STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135146	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascadia of Boise	6000 W Denton St Boise, ID 83704

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interviews, it was determined the facility failed to notify a resident's representative of an accident. This was true for 1 of 3 residents (Resident #20) reviewed for notifications. This deficient practice had the potential to prevent Resident #20 and/or their representative from making timely and informed decisions regarding the resident's medical care. Findings include: The Facility's Fall Response & Management policy, revised 8/21/25, documented facility will notify the provider and resident representative if a resident sustains a fall.Resident #20 was readmitted to the facility on [DATE] with multiple diagnoses including Alzheimer's, dementia, anxiety, kidney disease, and diabetes.The fall report dated 12/16/25, documented Resident #20 was found face down on the floor next to her bed. Upon examination, Resident #20 had a significant bump to the back of the right side of her head and small red mark under her right eye. The I&A report dated 12/16/25, identified Resident #20's representative was not notified. On 5/12/26 at 5:03 PM, the CNO confirmed Resident #20's representative had not been notified of her fall and he should have been.

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to follow the physician's order to monitor urinary output. This was true for 1 of 3 residents (Resident #4) whose bowel and bladder records were reviewed. This deficient practice had the potential to affect Resident #4's hydration status when physicianˆordered monitoring was not completed. Findings include:Resident #4 was admitted to the facility on [DATE] with multiple diagnoses including quadriplegia (the partial or total paralysis of all four limbs, both arms and both legs, and the torso), epilepsy, and retention of urine.A physician's order initiated 4/24/25 and revised on 1/20/26, documented to measure and record output for Resident #4's indwelling urinary catheter every shift for hydration management.A review of Resident #4's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for the months of October 2025 through April 2026 showed the physicianˆordered monitoring of urinary output was not consistently documented. The following missed opportunities were identified:- October 2025: 9 of 58 opportunities were blank- November 2025: 11 of 60 opportunities were blank- December 2025: 6 of 54 opportunities were blank- February 2026: 3 of 54 opportunities were blank- March 2026: 4 of 62 opportunities were blank- April 2026: 6 of 54 opportunities were blankOn 5/12/26 at 4:25 PM, on review of Resident #4's record, the CNO confirmed urinary output was not recorded.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on resident interviews, representative interviews, staff interviews, observations, review of grievances, and review of the three-week nursing schedule, it was determined the facility failed to ensure sufficient staffing was available to meet resident needs according to their plan of care. This failure had the potential to affect all residents residing in the facility if staff were not available to ensure resident needs and safety measures were provided. Findings include: The National Academies of Sciences, Engineering, and Medicine (NASEM) website accessed on 5/13/26, article titled The National Imperative to Improve Nursing Home Quality (2022) documents, inadequate staffing contributes to delayed care, missed care tasks, and reduced resident safety. Staffing must be aligned with resident acuity, not just minimum numbers.A review of facility Grievance Forms, dated 10/3/25 through 5/4/26, showed multiple concerns reported by residents and their representatives related to call light response times, delayed care, untimely medication administration, staff attitude, and unmet care needs. The facility's investigations confirmed the allegations in the majority of grievances reviewed. Examples include: -10/3/25: A resident's representative reported staff were not rounding every two hours and the resident was frequently wet, and antiˆdiarrheal medication was not provided timely. The investigation confirmed residents were not being changed timely. -10/6/25: A resident's representative reported staff were not changing the resident's clothing, not giving medications on time, and not positioning the resident during meals. The investigation confirmed the allegation. -10/23/25: A resident reported long wait times for pain medication. The investigation confirmed the allegation. -10/31/25: A resident's representative reported a call light was activated at 4:54 PM for incontinence care; direct care staff were not able to provide care until 6:22 PM. The grievance did not include an investigation. -10/31/25: A resident's representative reported the resident was not prepared in time for a family function. The investigation confirmed the allegation. -11/11/25: A resident's representative reported long call light response times and staff attitude concerns. The investigation confirmed the allegation; however, the investigation did not address the long call light response time. -11/18/25: A resident reported staff were not checking on her during the night or when family was present. The investigation confirmed the allegation. -12/1/25: A resident's representative reported medication was provided at 6:30 PM and staff tone was inappropriate. The investigation confirmed the allegation. -12/1/25: A resident's representative reported staff were not responding to call lights quickly enough to prevent the resident from soiling himself. The investigation confirmed the allegation. -12/2/25: A resident's representative reported call light response times of 30-40 minutes. The investigation confirmed the allegation. -12/4/25: A resident's family reported staff were not responding to call lights. The investigation confirmed the allegation.-12/16/25: A resident's family reported delayed call light response, staff cell phone use, missed medication coordination, unclean room conditions, and cold meals. The investigation confirmed the allegation. The family transferred the resident to another facility.-12/23/25: A resident's family reported delayed call light response, staff phone usage, and unmet ADL needs. The investigation confirmed the allegation. On 12/26/25, the family requested the resident be transferred.-1/6/26: A resident's physician reported wound maceration and that the resident's incontinence brief was saturated with urine. The investigation confirmed the allegation.-1/14/26: A resident reported long call light wait times. The investigation confirmed the allegation.-1/14/26: A resident reported long call light response times and staff attitude concerns. The investigation confirmed the allegation. The resident was later sent to the emergency room and did not return.-2/20/26: A resident reported staff attitude concerns and delayed call light response. The investigation confirmed the allegation. -3/17/26: A resident reported long call light wait times during morning and night shifts. The investigation confirmed the allegation.-3/18/26: A resident's representative reported staff turned off the resident's call light without providing care and returned an hour later. The investigation confirmed the allegation. -3/23/26: A resident's (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	representative reported long call light wait times. The investigation confirmed the allegation. -4/7/26: A resident reported their call light was on for two hours. The investigation confirmed the allegation.-4/9/26: A resident's representative reported long call light wait times during the day shift. The investigation confirmed the allegation. -4/18/26: A resident reported concerns with call light response. The investigation confirmed the allegation.-4/27/26: A resident and family reported the facility was not answering the doorbell or phones on weekends and call light response was delayed. The investigation confirmed the allegation.-5/1/26: A resident reported long call light response times and lack of followˆthrough on requests. The investigation confirmed the allegation.-5/4/26: A resident's representative reported delayed call light response over the weekend. The investigation confirmed the allegation.A review of Resident Council Meeting minutes dated October 2025 through February 2026 showed residents repeatedly voiced concerns related to call light response times and staff attitude. Examples include:-October 2025: Residents voiced concerns regarding call light wait times and staff attitude.-November 2025: Residents voiced concerns regarding call light wait times.-December 2025: Residents voiced concerns regarding the length of call light response times.-January 2026: Residents voiced concerns regarding call light wait times, particularly during evening hours, and concerns regarding staff attitude.-February 2026: Residents voiced concerns regarding night shift call light response times.-March-May 2026: Resident Council Meeting minutes were not available for review.A review of the threeˆweek facility staffing schedule dated 4/19/26 through 5/9/26 documented consistently lower staffing hours on weekends compared to weekdays, as follows:Week 1- 4/19/26 (Sunday): Census 92 - Staffing hours: 297.9- 4/20/26 (Monday): Census 91 - Staffing hours: 343.6- 4/21/26 (Tuesday): Census 92 - Staffing hours: 401- 4/22/26 (Wednesday): Census 94 - Staffing hours: 370- 4/23/26 (Thursday): Census 97 - Staffing hours: 402.8- 4/24/26 (Friday): Census 98 - Staffing hours: 395.1- 4/25/26 (Saturday): Census 99 - Staffing hours: 312.5Week 2- 4/26/26 (Sunday): Census 99 - Staffing hours: 318- 4/27/26 (Monday): Census 96 - Staffing hours: 396- 4/28/26 (Tuesday): Census 97 - Staffing hours: 384.1- 4/29/26 (Wednesday): Census 96 - Staffing hours: 370- 4/30/26 (Thursday): Census 92 - Staffing hours: 367.9- 5/1/26 (Friday): Census 92 - Staffing hours: 367.9- 5/2/26 (Saturday): Census 93 - Staffing hours: 314Week 3- 5/3/26 (Sunday): Census 93 - Staffing hours: 328.6- 5/4/26 (Monday): Census 93 - Staffing hours: 368.6- 5/5/26 (Tuesday): Census 96 - Staffing hours: 399.5- 5/6/26 (Wednesday): Census 94 - Staffing hours: 378.7- 5/7/26 (Thursday): Census 94 - Staffing hours: 385.4- 5/8/26 (Friday): Census 93 - Staffing hours: 379- 5/9/26 (Saturday): Census 91 - Staffing hours: 329.4On 5/12/26 at 4:42 PM, the CEO stated the census on the skilled side was the highest it has ever been and the increase in grievances has gone up.On 5/13/26 at 9:57 AM, Resident #25's representative stated weekends were kind of dead, and the resident reported it was like a ghost town. She stated she keeps a record of concerns and, upon arriving that morning, found Resident #25 soaked in urine, shivering, and wearing only an incontinence brief. She stated, They don't have enough staff.On 5/13/26 at 10:27 AM, CNA #1 stated, Night shift has been a challenge, and reported working multiple shifts until additional staff could be trained and hired. CNA #1 stated they encourage residents to voice concerns during Resident Council meetings if they feel they are not receiving enough help.On 5/13/26 at 10:36 AM, it was observed that a resident's representative asked staff if the resident could receive a shower that day.On 5/13/26 at 10:40 AM, RN #1 stated staffing could be better and reported that recent Medicaid cuts resulted in the facility reducing one nurse position and some CNA positions. RN #1 stated the facility had begun slowly reinstating positions due to workload needs. On 5/13/26 at 11:55 AM, the CEO stated staffing is based on the needs and acuity of the patients and appropriate staff are assigned; however, there are two-unit managers during the week and a wound nurse on Tuesdays whose hours are accounted for during the week. On weekends we have one unit manager.