) Routinely inspecting incoming shipments of food and supplies; (B) Routinely inspecting the

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interview, it was determined the facility failed to implement effective infection control practices during medication administration and shower room sanitation. This failure created the potential to affect all residents who reside in the facility due to risk for cross-contamination and adverse outcomes. Findings include:1. On 8/6/25 at 9:57 AM, during an inspection of Shower room [ROOM NUMBER] with the Director of Maintenance, the following environmental concerns were observed:The shower floor, specifically the area where residents stand during bathing, lacked grout between the tiles. Black mold-like substances were visible along the bottom edges of the shower walls.An adhesive trim affixed to the lower portion of the shower walls was peeling away. Upon closer inspection, the underside of the peeling adhesive trim also showed the presence of black mold-like material extending along the edge of the wall.On 8/6/25 at 9:57 AM, the Director of Maintenance stated the lack of grouting created uneven and potentially unsanitary conditions.On 8/7/25 at 12:25 PM, the CEO stated the facility did not have a log of who is responsible for cleaning the shower rooms, but they should be cleaned daily. 2. On 8/5/25 at 9:11 AM, during a medication administration observation the following was observed:LPN #1 was observed preparing to administer a subcutaneous injection. She performed hand hygiene and gathered her supplies. LPN #1 then proceeded to walk to the residents' room knocked on the door and entered the room. She greeted the resident then walked over to the sink to perform hand hygiene. LPN #1 took the injectable pen and two alcohol wipes and placed then on the ledge of the sink. No observation of the use of sanitary barrier was observed. She washed and dried her hands and proceeded to take the injectable pen and alcohol wipes. LPN #1 applied gloves and informed the resident she was going to administer her once a week injection. She cleansed the site with the wipe and proceeded to administer the injection. LPN #1 disposed of her supplies and performed hand hygiene.On 8/5/25 at 9:32 AM, LPN #1 stated she should have used a paper towel as a barrier instead of placing the injectable pen directly on the sink ledge.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, record review, resident and staff interview, it was determined the facility failed to provide a pest-free environment and an effective pest control program. This deficient practice created the potential for facility residents (#3, #4, #6, #7, #12, #13, #16, #19, #24, #25, #26, #27, #28, #29, and #39) to experience pest infestation if measures were not taken to eradicate and contain common household pests like flies. Findings include:The facility's Resident Environment policy, revised 11/28/19, documented the facility will provide a homelike environment that is similar to that of a private home/ The facility's Pest Control policy, revised 10/18/23, documented routine inspections are conducted periodically at the facility for evidence of pests. Insect or pest sightings are reported to the housekeeping/maintenance supervisor. From 8/4/25 through 8/7/25, the following was observed:On 8/4/25 at 8:05 AM, a full fly trap was found hanging outside the facility on a nearby fence, two additional full fly traps were observed around the exterior fence of the facility.On 8/4/25 from 8:30 AM to 4:45 PM, 9 of 12 Resident's rooms were observed to have fly swatters hanging on the wall.On 8/4/25 at 12:15 PM, flies were observed in the dining room landing on Resident #3 and Resident #12's food plate. Multiple flies were observed on the main dining table. A red fly swatter was observed hanging on the wall at the entrance of the dining room.On 8/4/25 at 4:10 PM, Resident #12 was observed attempting to swat a fly, but stopped when she said, I can't move fast enough to catch them.On 8/4/25 at 4:15 PM, Resident #12 stated the flies in facility were worse last fall [2024] than they were this summer [2025.] She was concerned with the increase of flies as she was unable to move fast enough to use the fly swatter effectively, and she did not like the flies buzzing around her room. Resident #12 stated the flies in the dining room frequently landed on her food and she had to shoo them away.On 8/5/25 at 8:15 AM, the Director of Maintenance, with the surveyor, provided a tour of the facilities pest control devices. The following was observed: Air Curtain #1: Was observed not turned on, and the Director of Maintenance stated it had not been functioning for sometime. Air Curtain #2: Was observed not turned on, the off button had been selected. When the Director of Maintenance turned it into the on position, Air Curtain #2 turned on. The dining room insect catcher was observed not plugged in. The front door was observed to have two interior insect catchers, the right side was unplugged, and the insect trap was full; the left side was functioning and the trap was full with live insects. There were two kitchen insect catchers observed, the interior on was unplugged with a non-functioning blue light. The exterior entrance insect catcher turned on when it was plugged in. There were three exterior fly traps hanging on the fence outside of the facility building, all the traps were full. On 8/5/25 at 8:25 AM, the Director of Maintenance stated the exterior fly traps should have been emptied more often as they may have been changed about 6-8 weeks prior. He stated staff frequently turn off Air Curtain #2, but Air Curtain #1 had been broken since he could remember. The Director of Maintenance stated Pest Control Services come to the building at least monthly, but more often if needed. He confirmed the front door insect traps had not been changed in a while. On 8/5/25 at 10:30 AM, Resident #25 was seen walking around the facility with a fly swatter on his walker. When asked about the fly swatter, Resident #25 stated he used it to kill the flies. He was sure housekeeping cleaned up any of the dead fly's he killed. On 8/6/25 from 8:10 AM to 10:30 AM, 10 facility staff entry and exits were observed where Air Curtain #2 should have been on and functioning. Air Curtain #2 was not turned on for 6 of the 10 entries observed. On 8/6/25 at 10:30 AM, surveyors met with 16 residents at a Resident Council (#3, #4, #6, #7, #12, #13, #16, #19, #24, #25, #26, #27, #28, #29, and #39), who resided at the facility. The Resident's stated they were offered fly swatters if they wanted them, but most were unable to use them effectively. They were not sure what happened to any flies killed, if they were lucky to swat them. The Resident's were asked if they were aware of the facility's pest control program and the fly traps around the facility. The Resident's were unable to identify where any interior fly traps were located, but did mention the outdoor fly traps appeared full. Resident #25 stated he had observed the Director of Maintenance the day before empty the fly traps at the front door, and he was surprised at the thousands of bugs trapped. A review of Pest Control Services provided from May - July 2025, documented: May 2025: Pest control services provided BiMonthly - Interior/Exterior.June 2025: No documentation provided.July 2025: Pest control services provided BiMonthly - General Maintenance. On 8/6/25 at 11:30 AM, the Director of Maintenance stated residents who request fly swatters receive them. He stated housekeeping cleans the facility daily and would get any swatted flies when they clean.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135095	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherry Ridge of Cascadia	501 West Idaho Boulevard Emmett, ID 83617

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and staff interview, the facility failed to provide a minimum of 12 hours of in-service education per year for 2 of 3 CNAs (Certified Nursing Assistants; #1 and #2) reviewed for sufficient and competent CNA staffing. This deficient practice placed residents at risk of receiving care from staff who were not adequately trained to meet residents' needs. Findings include:A review of CNA staff records documented CNA #1 and CNA #2 had been employed at the facility for over 12-months. On 8/6/25 at 4:15 PM, a review of CNA #1's training records did not document completed hours for the previous 12-month annual evaluation period for 2024/2025.On 8/6/25 at 4:25 PM, a review of CNA #2's training records did not document completed hours for the previous 12-month annual evaluation period for 2024/2025.On 8/7/25 at 8:35 AM, the CEO stated the facility was unable to produce any records that CNA #1 and CNA #2 had the required annual 12-hours of training for the evaluation period of 2024/2025.