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	11/19/2025

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

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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 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 record review and staff interview, it was determined the facility failed to ensure residents' Minimum Data Set (MDS a standardized assessment tool that measures health status in nursing home residents) Assessments were accurate. This was true for 3 of 6 residents (#5, #16, and #59) whose MDS assessment records were reviewed for accuracy. This deficient practice created the potential for negative outcomes if residents were not assessed and/or monitored due to assessment inaccuracies'. Findings include: 1. Resident #5 was admitted to the facility on [DATE] with multiple diagnoses including chronic respiratory failure, anxiety disorder, panic disorder, and depression. Resident #5's PASRR Level I, dated 6/26/23, documented, in Section I at #1, diagnoses of depressive disorders and anxiety disorders, and at #3, panic disorder. Resident #5's PASRR Level II, dated 7/20/26, documented, in Section IX at #33, Individual has a current diagnosis of sever mental illness per PASRR criteria: Depression, Anxiety, Panic Disorder. Resident #5's Annual MDS assessment dated [DATE], documented under A1500 in Section A, the question, Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition? was answered no. On 9/24/25 at 5:45 PM, the MDS Nurse stated his understanding was if the PASRR level II had box 36 checked and no additional services were recommended then Resident #5 was considered not reviewed for a level II PASRR, on review of Resident #5's Annual MDS dated [DATE] the MDS Nurse stated her assessment was inaccurate. 2. Resident #16 was admitted to the facility on [DATE] with multiple diagnoses including spastic quadriplegic cerebral palsy (paralysis of all four limbs with muscle stiffness due to brain damage at birth or abnormal development), chronic respiratory failure, and epilepsy. Resident #16's PASRR Level I, dated 1/10/25, documented at Section IV, #15, Does the individual have a diagnosis of intellectual disability (ID) - An intellectual disability is evidenced by an IQ of less than 70 based on standardized, reliable tests; onset before age [AGE]? answered yes, at birth cerebral palsy and developmental delay. Resident #16's Admissions MDS assessment dated [DATE], documented under A1500 in Section A, the question, Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition? was answered no. (continued on next page)

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	On 9/24/25 at 5:49 PM, the MDS Nurse stated, Resident #16's Admissions MDS assessment was inaccurate due to his diagnosed intellectual disability. 3. Resident #59 was admitted to the facility on [DATE], with multiple diagnoses including quadriplegia (paralysis that affects the ability to voluntarily move the upper and lower body), depression and anxiety. Resident #59's comprehensive MDS assessment dated [DATE], documented under A1500 in Section A, no for the questions, Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition? Resident 59's electronical record included documentation of a PASRR level II dated 9/12/25, documenting Resident #59 was considered to have a severe mental illness. On 9/24/25 at 5:42 PM, the MDS Nurse stated his understanding was if the PASRR level II had box 36 checked and no additional services were recommended then Resident #59 was considered not reviewed for a level II PASRR, on review of Resident #59's Comprehensive MDS dated [DATE] the MDS Nurse acknowledged it was inaccurately completed.

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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 and staff interview it was determined the facility failed to ensure residents' care plans were revised according to their post fall needs. This was true for 1 of 22 residents (Resident #33) whose records were reviewed for care plan timing and revision. This deficient practice created the potential for harm when residents' needs were not identified and or met. Findings include:Resident #33 was admitted to the facility on [DATE] with multiple diagnoses including a broken right leg, difficulty walking, muscle weakness, Alzheimer's disease, and dementia.On 9/22/25 at 5:28 PM, Resident #33's representative stated her mom had fallen out of bed a few times as she is a restless sleeper and was on a new mattress. Resident #33's representative stated fall precautions had been put into place. There was a floor pad placed, and Resident #33's bed was in the lowest position while she was in bed.An Incident & Accident (I&A) fall report, dated 8/21/25, documented an unwitnessed fall with Resident #33. She was laying on right side and in noted distress. The report further documented an Interdisciplinary (IDT) review, dated 8/22/25, documented Resident #33 did not have an injury related to her fall and that she would be out of the room when in her wheelchair. The fall report documented a fall assessment was completed, on 8/21/25, where the intervention to prevent a future fall would be a fall mat. A Post Fall Evaluation, dated 8/21/25, documented Resident #3 had an unwitnessed fall and was found on the floor within one (1) foot of her bed. At the time of the fall, Resident #33 had gripper socks on her feet and a fall mat assistive device.A review of Resident #33's care plan documented the following fall risk precautions:Door of room open as resident will allow, initiated 7/25/25. Keep adjustable bed in position for safe transfers. Lock bed brakes initiated 7/25/25. Out of room when up in wheelchair, initiated on 8/22/25. From 9/22/25 through 9/25/25, a fall mat was observed on the floor near Resident #33's bed. When Resident #33 was in bed, the bed was in the lowest position. Resident #33 was in the main dining room area when up in her wheelchair, and her door was open most of the time, except during cares.On 9/25/25 at 3:21 PM, the CRN stated the fall mat was not in Resident #33's care plan. She further stated if the fall mat is in Resident #33's room, it should be on her care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and Insulin Lispro website, it was determined the facility failed to ensure residents' medications were administered according to professional standards of practice. This was true for 1 of 2 residents (Resident #36) whose insulin administration was observed. This failed practice created the potential for Resident #36 experience low or high blood sugar if she receives an incorrect amount of insulin. Findings include:Resident #36 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including diabetes.A physician's order, dated 9/2/25 documented Resident #36 was to receive Insulin Lispro 100 unit/ml, inject two units subcutaneously (under the skin) before meals for diabetes management.On 9/24/25 at 11:58 AM, RN #3 took the Insulin Lispro pen, removed the needle, sanitized the tip of the insulin pen, placed a new needle and dialed the pen to two units. RN #1 stated she did not prime the needle because it was an old pen, if it was a new pen then she would prime it. On 9/24/25 at 4:45 PM, the Acting DON stated the insulin pen should be primed before each administration.The Insulin Lispro website, accessed on 9/29/25 stated, priming your insulin pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin.

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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** Based on record review and staff interview it was determined the facility failed to ensure professional standards of practiced were followed. This was true for 3 of 22 residents (#6, #7, and #58) reviewed for following physician's orders. This deficient practice created the potential for harm if the facility failed to follow physician's orders and if resident's experienced complications related to catheter placement and care, and hypoglycemia (a condition in which blood glucose (BG, sugar) falls below normal.) Findings include: 1.Resident #7 was admitted to the facility on [DATE] with multiple diagnoses including diabetes. A physician's order, dated 8/22/25, directed staff to check blood glucose for hypoglycemic (low blood sugar) and/or hyperglycemic (high blood sugar) symptoms. If blood sugar (BG) is less than 70 initiate hypoglycemic protocol and notify MD as indicated. If BG is greater than 400 notify MD and follow directives. A physician's order, dated 8/20/2025, documented staff provide: Gvoke HypoPen 1-Pack Solution Auto-injector 1 mg/0.2 ml (Glucagon; medically used to treat very low blood sugar.) Inject 1 mg subcutaneously as needed for blood sugar less than 70 mg/dl and unable to swallow. Take dose from E-kit .Give 1mg of Gvoke, recheck in 15 minutes. If no improvement, notify the MD immediately. If improving, may repeat. Recheck BG in 15 minutes and Inject 1 mg subcutaneously as needed for blood sugar less than 70 mg/dl and unable to swallow Take dose from E-kit .Give 1 mg of Gvoke, recheck in 15 minutes. If no improvement notify the MD immediately. If improving, may repeat. Recheck BG in 15 minutes Resident #7's medical record documented a BG of 50 mg/dL. A second BG was not taken and recorded as ordered by the physician. On 9/25/25 at 4:29 PM, CRN stated the staff in question did not follow the hypoglycemic protocol to retake a BG 15 minutes later if levels were below 70 mg/dl. 2.Resident #58 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including amyotrophic lateral sclerosis (a progressive neurodegenerative disease that affects nerve cells in the brain and spinal cord, leading to muscle weakness and paralysis), acute and chronic respiratory failure with hypoxia (low levels of oxygen in the body's tissue) and encounter for attention to tracheostomy. On 9/23/25 at 10:56 AM, 9/24/25 at 8:23 AM and 9/25/25 at 10:58 AM, Resident #58 was observed to have a urinary catheter. Review of Resident #58's physician's order did not include an order for urinary catheter. On 9/24/25 at 3:45 PM, when asked about Resident #58's urinary catheter, the Acting DON stated the facility would review physician's order within 24 hours of admission of residents in the facility. The Acting DON stated Resident #58 was readmitted to the facility on [DATE] and his physician's order was not updated due several admissions they had and unforeseen circumstances.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on record review and staff interview, it was determined the facility failed to ensure medication orders were clarified. This was true for 1 of 6 residents (Resident #87) whose records were reviewed for unnecessary medications. This failure placed Resident #87 at risk for over medication when her rescue seizure medication orders did not clearly direct their use. Findings include: Resident #87 was admitted the facility on 4/5/23 with multiple diagnoses including spastic quadriplegic cerebral palsy (characterized by stiff muscles and movement difficulties in all four limbs, the trunk, and the face due to early-life brain damage), a seizure disorder, and congenital hydrocephalus (a condition present at birth where excess cerebrospinal fluid (CSF) builds up in the brain, increasing pressure and potentially causing brain injury and developmental problems). Resident #87's medical record contained the following physician orders:Nayzilam Nasal Solution 5 MG/ 0.1 ML, Midazolam (benzodiazepine anticonvulsant), give 1 spray in 1 nostril as needed for seizure that lasts for more than 5 minutes or for more than 3 seizures in 24 hours, dated 7/13/23.Valtoco Nasal Liquid 5 MG/ 0.1 ML, Diazepam (benzodiazepine anticonvulsant), give 15 MG in 1 nostril as needed for seizure lasting 5 minutes or 2 seizures in 24 hours, dated 7/23/25. On 9/26/25 at 10:02 AM, the Acting DON stated, Resident #87's Nayzilam and Valtoco directions were not clear which medication should be given when they had a seizure and needed to be clarified to avoid medication error or over medication.

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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. Based on observation, the Food Drug Administration (FDA) Food Code, and staff interview, it was determined the facility failed to ensure ice machines were cleaned, and resident freezers were not contaminated by non-food items, or undated, opened food. These deficiencies had the potential to affect the 70 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 3-501.17 Ready-to-Eat, TCS (time/temperature control for safety) food, date marking, states marking 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 9/26/25 at 12:08 PM, it was observed in the Alpine Resident freezer, undated lemon ices, a frozen yogurt, and a frozen entree meal were not labeled with the resident's name or dated. A therapy ice pack was wrapped in a pillowcase and stored on the top shelf of the freezer.On 9/26/25 at 12:10 PM, RN#2 stated the pillowcase wrapped ice pack should not be in the food freezer. When asked if he was aware the freezer & frozen food was now contaminated, RN #2 stated the freezer food was contaminated and it would get thrown away. On 9/26/2025 at 12:14 PM, the CDM was unaware resident's spouses were storing non-food items in the resident's freezer as there is a resident food policy in all admission packets. She agreed the freezer would need to be clean and sanitized, with the resident's food thrown away. 2. The FDA Food Code Section 4-602.11 Equipment Food-Contact Surfaces and Utensils documented surfaces of utensils and equipment contacting food that is not time/temperature control for food shall be cleaned.On 9/22/25 at 10:50 AM, the ice machine in the kitchen was observed to have a dark residue on the interior portion of the white plastic ice separator.On 9/22/25 at 10:55 AM, the RD identified the same dark residue and stated the ice machines are cleaned quarterly. She was not sure why the machine did not appear to be cleaned.On 9/22/25 at 11:35 PM, it was observed in the Alpine ice room, the ice machine had a dark resident on the interior portion of the white place ice separator.On 9/22/25 at 11:37 PM, RN #2 identified the same dark residue and stated the ice machines are cleaned regularly, but he was not sure when it had last been cleaned.

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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** Based on record review and staff interview it was determined the facility failed to ensure resident's records contained accurate documentation related to their vital signs. This was true for 1of 22 residents (Resident #7) whose record was reviewed for accurate documentation. This deficient practice had the potential for adverse outcomes and harm if Resident #7's blood pressure was taken in an unsafe manner. Findings include:Resident #7 was admitted to the facility on [DATE] with multiple diagnoses including high blood pressure, end stage renal disease (ESRD), and dependence on renal dialysis.A physician's order, dated 8/20/25 and 8/26/25, documented, Check fistula sight to the Left arm for signs and symptoms of infection and if bruit or thrill present, enter = if present and - if not present. Enter NA if not applicable. Every shift for dialysis monitoring. A physician's order, dated 8/20/25, documented, Do NOT take blood pressure on Left arm.A review of blood pressure (BP) measurements documented BP was taken on the Left arm on the following dates: 9/1/25; 9/2/25; 9/6/25; 9/7/25; 9/9/25; 9/10/25; 9/15/25; 9/17/25; 9/22/25 8/20/25; 8/24/25; 8/26/25; 8/29/25; 8/30/25; 8/31/25On 9/25/25 at 10:40 AM RN #2 stated, nurses know not to take BP from a fistula arm. However, they may accidently record taking a BP on the left arm when they meant to document taking the BP on the right arm. This would be inaccurate documentation.

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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, staff interviews, and review of Centers for Disease Control and Prevention (CDC) guidance, it was determined the facility failed to implement infection prevention and control practices to prevent cross-contamination for 2 of 2 Residents (Resident #85 and Resident #59) reviewed for infection control. This failure created the potential for adverse health outcomes, including infection. Findings include:The Centers for Disease Control and Prevention (CDC) web page titled, Clinical Safety: Hand Hygiene for Healthcare Workers, updated 2/27/24, documented hand hygiene should be performed:Immediately before touching a patient.Before performing aseptic task such a placing an indwelling catheter device or handling invasive medical device.Before moving from a soiled body site to a clean body site on the same patient.After touching a patient or patients' surroundings.After contact with blood, body fluids, or contaminated surfaces. Immediately after glove removal.1.Resident #85 was admitted to the facility on [DATE], with multiple diagnoses including respiratory failure, malnutrition, and seizures. On 9/25/25 at 12:03 PM, RT #2 was observed approaching the doorway to Resident #85's room, knocked on the door and entered the room, RT #2 walked up to the supply of personal protective equipment (PPE). She donned her gown, gloves, and mask. No hand hygiene was observed prior to donning her PPE. She then proceeded to approached Resident #85 to assist with cleaning the phlegm off his chest and to suction him. Upon completion of cares RT #2 was observed doffing her gown, gloves, and mask and performing hand hygiene. On 9/25/25 at 12:07 PM, RT #2 stated she should have performed hand hygiene before the application of her PPE. 2.Resident #59 was admitted to the facility on [DATE], with multiple diagnoses including quadriplegia (paralysis that affects the ability to voluntarily move the upper and lower body), depression and anxiety. On 9/24/25 at 10:27 AM, during a wound care observation LPN #1 was observed took one skin prep pad and wiped Resident #59's right heel in a circular motion. She allowed it to dry and proceeds to wipe the left heel with the second skin prep pad in a circular motion. After allowing time for the left heel to dry LN #1 and CNA #1 assisted Resident #59 to reposition in a left lateral position. LN assisted Resident #59 with peri care, discarded the wipes and proceeded to take a gauze socked with normal saline and cleansed the open wound site. No glove change or hand hygiene was observed between peri care and wound care. LN applied venelex and attempted to place a dressing, which fell off. She used a skin prep pad to reattempt placement and later removed the dressing, stating she would return with a larger one. On 9/24/25 at 10:41 AM, LN stated she should have removed her gloves and performed hand hygiene when transitioning between body sites and after peri care. She also stated that a new order had been implemented to leave the wound site uncovered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #58 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including amyotrophic lateral sclerosis (a progressive neurodegenerative disease that affects nerve cells in the brain and spinal cord, leading to muscle weakness and paralysis), acute and chronic respiratory failure with hypoxia (low levels of oxygen in the body's tissue) and encounter for attention to tracheostomy. On 9/22/25 at 3:19 PM. an Enhanced Barrier Precautions signage was observed posted at the entrance of Resident #58's room directing staff to wear gloves and a gown for the following high contact resident activities including device care or use such as tracheostomy (a surgical hole in the windpipe that helps with breathing when the usual way is blocked or reduced). On 9/25/25 at 11:19 AM, RT #1 with a gloved hand was observed suctioning Resident #58's endotracheal tube (a flexible tube inserted into the trachea [windpipe] to maintain an open airway and assist with breathing). RT #1 was not wearing a gown. On 9/25/25 at 11:23, RT #1 stated he should have worn a gown while suctioning Resident #58's endotracheal tube and he did not.