STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135145	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascadia of Lewiston	2852 Juniper Drive Lewiston, ID 83501

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 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** 39540 Based on record review, policy review, grievance review, and resident and staff interview, the facility failed to ensure grievance concerns and/or complaints were thoroughly investigated and resolved to the satisfaction of the complainant without fear of reprisal. This was true for 2 of 4 residents (#7 and #143) whose grievances were reviewed. This deficiency had the potential for harm should residents experience a loss of self-worth and psychosocial distress. Findings include: The facility's Complaint and Grievances policy, dated 11/28/17, documented An individual has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC [Long Term Care] facility stay. The facility should make prompt efforts by the facility to resolve grievances the resident may have. 1. Resident #7 was admitted on [DATE] and readmitted on [DATE] with multiple diagnoses including syncope (fainting most often occurs when blood pressure is too low) and systemic lupus erythematosus (an autoimmune disease in which the immune system attacks its own tissues, causing widespread inflammation and tissue damage in the affected organs). An MDS assessment, dated 2/8/24, documented Resident #7 was cognitively intact. The facility's Grievance Log did not include a grievance submitted by Resident #7 on 3/24/24. Review of LPN #2's personnel file included a grievance from Resident #7, dated 3/25/24. The grievance documented the following from Resident #7: This morning after breakfast [LPN #2] came in with what she said were my pills. I started to dump them in my mouth. I looked at them as I was about to put them in my mouth. I told her they were not my pills. She took them back and said she just wanted to see if I was awake. She walked out and got mine. I could have been poisoned. [CNA #4] walked in as she was saying that. I was a bit shocked! I don't think I have ever given her reason to resent me. I must remind her of someone she does not like. Please read above. I am thankful I actually recognized they were not my meds [medications]. I could have been poisoned. [LPN #2] never apologized or showed any concern. Sunday 3/24/23 at around 9 AM. The grievance did not include a summary of the incident from leadership. The section on the grievance form for resolution and corrective actions taken by the facility was blank and the signature line for the Executive Director was blank. (continued on next page)

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/24 at 12:33 PM, the Social Services (SS) representative explained the grievance process. She stated once the grievance form was initially completed, the concern was presented at the facility's morning stand up meeting, and then a review with the resident was conducted to get more information and clarify their concerns were documented on the form. The SS stated the concern was then summarized and assigned to a manager for follow-up and outlined who to do what on the back of the form. During an interview on 5/1/24 at 5:04 PM, the CNO and the Human Resources Director found the incomplete grievance form in the personnel file for LPN #2. The CNO and Human Resources Director stated they saw the form and did not follow up on the grievance documented by Resident #7. The SS representative stated she had not seen the form from Resident #7 dated 3/24/24 and it was not followed up on. She stated Resident #7 was not interviewed for more information or clarity about the incident and no resolution was identified. 16752 2. Resident #143 was admitted to the facility on [DATE], with multiple diagnoses including post-surgical care following a spinal fusion, Diabetes Mellitus, Sjogren's Syndrome (autoimmune disease affecting the functioning of the glands that produces tears and salvia), Major Depressive Disorders and Post Traumatic Stress Disorder (PTSD). An admission MDS assessment, dated 11/20/23, documented Resident #143 was cognitively intact and able to make her own decisions. Review of the facility's grievance log for December 2023 documented Resident #143 filed a grievance/complaint on 12/8/23 concerning the way LPN #2 spoke to her regarding her pain medication. Resident #143 documented on 12/8/23 at 3:45 AM that LPN #2 approached her about the amount and frequency of pain medication Resident #143 was receiving. Resident #143 documented LPN #2 stated there were other pain medications and other pain-relieving options available to her. Resident #141 documented on 12/8/23 at 8:37 AM that LPN #4 also approached her about the frequent use of pain medication. The 12/8/23 grievance form documented the Unit Manager, CNO, and CEO were notified of the incident on 12/12/23. The CNO summarized the incident as inappropriate conversations with Resident #143 regarding narcotic use by two different nurses in her room. The grievance documented the CNO determined this was not abuse. The CNO documented the grievance/complaint was resolved on 12/12/23. The grievance documented resolution consisted of staff education on appropriate and non-appropriate conversations with residents. The CNO documented Resident #143 was satisfied with the resolution. However, the form did not include Resident #143's signature confirming she was satisfied with the resolution. The form also did not include the signature of the CEO indicating the investigation was complete. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/24 at 10:06 AM, Resident #143 stated LPN #2 made a comment about her frequent use of narcotic medications for pain. Resident #143 stated LPN #2 mentioned using other medications and techniques to relieve her pain. Resident #143 stated LPN #4 later entered the room talking about Resident #143's use of narcotics. Resident #143 stated she felt the nurses were talking behind her back. Resident #143 also stated the way both nurses approached her about the pain medication, hurt her to the core. Resident #143 stated the nurses' behavior made her reluctant to request pain medication. Resident #143 also stated LPN #4 wanted her to change the grievance/complaint that she had completed. Resident #143 said she requested to see the Unit Manager or the SS representative. Resident #143 further stated the nurses' behavior toward her was abusive at the time. Resident #143 stated since that time the issue had been resolved. She stated after the grievance/complaint was filed, LPN #2 was moved to a different unit and LPN #4's agency contract was not renewed. During an interview on 4/30/24 at 5:20 PM, the CEO stated the incident between Resident #143, LPN #2, and LPN #4 was investigated. The CEO stated at the time, he did not feel the incident rose to the level of abuse. The CEO stated Resident #143 may have misunderstood what the nurses were trying to tell her. The CEO stated the Nurse Practitioner had planned to have a conversation with the resident about decreasing the amount of pain medication. The CEO felt this should have been documented in Resident #143's chart by Social Services. The CEO agreed that SS should have followed-up with Resident #143 on the resolution of the incident and documented it in her chart. The CEO reviewed the grievance form and stated ideally Resident #143 should have signed the form indicating acceptance of resolution and the form was missing the CEO signature which meant the form was incomplete.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on review of the State Agency's Long Term Care Reporting Portal, record review, grievance report review, and resident and staff interview, it was determined the facility failed to ensure allegations of resident abuse were reported to the State Survey Agency within 2 to 24 hours. This affected 1 of 3 residents (Resident #7) who were reviewed for abuse. This failure created the potential for residents to be subjected to ongoing abuse without detection and protective measures implemented by the facility. Findings include: The facility's policy, titled Abuse, revised 8/1/23, documented: Allegations of verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, and neglect of the resident as well as mistreatment, injuries of unknown source, exploitation, deprivation of goods and services by staff, and misappropriation of resident property are reported to the CEO immediately and the state agency . a. Within 2 hours if there was alleged abuse or serious bodily injury as a result of an event. b. Within 24 hours if the event that caused the injury did not involve abuse or did not result in serious bodily injury. Resident #7 was admitted on [DATE] and readmitted on [DATE], with multiple diagnoses including syncope (fainting most often occurs when blood pressure is too low) and systemic lupus erythematosus (an autoimmune disease in which the immune system attacks its own tissues, causing widespread inflammation and tissue damage in the affected organs). An admission MDS assessment, dated 2/8/24, documented Resident #7 was cognitively intact. During an interview on 4/29/24 at 2:42 PM, Resident #7 stated LPN #2 seemed to be rude to her. Resident #7 stated she was worried about retaliation from LPN #2 and not being able to return to the facility if needed in the future. Resident #7 said LPN #2 was a little vengeful meaning hateful. Resident #7 said she could not trust LPN #2. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility grievance form, dated 3/10/24, initiated by Resident #7, documented the following on a grievance form: Date of occurrence- Ongoing, I feel bad [LPN #2] thinks that I am sleeping every time she comes in, not true! I feel if she had been wanting to help me that my incision would not have burst. I told her last Monday that it was hot, swollen, and discolored, she said it was fine and I felt if I hesitated to make an issue of this, I would have a problem. She said it was okay, but it wasn't, and it burst dressing on Wednesday. I have a bad immune system and wanted antibiotics. I feel that if something is not her idea that it doesn't ___ [sic]. Very rude and dismissive, asked me for details. I can't write with my right hand. She is a bully. The resolution and/or corrective action taken section documented Facility MD [Medical Doctor] following up with concerns, ortho [orthopedic physician] also notified and provided treatment orders-Resident concerns with [LPN #2] being dismissive-Education and resources provided on effective communication. [LPN #2] to not provide non-emergency cares, CNO had a conversation with [LPN #2]. The grievance form was signed at the bottom by the CEO. A facility grievance form, dated 3/24/24, initiated by Resident #7, documented the following: This morning after breakfast [LPN #2] came in with what she said were my pills. I started to dump them in my mouth. I looked at them as I was about to put them in my mouth. I told her they were not my pills. She took them back and said she just wanted to see if I was awake. She walked out and got mine. I could have been poisoned. [CNA) #4] walked in as she was saying that. I was a bit shocked! I don't think I have ever given her reason to resent me. I must remind her of someone she does not like. Please read above. I am thankful I actually recognized they were not my meds. I could have been poisoned. [LPN #2] never apologized or showed any concern. Sunday 3/24/23 at around 9 AM. The form did not include documentation for the summary of the incident by the department head. The section for resolution and corrective actions taken was blank and the signature line for the Executive Director was blank. Review of the State Agency's Long Term Care Reporting Portal did not include a report by the facility to the State Agency within 2 hours of Resident #7's allegation of verbal abuse by LPN #2. During an interview on 4/30/24 at 1:14 PM, the CEO stated there was an investigation of the grievance for Resident #7, dated 3/10/24 and the conclusion was education and counseling by the CNO and did not identify that abuse should have been investigated. During an interview on 04/30/24 at 1:25 PM, the CEO stated the investigation of the grievance dated 3/10/24, should have been conducted to rule out abuse and was not investigated for abuse. The CEO said he was unaware of the grievance documented by Resident #7 on 3/24/24 and if aware of the grievance, would have functioned as outlined in the facility abuse policy and investigated for abuse. During an interview on 05/01/24 at 5:04 PM, in reference to the 3/24/24 grievance, the CEO confirmed the language in the form completed by Resident #7 was abusive by LPN #2 and should have been investigated as abuse and confirmed it was not investigated as abuse.

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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** 39540 Based on record review, policy review, and staff interview, the facility failed to ensure abuse allegations documented on grievance forms were recognized, reported, and investigated for 1 of 3 residents (Resident #7) reviewed for abuse. This failure created the potential for residents to be subjected to ongoing abuse without detection and protective measures implemented by the facility. Findings include: The facility's policy, titled Abuse, revised 8/1/23, documented The facility respects the resident right to be free from abuse . Prohibitions on abuse including and not limited to verbal . prohibitions apply to . facility staff. The facility's policy, titled Identification and Investigation of Abuse, Neglect, Misappropriation, and Injuries of Unknown Origin Identification of Incidents and Occurrences that may Constitute or Contribute to Abuse and Neglect, revised 8/1/23, documented Review reports of grievances, complaints, and allegations of abuse, neglect, injuries of unknown injury, and misappropriation for patterns or isolated incidents of unexplained functional regression, or other evidence of physical, verbal, sexual or psychological abuse or punishment posing a serious and immediate threat to individuals. Resident #7 was admitted on [DATE] and readmitted on [DATE], with multiple diagnoses including syncope (fainting most often occurs when blood pressure is too low) and systemic lupus erythematosus (an autoimmune disease in which the immune system attacks its own tissues, causing widespread inflammation and tissue damage in the affected organs). An admission MDS assessment, dated 2/8/24, documented Resident #7 was cognitively intact. During an interview on 4/29/24 at 2:42 PM, Resident #7 stated LPN #2 seemed to be rude to her. Resident #7 stated she was worried about retaliation from LPN #2 and not being able to return to the facility if needed in the future. Resident #7 said LPN #2 was a little vengeful meaning hateful. Resident #7 said she could not trust LPN #2. A facility grievance form, dated 3/10/24, initiated by Resident #7, documented the following on a grievance form: Date of occurrence- Ongoing, I feel bad [LPN #2] thinks that I am sleeping every time she comes in, not true! I feel if she had been wanting to help me that my incision would not have burst. I told her last Monday that it was hot, swollen, and discolored, she said it was fine and I felt if I hesitated to make an issue of this, I would have a problem. She said it was okay, but it wasn't, and it burst dressing on Wednesday. I have a bad immune system and wanted antibiotics. I feel that if something is not her idea that it doesn't ___ [sic]. Very rude and dismissive, asked me for details. I can't write with my right hand. She is a bully. The resolution and/or corrective action taken section documented Facility MD [Medical Doctor] following up with concerns, ortho [orthopedic physician] also notified and provided treatment orders-Resident concerns with [LPN #2] being dismissive-Education and resources provided on effective communication. [LPN #2] to not provide non-emergency cares, CNO had a conversation with [LPN #2]. The grievance form was signed at the bottom by the CEO. (continued on next page)

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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	A facility grievance form, dated 3/24/24, initiated by Resident #7, documented the following: This morning after breakfast [LPN #2] came in with what she said were my pills. I started to dump them in my mouth. I looked at them as I was about to put them in my mouth. I told her they were not my pills. She took them back and said she just wanted to see if I was awake. She walked out and got mine. I could have been poisoned. [CNA) #4] walked in as she was saying that. I was a bit shocked! I don't think I have ever given her reason to resent me. I must remind her of someone she does not like. Please read above. I am thankful I actually recognized they were not my meds. I could have been poisoned. [LPN #2] never apologized or showed any concern. Sunday 3/24/23 at around 9 AM. The form did not include documentation for the summary of the incident by the department head. The section for resolution and corrective actions taken was blank and the signature line for the Executive Director was blank. During an interview on 4/30/24 at 1:14 PM, the CEO stated there was an investigation of the grievance for Resident #7, dated 3/10/24 and the conclusion was education and counseling by the CNO and did not identify that abuse should have been investigated. During an interview on 04/30/24 at 1:25 PM, the CEO stated the investigation of the grievance dated 3/10/24, should have been conducted to rule out abuse and was not investigated for abuse. The CEO said he was unaware of the grievance documented by Resident #7 on 3/24/24 and if aware of the grievance, would have functioned as outlined in the facility abuse policy and investigated for abuse. During an interview on 05/01/24 at 5:04 PM, in reference to the 3/24/24 grievance, the CEO confirmed the language in the form completed by Resident #7 was abusive by LPN #2 and should have been investigated as abuse and confirmed it was not investigated as abuse.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a transfer notice was provided in writing to a resident, their representative, and the Office of the State Long-Term Care Ombudsman prior to transfer. This was true for 1 of 1 residents (Resident #30) reviewed for transfers. The deficient practice created the potential for psychosocial distress if residents and their representatives were not made aware of or able to exercise their rights related to transfer from the facility. Findings include: The facility's policy, Transfer and Discharge, revised 10/15/22, documented If the facility determines a resident who was transferred with an expectation of returning to the facility . The written notice of transfer/discharge includes: 1) Reason for transfer/discharge, 2) Effective date of transfer/discharge, 3) Location to which the resident is transferred/discharged , 4) Statement that the resident has the right to appeal the action to the state. Resident #30 was admitted to the facility on [DATE], with multiple diagnoses including post-surgical care for a total joint replacement. A progress note, dated 3/21/24 at 10:39 AM, documented Resident #30 had an order to send her to the hospital for a cardiac evaluation due to epigastric pain and positive troponin level (protein that's found in the cells of the heart muscle and when elevated in the bloodstream can indicate heart damage), and she was being transported to the hospital at that time. Resident #30's record did not include documentation of notification in writing of transfer to the hospital. During an interview on 5/3/24 at 11:50 AM, the Social Services (SS) representative stated the facility was not sending discharge/transfer notices to residents and/or their representative for facility-initiated transfers to the hospital for a higher level of care. The SS said the ombudsman was notified when a resident was discharged from the facility, but not if the resident was sent to the hospital. During an interview on 5/3/24 at 12:52 PM, the CRN stated notices should be sent for residents discharged to the hospital including notification to the ombudsman. She stated the facility was not following the policy.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a bed hold notice was provided to a resident or their representative upon transfer to the hospital. This was true for 1 of 1 resident (Resident #30) reviewed for transfers. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time. Findings include: The facility's policy, Transfer and Discharge, revised 10/15/22, documented At the time of transfer/discharge, the resident and a family member or legal representative are given a written notice of the bed-hold policy that specifies the duration of the bed-hold and readmission criteria after the bed-hold period ends . Resident #30 was admitted to the facility on [DATE], with multiple diagnoses including post-surgical care for a total joint replacement. A progress note, dated 3/21/24 at 10:39 AM, documented Resident #30 had an order to send her to the hospital for a cardiac evaluation due to epigastric pain and positive troponin level (protein that's found in the cells of the heart muscle and when elevated in the bloodstream can indicate heart damage), and she was being transported to the hospital at that time. Resident #30's record did not include documentation of notification in writing a bed hold notice was provided to her or her representative upon transfer to the hospital. During an interview on 5/3/24 at 11:50 AM, the Social Services (SS) representative stated the facility was not sending bed hold notices to residents and/or their representative for facility-initiated transfers to the hospital. During an interview on 5/3/24 at 12:08 PM, the Resident Care Manager (RCM) said the bed hold notices were not sent out and a process was needed to be revisited for implementation. During an interview on 5/3/24 at 12:52 PM, the CRN stated bed hold notices should be sent for anyone discharged to the hospital and the facility was not following the policy.

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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** 16752 Based on record review, policy review, and staff 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 2 of 12 residents (#26 and #84) reviewed for baseline care plans. This failure created the potential for harm if the care plan failed to provide direction for care. Findings include: The facility's Care Plans policy, revised 10/15/22, documented the baseline care was developed within 48 hours of admission to address the immediate needs of the resident until a comprehensive care plan could be developed. The baseline care plans were required to address at a minimum, physician orders, dietary orders, therapy orders, social services; initial goals based on admission orders and desired outcomes. 1. Resident #84 was admitted to the facility on [DATE], with multiple diagnoses including End Stage Renal Disease (ESRD), Hypertension (elevated blood pressure), Sepsis (infection in blood stream), Methicillin Resistant Staphylococcus Aureus (MRSA) Infection, and Type 2 Diabetes Mellitus. A physician admission order, dated 4/23/24, documented Resident #84 was to receive hemodialysis on Monday, Wednesday, and Friday at 11:00 AM. Resident #84's Baseline Care Plan, initiated 4/24/24, did not include baseline care development for his dialysis. During an interview on 5/3/24 at 5:35 PM, the MDS Coordinator reviewed the baseline care plan for Resident #84 initiated during the admissions process by nursing and completed within 48 hours of the resident's admission to the facility. The MDS Coordinator stated the baseline care plan should have included the dialysis treatment and interventions. 39540 2. Resident #26 was admitted to the facility on [DATE], with multiple diagnoses including End Stage Renal Failure. An admission physician order, dated 4/11/24, documented Resident #26 was to receive dialysis every evening on Monday, Wednesday, and Friday for End Stage Renal Disease. Resident #26's Baseline Care Plan, dated 4/12/24, did not include baseline care development for her dialysis. During an interview on 5/2/24 at 2:05 PM, LPN #1 reviewed the process for Resident #26 for dialysis and confirmed the 48-hour care plan did not include dialysis care. During an interview on 5/2/24 at 3:32 PM, the CNO and the CRN reviewed the 48-hour care plan for Resident #26 and confirmed there was no focus or plan of care for dialysis and said there should have been a plan of care for dialysis in place upon admission.

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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** 39540 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure comprehensive resident-centered care plans were developed and implemented. This was true for 1 of 12 residents (Resident # 26) whose care plans were reviewed. This failure placed Resident #26 at risk of negative outcomes if services were not provided or provided incorrectly due to lack of information in the care plan. Findings include: The facility's Care Plan policy, revised 10/15/22, documented The facility develops and implements a comprehensive person-centered care plan for each resident, consistent with the resident rights and includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment. Resident #26 was admitted to the facility on [DATE] with multiple diagnoses including End Stage Renal Failure with Dialysis. An admission MDS assessment, dated 4/14/24, documented Resident #26 was cognitively intact and required special treatment for dialysis. A physician's order, dated 4/11/24, documented Resident #26 was to be transported for her dialysis to the hospital on Monday, Wednesday, and Friday at 12:00 PM. The order documented staff were to send her lunch and cushion in her wheelchair with her. The order further documented staff were to validate the Dialysis Communication Record was returned from the hospital, and if it was not returned, call the hospital, and make a progress note. The order stated if the Dialysis Communication Record was returned, to transcribe orders as indicated and to note and time the order transcription. Resident #26's care plan did not include a focus care area for her dialysis. During an interview on 5/2/24 at 2:05 PM, LPN #1 reviewed the process for Resident #26 for dialysis and confirmed the care plan did not include dialysis care. During an interview on 5/2/24 at 3:32 PM, the CNO and the CRN reviewed the comprehensive care plan for Resident #26 and confirmed there was no focus or plan of care for dialysis and there should have been a plan of care for dialysis in place upon completion of the comprehensive care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on record review, protocol review, and resident and staff interview, the facility failed to ensure physician orders for bowel care were followed for a resident. This was true for 1 of 1 resident (Resident #7) reviewed for bowel care. This deficient practice placed Resident #7 at risk for constipation or bowel obstruction. Findings include: The facility's protocol for Bowel Care, updated 1/27/11, documented the following process: 1. After 9 pm, the medication/charge nurse for each unit was responsible for reviewing the resident Certified Nursing Assistant (CNA) flowsheet records for bowel regularity. When a resident has not had a documented BM (bowel movement) in the last 48 hours the nurse was responsible to ensure the physicians orders provide coverage for the bowel regime and then follow the directives. 2. Bowel Regime: a. Follow specific physician orders for residents that require an increase in frequency over protocol. b. If resident is 48-hours without a BM documented, administer 30cc [by mouth] Milk of Magnesia (MOM) as per medical doctor (MD) orders. c. If resident is 72-hours without a BM documented, administer l5mg [by rectum] Dulcolax suppository as per MD orders. d. If no BM documented by the following morning, administer fleets enema [by rectum] as per MD order. e. If no BM within 2 hours, phone MD for additional orders. Resident #7 was admitted on [DATE] and readmitted on [DATE], with multiple diagnoses including syncope (fainting most often occurs when blood pressure is too low) and systemic lupus erythematosus (an autoimmune disease in which the immune system attacks its own tissues, causing widespread inflammation and tissue damage in the affected organs). An admission MDS assessment, dated 2/8/24, documented Resident #7 was cognitively intact. A physician order, dated 2/2/24, documented the following bowel care for Resident #7: - Milk of Magnesia (MOM - medication used to relieve constipation) 1200 mg/15 ml by mouth as needed for no bowel movement for 2 days. If no results in 24 hours, see Dulcolax suppository order. - Dulcolax suppository (stool softener) 10 mg rectally as needed for bowel care. Administer if no results from the MOM. If no results in 24 hours, see Fleets enema order. - Fleets enema 7-10 gm/118ml - 1 unit rectally as need for bowel care if no results from MOM and subsequent Dulcolax suppository. Complete bowel assessment and notify MD if no results. During an interview on 4/30/24 at 2:42 PM with Resident #7, LPN #3 came into the room and Resident #7 said, I have not had a BM [bowel movement] for more than three days. During an interview on 5/1/24 at 2:55 PM, Resident #7 explained last Wednesday [4/24/24] was the last time she had a BM and was telling someone every day. She stated she had MiraLAX (stool softener) on Saturday and every day since. Resident #7 stated she was not offered Milk of Magnesia, had a lot of gas, and finally started having BMs today. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7's TAR for bowel function, documented she had a BM on 4/24/24 and no BM on 4/25/24, 4/26/24, 4/27/24, 4/28/24, 4/29/24, and 4/30/24 (6 days). Resident #7 MAR for April 2024, did not include documentation of administration of MOM. A Dulcolax 10 mg suppository was administered on 4/30/24 at 11:27 AM, 6 days after her last BM. During an interview on 5/3/24 at 8:41 AM, the CRN stated the bowel protocol was reviewed and compared to Resident #7's record. Resident #7's record was reviewed for the bowel function task, the physician orders, and the MAR for April 2024. The CRN stated the physician orders were not followed and the bowel protocol was not followed and should have been implemented when Resident #7 reported not having a BM on 4/26/24.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on record review, policy review, and staff interview, the facility failed to ensure a licensed pharmacist reviewed each residents' medications at least monthly, and the physician/prescriber addressed the medications irregularities identified by the pharmacist. This was true for 2 of 5 residents (#3 and #17) whose medications were reviewed. These deficient practices created the potential for harm if residents' medications were administered without a clinical rationale. Findings include: The facility's policy, Pharmacy Consultation, dated 11/28/17, documented the Pharmacy Consultant would conduct monthly medication regimen review (MRR) for each resident in the facility. The review should address any side effects of medication; allergic reactions to antibiotic therapy; significant medication interactions; if prescribed medication was consistent with the resident's condition; whether the physician and staff have documented progress towards or maintenance of goals for medication therapy; whether the physician and staff have noted and acted upon possible medication related causes of recent or persistent changes in the resident's condition such as worsening of an existing problem or the emergence of new signs or symptoms. The policy also stated the CNO, and the facility physician would respond to recommendations made by the Pharmacy Consultant. 1. a. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including Alzheimer's Disease. Physician Orders for the month of May 2024, documented Resident #3 was to receive Lexapro (antidepressant used to treat mood disorders) 20 mg daily and Zyprexa (used to treat Dementia) 2.5 mg daily. The order stated Resident #3 was to be monitored every shift for behaviors and side effects of the medications. Resident #3's record did not include documentation a Drug Regimen Review was completed by the Pharmacy Consultant. b. Resident #17 was admitted to the facility on [DATE], with multiple diagnoses including a craniotomy for a puncture wound to the head, major depressive disorder, and anxiety disorder. Physician Orders for the month of May 2024, documented Resident #17 was to receive Baclofen 10 mg daily (for bladder spasms), Diclofenac Gel 1% 2 gm (topical gel for pain), Doxepin 50 mg daily (for sleep), Eliquis 10 mg daily (anticoagulant for Deep Vein Thrombosis), Enoxaparin 40 mg subcutaneous injection (prevent Deep Vein Thrombosis), Gabapentin 100 mg daily (used to treat seizures and pain), Lexapro 20 mg daily (for depression), Melatonin 5 mg (treat insomnia), and Tramadol 50 mg (opioid for pain) every four hours as needed for pain. Resident #17's record did not include documentation a Drug Regimen Review was completed by the Pharmacy Consultant. The MMRs for the months of March 2024 and April 2024, did not include documentation of medication reviews for Resident #3 and Resident #17. The MMRs that included recommendations from the Pharmacy Consultant did not include reviews were completed by the physician. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/3/24 at 8:41 AM, the CRN stated the Pharmacy Consultant was notified of new admissions especially those residents receiving psychoactive medications. The CRN stated the Pharmacy Consultant would complete an Interim Drug Regimen Review remotely within 24 hours of the resident's admission. The review was faxed to the CNO to review with the facility physician. The CRN stated the Pharmacy Consultant conducted monthly Medication Regimen Reviews with recommendations. The CRN stated these reviews/recommendations were given to the CNO to review with the facility physician. The CRN also stated the facility did not have a system in place to ensure the physician reviewed the recommendations made by the Pharmacy Consultant. During a telephone interview on 5/3/24 at 11:34 AM, the Clinical Pharmacist stated the facility notified the pharmacist when a new resident arrived. He stated the Pharmacist would perform a remote evaluation (called Interim Medication Review) for those residents that were on psychotropic medications. The Clinical Pharmacist also stated another pharmacist was responsible for reviewing all the residents in the facility monthly. He stated that the Pharmacist would make the necessary recommendations; and this information was sent to the CNO. The Clinical Pharmacist further stated the Pharmacist that completed the MRRs for January, February, March, and April was unaware there was a new CNO and sent the reviews to the wrong CNO.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 16752 Based on record review, policy review, observation, and staff interview, the facility failed to ensure that 5 of 13 diabetic residents (#8, #15, #18, #26, and #85) with insulin medications kits located in their rooms were locked; 1 of 2 medication carts were locked; and daily medication refrigerator temperatures were documented. These deficient practices created the potential for harm if residents and unauthorized personnel accessed medications and they became missing or were administered incorrectly, needles were improperly used, or residents received medications with decreased efficacy from not being stored at the correct temperature. Findings include: The facility's policy, Medication Management, revised 10/15/22, directed the staff to ensure Medications and biologicals are stored appropriately according to the manufacturer's guidelines and to prevent unauthorized access. Unlocked medication/treatment carts are always under the nurse control. 1. The following diabetic kits were not securely stored: - On 4/29/24 at 1:10 PM, an unlocked green diabetic kit containing insulin injector pens, needles, glucometer, alcohol wipes, and cotton balls were observed in Resident #85's room. - On 5/1/24 at 12:21 PM, unlocked green diabetic kits containing insulin injector pens, needles, glucometers, alcohol wipes, and cotton balls were observed in Resident #8, Resident #15, Resident #18, and Resident #26's rooms. During an interview on 5/1/24 at 11:10 AM, RN #1 stated all the diabetic residents had a green diabetic kit that contained a glucometer, strips, needles, the residents' prescribed insulin pens, cotton balls, and alcohol wipes. RN #1 stated these kits were to be locked and maintained in the residents' rooms. RN #1 stated the keys to the insulin kit were maintained on the medication cart key rings. During an interview on 5/2/24 at 11:31 AM, LPN #1 stated the green diabetic kits were unlocked and contained glucometer, strips, alcohol wipes and cotton balls, and the residents prescribed insulin pens. However, it was identified there was a problem in locking the kits. During an interview on 5/2/24 at 1:58 PM, the CRN stated that green diabetic insulin kits were maintained in the resident's room. The CRN stated the kits were to be always locked. The CRN stated the facility did not have a policy for diabetic kits in the resident's rooms. The CRN also stated it was identified there was a problem with securely locking kits in the residents' rooms, so it was decided to remove all sharps (needles) from the kits thereby ensuring residents safety. 2. On 4/30/24 at 9:44 AM, the medication cart on Hall Two was observed unlocked in front of Resident #83's room. Residents and staff members were passing by the unsecured medication cart. During an interview on 4/30/24 at 9:58 AM, RN #1 stated the medication cart was left unlocked and was out of line of sight. RN #1 stated he was in a hurry to administer Resident #83's medication and forgot to lock the cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/30/24 at 4:10 PM, the CNO stated it was an expectation for the medication cart to always be locked when the nurse was not at the cart. 3. During inspection of the central medication room on 5/1/24 at 3:00 PM, the temperatures for the medication refrigerator were inconsistently documented. Review of the temperature logs for medication room refrigerator documented the following: for the month of December 2023 temperatures were recorded 9 days out of 31 days. For the month of January 2024 temperatures were recorded 12 days out of 31 days. For the month of February 2024 temperatures were recorded 11 days out of 29 days. For the month of March 2024 temperatures were recorded 10 days out of 31 days. For the month of April 2024 temperatures were recorded 15 days out of 30 days. During an interview on 5/1/24 at 4:47 PM, the CRN stated the night nurses were responsible for the daily checking and documenting the temperatures for the medication refrigerator. The CRN stated the nurses must record the date and time the temperature was taken. The CRN stated the nurse must also record the ambient/room temperature and then the actual temperature of the medication refrigerator. The CRN further stated no medications were stored in the freezer, so the nurse did not record temperatures for the freezer.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on record review, policy review, observation, and staff interview, it was determined the facility failed to ensure to keep accurate and complete clinical records for each resident. This was true for 1 of 12 residents (Resident #7) whose records were reviewed. This deficient practice created the potential for harm if inappropriate care and/or treatment was provided. Findings include: The facility's policy, Documentation of Resident Health Status Needs and Services, revised 10/15/22, documented The medical record must contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress, including his/her response to treatments and/or services, and changes in his/her condition, plan of care goals, objectives and/or interventions .factual .and accurate. The facility's policy, Oral Medication Administration, revised 1/1/18, documented After medication administration document in the electronic MAR the dose of the medication, route of administration, date, and exact time administered with your initials. Any assessments required prior to administration should be included in the documentation. Resident #7 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including syncope (fainting most often occurs when blood pressure is too low) and systemic lupus erythematosus (an autoimmune disease in which the immune system attacks its own tissues, causing widespread inflammation and tissue damage in the affected organs). An admission MDS assessment, dated 2/8/24, documented Resident #7 was cognitively intact. On 4/29/24 at 2:42 PM, Resident #7 stated LPN #2 was assigned to her room and did not come into the room. She stated when medications were administered, a different nurse brought the pills into the room for administration. Resident #7's MAR, dated 4/28/24, documented medications were administered by LPN #2. During an interview on 4/30/24 at 12:15 PM, RN #1 stated Resident #7 and LPN #2 had issues between them and Resident #7 requested LPN #2 not come into her room. RN #1 stated LPN #2 requested RN #1 to assist in medication administration on 4/28/24. RN #1 stated LPN #2 prepared the medications to be administered, gave the pills to RN #1, who took the medications into the room and administered them to Resident #7. RN #1 stated LPN #2 documented the medications as given in the MAR which documented LPN #2's initials in the administration box. RN #1 stated giving the pills prepared by LPN #1 was not following procedure which included to have one nurse document the administration of a medication and a different nurse do the actual administration of medications. During an interview on 5/2/24 at 10:54 AM, the CNO and the CRN stated the staff was to follow the medication administration policy and the nurse who documented the medication as given should have been the same nurse who administered the medication.

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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** 39540 Based on record review, observation, policy review, and staff interview, it was determined the facility failed to ensure infection control prevention practices were maintained to provide a safe and sanitary environment. This was true for 9 of 9 residents (#2, #5, #26, #81, #83, #84, #133, #135, and #137) observed for enhanced barrier precautions. These failures had the potential to impact all residents in the facility by placing them at risk for cross contamination and infection. Findings include: The CDC Website for Long-Term Care Facilities - Frequently Asked Questions about Enhanced Barrier Precautions in Nursing Homes, dated 4/2/24, and accessed on 5/16/24, states: - Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). - Enhanced Barrier Precautions expand the use of gown and gloves beyond anticipated blood and body fluid exposures. They focus on use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Standard Precautions still apply while using Enhanced Barrier Precautions. For example, if splashes and sprays are anticipated during the high-contact care activity, face protection should be used in addition to the gown and gloves. The facility's policy, Enhanced Barrier Precautions (Based upon Resident Risk), revised 4/2/24, states Enhanced Barrier Precautions (EBP) are recommended for use in resident rooms when residents have any of the following conditions, but do not require contact precautions: a, Open chronic wounds (not shorter lasting wounds such as skin breaks or skin tears with a Band-Aid) requiring dressing change. Chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcer, unhealed surgical wounds, and venous stasis ulcers. b. indwelling medical devices, central line, urinary catheter, feeding tube, . A peripheral intravenous line (not a peripherally inserted central catheter [PICC]) is not considered an indwelling medical device. c. Colonization with an [multi-drug resistant organism] (MDRO). Procedure included . Post the appropriate precaution signage outside the resident room. One side may say See Nurse with the backside stating specific directives for resident privacy protection. The following residents were observed not being provided enhanced barrier precautions (EBP) as ordered and/or who met the criteria for EBP. a. Resident #133 was admitted to the facility on [DATE], with a multiple diagnoses including Type 2 Diabetes with a Foot Ulcer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order, dated 4/23/24, documented staff were to administer peripherally inserted central catheter (PICC - a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart) dressing changes weekly and as needed one time a day every Sunday. The order also stated staff were to provide wound care to Resident #133's right foot diabetic ulcer as follows: cleanse with normal saline, pat dry, apply Hydrofera (type of dressing) to the wound bed, and wrap with Kerlix (gauze dressing), an ace wrap, and tape. The order stated to change dressings daily and as needed. Resident #133's Care Plan documented Enhanced barrier precautions to reduce the risk of MDRO transmission related to history of methicillin-resistant Staphylococcus aureus (MRSA), initiated on 4/23/24. On 4/30/24 at 12:58 PM, there was no sign observed on Resident #133's door to see the nurse before entering the room and no personal protective equipment (PPE) was available in or near the Resident #133's room. b. Resident #139 was admitted to the facility on [DATE], with multiple diagnoses including Acute Cystitis with Hematuria (infection of the urinary tract with presence of blood). A physician order, dated 4/23/24, documented staff were to change Resident #139's indwelling urinary catheter bag and tubing (urine is drained through a tube inserted into the bladder and connected to a collection bag) on admission and every 30 days for urinary catheter maintenance. On 4/30/24 at 9:24 AM, there was no sign observed on Resident #139's door to see the nurse before entering the room and no personal protective equipment (PPE) was available in or near the Resident #139's room. c. Resident #26 was admitted to the facility on [DATE], with a multiple diagnoses including End Stage Renal Failure. A physician order, dated 4/11/24, documented Resident #26 was to be placed in Enhanced barrier precautions for wound treatment and dialysis. Gown and gloves required for high-contact patient care dressing, bathing, transferring, incontinence or toileting care, dressing, changing linens, or device or wound care. A gown and gloves are not required when not performing high-contact care. Resident may leave room. On 4/30/24 at 9:43 AM, there was no sign observed on Resident #26's door to see the nurse before entering the room and no personal protective equipment (PPE) was available in or near the Resident #26's room. d. Resident #135 was admitted to the facility on [DATE], with a multiple diagnoses including MRSA Infection. A physician order, dated 4/11/24, documented staff were to provide wound care for Resident #135 to the right and left gluteal cleft (deep groove lying between the two buttocks) pressure ulcers. The order directed staff to cleanse the wound with normal saline, pat dry, apply protective ointment daily, and cover with a foam dressing on every day shift until resolved. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #135's Care Plan documented, was to be placed in Enhanced barrier precautions to reduce the risk of MDRO transmission related to history of MRSA, initiated on 4/22/24. On 4/29/24 at 1:20 PM, there was no sign observed on Resident #135's door to see the nurse before entering the room and no personal protective equipment (PPE) was available in or near the Resident #135's room. e. Resident #84 was admitted to the facility on [DATE], with multiple diagnoses including MRSA Infection and End Stage Renal Disease. A physician order, dated 4/11/24, documented Resident #84 wad to be placed in Enhanced barrier precautions for wound treatment and dialysis. Gown and gloves were required for high-contact patient care dressing, bathing, transferring, incontinence or toileting care, dressing, changing linens, or device or wound care. A gown and gloves are not required when not performing high-contact care. Resident may leave room. On 4/29/24 at 1:25 PM, there was no sign observed on Resident #84's door to see the nurse before entering the room and no personal protective equipment (PPE) was available in or near the Resident #84's room. f. Resident #81 was admitted to the facility on [DATE], with multiple diagnoses including infection and inflammatory reaction due to an internal right hip prosthesis. A physician order, dated 4/23/24, documented staff were to change Resident #81's PICC line dressing weekly and as needed one time a day every Sunday. Resident #81's Care Plan documented Resident #81 was to be placed in Enhanced barrier precautions to reduce the risk of MDRO transmission related to surgical incision, initiated on 4/23/24. On 5/1/24 at 11:25 AM, there was no sign observed on Resident #81's door to see the nurse before entering the room and no personal protective equipment (PPE) was available in or near the Resident #81's room. g. Resident #5 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including Acute Bronchitis due to Respiratory Syncytial Virus. A physician order, dated 3/23/24, documented Resident #5 was to be placed in Enhanced barrier precautions for wound treatment. Gown and gloves were required for high-contact patient care dressing, bathing, transferring, incontinence or toileting care, dressing, changing linens, or device or wound care. A gown and gloves are not required when not performing high-contact care. Resident may leave room. On 5/1/24 at 11:08 AM, there was no sign observed on Resident #5's door to see the nurse before entering the room and no personal protective equipment (PPE) was available in or near the Resident #5's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135145	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascadia of Lewiston	2852 Juniper Drive Lewiston, ID 83501

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. Resident #2 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including Chronic Multifocal Osteomyelitis (a disease that causes pain and damage in bones due to inflammation). A physician order, dated 2/13/24, documented Resident #2 was to be placed in Enhanced barrier precautions for wound treatment. The gown and gloves were required for high-contact patient care dressing, bathing, transferring, incontinence or toileting care, dressing, changing linens, or device or wound care. A gown and gloves are not required when not performing high-contact care. Resident may leave room. On 5/1/24 at 11:04 AM, there was no sign observed on Resident #2's door to see the nurse before entering the room and no personal protective equipment (PPE) was available in or near the Resident #2's room. i. Resident #83 was admitted to the facility on [DATE] with multiple diagnoses including Type 2 Diabetes Mellitus with a Foot Ulcer. A physician order, dated 3/23/24, documented Resident #83 was to be placed in Enhanced barrier precautions for PICC line. The gown and gloves were required for high-contact patient care dressing, bathing, transferring, incontinence or toileting care, dressing, changing linens, or device or wound care. A gown and gloves are not required when not performing high-contact care. Resident may leave room. On 4/30/24 at 10:01 AM, there was no sign observed on Resident #83's door to see the nurse before entering the room and no personal protective equipment (PPE) was available in or near the Resident #83's room. During an interview on 5/2/24 at 9:09 AM, LPN #1 stated there were no residents on hallway one that were on isolation precautions or enhanced barrier precautions. Resident #133, Resident #139, Resident #27, Resident #26, Resident#135 were located on hallway one. During an interview on 5/2/24 at 10:43 AM, RN #1 [who worked on hallway two] stated he was not sure what EBP meant; then RN #1 stated EBP was used on residents with wounds and the supplies needed when doing wound care, PPE (gown, mask, and gloves) were located in the supply room. RN #1 stated it was something new and was not sure what EBP involved, was not sure if CNAs should wear PPE. RN #1 was unable to identify which residents on hallway two were on EBP. RN #1 confirmed he did not have training on the EBP policy. Resident #84, Resident #81, Resident #5, Resident #2, and Resident #83 were located on hallway two. During an interview on 5/2/24 at 10:07 AM, the Infection Preventionist (IP) stated orders were placed in resident's electrtonic medical record (EMR) depending on criteria of EBP, the EBP be in the header for each resident in their EMR. The IP then confirmed residents who should have been on EBP did not have information listed for EBP on the header in the EMR. The IP stated there were no signs on the doors for residents who met the criteria for EBP, and no PPE supplies were located in or near the resident rooms for use. (continued on next page)

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	135145	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascadia of Lewiston	2852 Juniper Drive Lewiston, ID 83501

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/2/24 at 10:54 AM, the CNO and the CRN stated the staff was to initiate EBP for residents who met the criteria outlined in the procedure. They stated for direct resident care of a wound, dressing change of a PICC line, or care of a wound, PPE supplies should be located in or near the resident room. The CRN stated the signs were not located on the door, the PPE supplies were not in or near the resident rooms and staff were not aware of the updated transmission-based precautions policy.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure newly admitted residents were provided education for pneumococcal vaccines prior to refusing the vaccine. This was true for 5 of 5 residents (#2, #7, #14, #15, and #16) reviewed for pneumococcal immunizations. This failure created the potential for harm should residents contract Pneumococcal pneumonia and experience illness from pneumonia. Findings include: The facility's policy for their Pneumococcal Program, revised 5/31/23, stated Educate residents or resident advocate about the pneumococcal vaccination, the benefits, potential side effects and general safety of receiving the vaccine. Provide a copy of the VIS [Vaccination Information sheet] statement. The following residents did not receive education prior to refusing the pneumococcal vaccine. a. Resident #14 was admitted to the facility on [DATE]. A Vaccine Information Acknowledgement, dated 2/14/24, documented Resident #14 checked the box I do not wish to take (blank line filled in with word any) vaccine at this time and the boxes for information about the pneumococcal vaccine to be provided to the resident (Vaccine Information Sheet), were not checked. b. Resident #7's was admitted to the facility on [DATE] and readmitted on [DATE]. A Vaccine Information Acknowledgement, dated 2/2/24, documented Resident #7 checked the box I do not wish to take (blank line filled in with word any) vaccine at this time and the boxes for information about the pneumococcal vaccine to be provided to the resident (Vaccine Information Sheet), were not checked. c. Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE]. A Vaccine Information Acknowledgement, dated 2/2/24, documented Resident #2 checked the box I do not wish to take (blank line filled in with word any) vaccine at this time and the boxes for information about the pneumococcal vaccine to be provided to the resident (Vaccine Information Sheet), were not checked. d. Resident #15 was admitted to the facility on [DATE] and readmitted on [DATE]. A Vaccine Information Acknowledgement, dated 2/2/24, documented Resident #15 checked the box I do not wish to take (blank line filled in with word any) vaccine at this time and the boxes for information about the pneumococcal vaccine to be provided to the resident (Vaccine Information Sheet), were not checked. e. Resident #16 was admitted to the facility on [DATE]. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Vaccine Information Acknowledgement, dated 3/15/24, documented Resident #16 checked the box I do not wish to take (blank line filled in with word any) vaccine at this time and the boxes for information about the pneumococcal vaccine to be provided to the resident (Vaccine Information Sheet), were not checked. During an interview on 5/1/24 at 1:10 PM, the Infection Preventionist (IP) stated the process was to review the Vaccine Information Acknowledgement form at admission if the resident desired the pneumococcal vaccine and if they wanted th vaccine, then it would be provided. The IP confirmed the Vaccine Information Sheet was not provided to the residents during the admission process when the Vaccine Information Acknowledgement form was signed to provide the vaccine or not. During an interview on 5/2/24 at 10:59 AM, the CNO and the CRN stated the Vaccination Information Sheet was not provided during the admission process prior to the signing of the Vaccine Information Acknowledgement form and the Vaccination Information Sheet should have been provided to the residents prior to signing the form.