STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135138	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Teton Healthcare of Cascadia	3111 Channing Way Idaho Falls, ID 83404

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 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 observation, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with a clean, safe, homelike environment. This was true for all residents who resided in the facility who are transferred with Hoyer lift equipment. This deficient practice created the potential for harm from cross contamination due to equipment not being cleaned between use. Findings include:The facility Work Practices Cleaning policy dated 1/1/18, documented multiple use resident care items are properly cleaned/disinfected between each resident use. Resident care items may include but is not limited to resident lifts.The following areas were observed: - On 8/14/25 at 7:55 AM, observed in room [ROOM NUMBER], a sticky substance on the over the bed table and a dry black substance on commode. - On 8/14/25 at 8:25 AM, observed in room [ROOM NUMBER], next to Resident #89’s bed and by the bathroom door a trash can with soiled briefs in it. On 8/14/25 at 8:30 AM, CNA #4 stated the garbage should be taken out after each time a resident's brief had been changed. - On 8/14/25 at 8:31 AM, observed Resident #1’s wheelchair with a towel on the seat with a dry yellow substance on it and dried crumb like substance under the wheelchair cushion. On 8/14/25 at 8:31 AM, Resident #1 stated her daughter told her that her wheelchair needed to be cleaned because it stunk. On 8/14/25 at 8:33 AM, CNA #4 stated the wheelchairs are to be cleaned two times a week by the night shift. - On 8/14/25 at 8:36 AM, observed in room [ROOM NUMBER]’s bathroom, a dried brown substance on the commode seat and 1 opened bag of briefs on the floor. -On 8/14/25 at 8:47 AM, observed in room [ROOM NUMBER] a trash can with soiled briefs and dirty incontinent wipes. - On 8/14/25 at 9:45 AM, observed in room [ROOM NUMBER], a Hoyer sling lying on the floor, next to recliner and 2 bags of briefs sitting on the floor in the bathroom. (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	On 8/14/25 at 10:00 AM, Housekeeper #1 stated the rooms were to be cleaned daily and this included the over the bed table. On 8/14/25 at 10:31 AM, the DON stated the trash cans with dirty briefs should have been taken out every time the resident’s briefs were changed, the resident’s supplies should not have been stored on the floor, the CNAs should have cleaned the over the bed tables, and the night shift were to clean the wheelchairs at night, but they did not have documentation that the wheelchairs were being cleaned. On 8/14/25 at 1:02 PM, the Administrator with the Maintenance Assistant present, stated the over the bed tables should have been cleaned daily by the housekeepers. On 8/14/25 at 7:05 AM, the blue crossbeam pad on the Hoyer lift on the 100 hall was dirty with whitish and brown marks on it. LPN #1 stated she was not sure how they get dirty because they try not to allow the residents to touch the pad. On 8/14/25 at 7:12 AM, the gray crossbeam pad on the Hoyer lift on the 400 hall was dirty to the point of being black. CNA #1 stated she was not sure how or when the crossbeam pad gets cleaned. On 8/14/25 at 10:50 AM, the DON stated the Hoyer lift cross beam pads should be kept clean or removed.

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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 record review, policy review, and staff interview, it was determined the facility failed to ensure resident's care plans were revised to reflect current needs and interventions. This was true for 1 of 3 residents (Resident #5) whose care plans were reviewed. This placed residents at risk for adverse outcomes if care and services were not provided due to care plans not being revised as residents' needs changed. Findings include:The facility Accidents and Supervision to Prevent Accidents policy dated 10/15/22, documented under falls, development of a person-center plan of care by the interdisciplinary team can evaluate potential use of therapy, devices, environmental adjusts, review of medications, and treatment of other impacting factors may reduce the number of outcome severity of falls. If fall occurs, manage the fall, then determine root-cause analysis to assist with updates to the fall prevention plan. When reviewing root-cause, evaluate all the causal factors leading to the resident fall as the(y) may also assist in developing and implementing relevant, consistent, and person-centered interventions to prevent future occurrences.Resident #5 was admitted to the facility on [DATE], with multiple diagnoses including acute osteomyelitis on right ankle and foot (a bone infection, usually occurring within two weeks of the initial infection) and adult failure to thrive.Resident #5's medical record documented he had a fall on 3/14/25, when he leaned forward in his wheelchair to reach his drink and food in the dining room and he slipped out of his wheelchair to the ground. The IDT assessment directed that staff were to ensure Resident #5's drink and food are closer to him in the dining room, so he did not have to lean forward in his wheelchair. Resident #5's care plan fall prevention interventions had not included the IDT assessment recommendationsOn 8/14/25 at 11:10 AM, the DON stated Resident #5's care plan fall interventions had not including the IDT assessment recommendation from the 3/14/25, fall and should have.

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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 observation and staff interview, it was determined the facility failed to ensure medications available for residents were stored appropriately; this was true for 1 of 18 resident's rooms inspected (Resident #1). This failure created the potential for adverse effects if residents self-administered medications inappropriately or did not take their medications. Findings include:Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including Chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and hypertension.On 8/14/25 at 8:44 AM, observed on Resident #1's bedside table a medication cup with a purple substance with multi-colored specks and a spoon in it.On 8/14/25 at 8:48 AM, RN #1 stated Resident #1 did not have an order to self-administer medications, she did not have it documented in her care plan to self-administer medication so she should not have left the medications in her room.On 8/14/25 at 11:38 AM, the DON stated residents should not have medications left in their room.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, the facility failed to ensure adherence to infection control and prevention practices to provide a safe and sanitary environment, when staff did not follow proper enhanced barrier precautions protocol. These failures had the potential to impact 1 of 5 residents (Resident #70) observed with EBP signs on their room doors, placing them all at risk for cross-contamination and infection. Findings include:Resident #70 was admitted to the facility on [DATE], with multiple diagnoses including acute cystitis (inflammation of the bladder) and dysphagia (difficulty or pain with swallowing). On 8/14/25 at 7:36 AM, observed CNA #2 had not donned a gown or gloves when she assisted Resident #70 with a transfer from her bed into her wheelchair and then into the shower room where she assisted her with a shower. Resident #70 was on EBP with a sign on her door that documented for staff to wear gown and gloves when assisting with transfers and showering. On 8/14/25 at 7:40 AM, CNA #2 stated she thought she only needed to donn gown and gloves when assisting Resident #70 with her catheter.On 8/14/25 at 7:45 AM, CNA #3 stated the EBP sign indicated staff were to wear gloves and gown when assisting residents with bathing/showering, transferring, and catheter care.On 8/14/25 at 11:00 AM, the DON stated staff were to wear gloves and gowns when assisting residents with cares who have EBP signs on their door.