STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135079	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Valley of Cascadia	8211 Ustick Road 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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 48401 Based on resident group interview, review of resident council meeting minutes, and staff interview, it was determined the facility failed to ensure resident concerns were addressed. This deficient practice placed residents at risk for their needs going unmet, diminished quality of life, and decreased sense of self-worth. Findings include: On 4/3/24 at 10:30 AM, 13 residents attended a group interview. All residents in attendance voiced concerns about poor communication between the resident council and the facility administration and unaddressed grievances. Resident Council Meeting minutes from May 2023 through March 2024 included concerns regarding hot meal carts that deliver trays to the halls sitting with their food in them for hours before it was served, and staffing regarding call light response time. The facility did not document what actions were taken to address and resolve these concerns. On 4/5/23 at 12:30 PM, the CEO stated he was unaware grievances were not being completed for concerns brought up at resident council, so their concerns were not resolved.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with a safe, clean, homelike environment. This was true for 5 of 8 residents (#23, #35, #45, #81 and #350) observed or interviewed for their environment and had the potential for all 106 residents who resided in the facility to be affected, whose common area environment was observed. This deficient practice created the potential for harm if: a) residents were embarrassed by dirty equipment and/or felt the lack of cleanliness in the facility was unacceptable, disrespectful, or undignified, and b) cross-contamination from spread of microorganisms. Findings include: The facility's Resident Environment policy, revised 11/28/19, documented housekeeping and maintenance services were to be provided to maintain a sanitary, orderly, and comfortable interior. The following residents were observed with equipment that was soiled or voiced concerns about the cleanliness of their environment: - On 4/1/24 at 2:23 PM, Resident #45's wheelchair was observed with a hair-like substance in the wheels and a layer of gray substance on the black, metal bars of her wheelchair. -On 4/2/24 at 12:11 PM, a dry, cream-colored substance on an IV pole and base of the IV pole was observed in Resident #350's room. On 4/2/24 at 2:25 PM, RN #1 stated the residents' equipment was cleaned weekly by the CNAs and as needed. RN #1 stated the cream-colored substance on Resident #350's IV pole would not wash off. On 4/2/24 at 2:27 PM, RN #1 was able to wipe off the cream-colored substance from Resident #350's IV pole and base - On 4/3/24 at 10:43 AM, Resident # 23's wheelchair was observed with a layer of gray substance on the bars of the wheels and the black, metal bars under the seat of his wheelchair. - On 4/5/24 at 9:56 AM, Resident # 35's wheelchair was observed with a layer of gray substance on the black, metal bars and the bars of the wheels, and hair like substance hanging from the bars of her wheelchair. - On 4/1/24 at 1:17 PM, Resident #81 stated his shower had not been cleaned for several weeks, his linens did not get taken out, and his trashcans had not been emptied on a regular basis. Resident #81 also stated housekeeping cleaned his room maybe 2 times a week. The following common residential environment areas were observed as unsanitary: - On 4/2/24 at 10:57 AM, the 700 hall wall outside room [ROOM NUMBER] was observed with a dried light brown substance. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 4/2/24 at 12:49 PM, the railing on the left side of the 500 hall by the floor scale, a dark brown dry substance was observed. - On 4/2/24 at 3:51 PM, the wall outside of room [ROOM NUMBER] was observed with a brown, dried splattering and the common area windows that looked into the room with the television, had a cloudy film. - On 4/4/24 at 10:01 AM, the 500 hall shower room toilet was observed with a dark brown ring in the commode. The toilet base had a gray substance on it. The sharps container (container in which used needles are disposed of) was past the full line. -On 4/4/24 at 4:33 PM, the 700 hall shower room floors were observed with gray film on the floor. The railing in the shower stall had a brown colored substance under the plastic cover. There were holes in the dry wall and there was dust on vent cover. - On 4/5/24 at 9:08 AM, the 800 hall shower room was observed with a dark gray film on the floor, the rail in the shower stall had a brown substance under the plastic wrap. The shower curtain in the 800 hall shower stall had a brown substance on the bottom of the curtain. Linens were observed on the floor. On 4/5/24 at 9:00 AM, Housekeeper #1 stated the shower rooms should be cleaned daily. Housekeeper #1 also stated the halls and resident rooms were to be cleaned daily, and CNAs and housekeepers took out the trash. On 4/5/24 at 9:08 AM, CNA #1 stated the shower room was to be cleaned daily and linens should not be on the floor. On 4/5/24 at 10:40 AM, the Housekeeping Manager stated resident rooms were to be cleaned daily including bathrooms and floors. The Housekeeping Manager also stated cleaning of the common areas was to be done daily. He stated the housekeepers did not document what was cleaned or when it was cleaned, it was just part of their job.

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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	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** 49552 Based on policy review, record review, review of the State Survey Agency's Long-Term Care Reporting Portal, and resident and staff interview, it was determined the facility failed to report potential neglect to the State Survey Agency within 5 days of the alleged occurrence. This was true for 1 of 7 residents (Resident # 81) reviewed for neglect reporting and investigation. This failure created the potential for residents to be subjected to ongoing neglect without detection and protective measures implemented by the facility. Findings include: The facility's Abuse policy revised 8/1/23, documented the staff reports any alleged violations involving verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, and neglect of the resident as well as mistreatment to a Senior Clinician or Operational Leader at the facility, or other officials in accordance with State regulations through established procedures (including to the State survey and certification agency). Resident # 81 was admitted to the facility on [DATE], with multiple diagnoses including muscle wasting and fracture of the neck. Resident #81's quarterly assessment, dated 3/13/24, documented Resident #81 was cognitively intact. On 4/3/24 at 2:44 PM, Resident #81 stated the number of pills he received in the morning was not always the same. He stated he received 7-8 pills during the morning medication pass and several nurses left his medication on his bedside table. Resident #81 stated one time the medication cup with pills in it was left on his bedside table. He stated the medication cup contained 4 pills [not 7 or 8] and written on the side of the cup was 604. Resident #81 stated he did not think they were his pills, so he kept them until LPN #4 came in later the same day and he asked her about the pills. Resident #81 said LPN #4 told him he should not have received those pills. On 4/4/24 at 9:05 AM, LPN #4 stated about 2 weeks ago Resident #81 gave her a medication cup containing 4 pills and 604 was written on the cup. Resident #81 told LPN #4 the pills were left on his bedside table. LPN #4 stated she thought it was left on Resident #81's bedside table by the night nurse because of the number of pills in the medication cup. LPN #4 also stated medication was not to be left on a resident's bedside table. LPN #4 stated she disposed of the medication with another floor nurse then reported it to the IP. On 4/4/24 at 6:05 PM, the IP stated he could not remember the exact date of when the medication was left on Resident #81's bedside table but LPN #4 told him she thought the weekend staff had left the medication on the bedside table. RN #1 stated he did not see the medication because LPN #4 had disposed of it, so he did not know if Resident #81 received the wrong medication. The IP stated he was not sure if an I&A report was completed. On 4/5/24 at 6:15 PM, the CNO, CEO, and the IP were interviewed together. The IP stated he did not immediately submit an I&A report related to the incident. The CEO stated he was not made aware of the incident until 4/4/24 and it was not reported to the State Survey Agency's Long-Term Care Reporting Portal.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on policy review, record review, review of the State Survey Agency's Long-Term Care Reporting Portal, and resident and staff interview, it was determined the facility failed to ensure an allegation of neglect was thoroughly investigated. This was true for 1 of 7 residents (Resident # 81) reviewed for abuse and neglect. This failure created the potential for residents to be subjected to ongoing neglect without detection and protective measures implemented by the facility. Findings include: The facility's Abuse policy, revised 8/1/23, documented the staff reports any alleged violations involving verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, and neglect of the resident as well as mistreatment to a Senior Clinician or Operational Leader at the facility, or other officials in accordance with State regulations through established procedures (including to the State survey and certification agency). Resident #81 was admitted to the facility on [DATE], with multiple diagnoses including muscle wasting and fracture of the neck. Resident #81's quarterly assessment, dated 3/13/24, documented he was cognitively intact. On 4/3/24 at 2:44 PM, Resident #81 stated the number of pills he received in the morning was not always the same. He stated he received 7-8 pills during the morning medication pass and several nurses left his medication on his bedside table. Resident #81 stated one time the medication cup with pills in it was left on his bedside table. He stated the medication cup contained 4 pills [not 7 or 8] and written on the side of the cup was 604. Resident #81 stated he did not think they were his pills, so he kept them until LPN #4 came in later the same day and he asked her about the pills. Resident #81 said LPN #4 told him he should not have received those pills. On 4/4/24 at 9:05 AM, LPN #4 stated about 2 weeks ago Resident #81 gave her a medication cup containing 4 pills and 604 was written on the cup. Resident #81 told LPN #4 the pills were left on his bedside table. LPN #4 stated she thought it was left on Resident #81's bedside table by the night nurse because of the number of pills in the medication cup. LPN #4 also stated medication was not to be left on a resident's bedside table. LPN #4 stated she disposed of the medication with another floor nurse then reported it to the IP. Review of the facility's I&A reports did not include an investigation of Resident #81's allegation of having the wrong mediation left at his bedside. There was no investigation in the State Agency's Long-Term Care Reporting Portal. On 4/4/24 at 6:05 PM, the IP stated he could not remember the exact date of when the medication was left on Resident #81's bedside table but LPN #4 told him she thought the weekend staff had left the medication on the bedside table. The IP stated he did not see the medication because LPN #4 had disposed of it, so he did not know if Resident #81 received the wrong medication. The IP stated he was not sure if an I&A report was completed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/5/24 at 6:15 PM, the CNO, CEO, and the IP were interviewed together. The IP stated he did not immediately submit an I&A report related to the incident. The CEO stated he was not made aware of the incident until 4/4/24 and it was not reported to the State Survey Agency's Long-Term Care Reporting Portal. The facility failed to conduct a thorough investigation of Resident #81's missing medications, which resident the medications left on his bedside table were intended for, or if Resident #81 and the unknown resident received their medications on the day in question.

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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 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** 36193 Based on observation, record review, and staff interview, it was determined the facility failed to to ensure professional standards of practice were followed for 1 of 6 residents (Resident #30) reviewed for bowel and bladder incontinence and 1 of 5 residents (Resident #47) whose medication administration was observed. These failed practices created the potential for harm should residents experience constipation and adverse outcomes when their medications were not administered according to the physician's order. Findings include: 1. Resident #30 was admitted to the facility on [DATE], with multiple diagnoses including multiple sclerosis (a long lasting disease of the central nervous system). The facility's Bowel Care Protocol, undated, directed staff to administer bowel medications and if no bowel movement following administration of bowel medicatations, notify the physician for additional orders. Resident #30's physician orders included the following: - Senna-Docusate Sodium tablet (laxative) 8.6 - 50 mg, give two tablets by mouth two times a day for bowel care, hold for loose stool. - Dulcolax (Bisacodyl - laxative) suppository 10 mg, insert one suppository rectally as needed for constipation. - Fleet Enema 7-19 gm/118 ml (Sodium Phosphates), insert one unit rectally as needed for constipation. - Miralax Powder (laxative) 17 gm/scoop by mouth as needed for constipation. Resident #30's physician orders did not include how many days of no bowel movement the Dulcolax and Fleet Enema should be administered to Resident #30. Resident #30's Bowel Movement Records, dated 3/7/24 through 4/5/24, documented she did not have a bowel movement from 3/8/24 through 3/11/24 (4 days), 3/13/24 through 3/18/24 (6 days), and 3/24/24 through 4/2/24 (10 days). On 4/4/24 at 5:05 PM, the CNO stated Miralax should have been administered to Resident #30 when she did not have a bowel movement on the fourth day and followed with a Dulcolax suppository if she did not have a bowel movement the following day. When asked if the bowel protocol was followed, the CNO reviewed Resident #30's record and stated the bowel protocol was not followed. 2. Resident #47 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (progressive lung disease characterized by increasing breathlessness). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #47's physician orders, included Trelegy Ellipta inhalation aerosol powder breath activated 100-62. 5 -25 mcg/act (Fluticasone - Umeclidinium - Vilanterol), one puff once a day. The order included instructions for Resident #47 to rinse his mouth with water after administration of the medication. The Trelegy website: https://www.trelegyhcp.com/dosing-and-delivery/, accessed on 4/9/24, stated to instruct all patients to: - Take Trelegy as 1 inhalation, once daily, at the same time every day - Use Trelegy only once every 24 hours - After inhalation, rinse the mouth with water without swallowing to reduce the risk of oropharyngeal candidiasis [yeast infection]. On 4/3/24 at 7:43 AM, LPN #5 gave the Trelegy Ellipta inhaler to Resident #47. Resident #47 took three inhalations of the medication consecutively and handed it back to LPN #5. LPN #5 did not ask Resident #47 to rinse his mouth with water after inhaling the Trelegy Ellipta. On 4/3/24 at 8:22 PM, LPN #5 stated Resident #47 took three inhalations of his Trelegy Ellipta instead of one inhalation. LPN #5 stated she usually reminded Resident #47 to take only one inhalation/puff but failed to remind him that morning. When asked if she asked Resident #47 to rinse his mouth after inhaling the Trelegy Ellipta, LPN #5 stated she did not and she should have instructed Resident #47 to rinse his mouth with water after using the Trelegy Ellipta inhaler.

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	135079	A. Building B. Wing	04/05/2024

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure residents received treatment and assistive devices to maintain their vision. This was true for 1 of 1 resident (Resident #6) reviewed for activities of daily living. This failed placed Resident #6 at risk for decreased quality of life and psychosocial distress related to his inability to see effectively. Findings include: Resident #6 was admitted to the facility on [DATE], with multiple diagnoses including diabetes, restless leg syndrome, and dementia. A Clinical Evaluation, dated 1/27/24, documented Resident #6 had vision impairment. On 4/1/24 at 3:32 PM, Resident #6 stated he had diabetes for a long time and could not see very well. He stated his right eye could see a little, but his left eye could not see that much. Resident #6 stated he had trouble seeing his food. When asked if he could see the surveyor, Resident #6 stated he could only see a pattern. When asked if he participated in activities in the facility such as playing Bingo, Resident #6 stated he would like to play Bingo if he could see the numbers. On 4/5/24 at 10:14 AM, the Activity Director (AD) stated they invited Resident #6 to the activities in the facility but he refused to attend. The Assistant Activity (AA) stated they also provided the residents with the Daily Chronicle which contained puzzles, coloring, picture for the day, quotes of the day, famous birthday celebrant of the month, and other items. The AA stated she did not think Resident #6 liked the Daily Chronicle because he could not read it. The Activity Assistant stated Resident #6 enjoyed the pet visits. On 4/5/24 at 10:35 AM, the surveyor together with AD visited Resident #6 in his room. When asked what he would like to read, Resident #6 stated How could I do that, I could not see. I could not even see my food on the table. Resident #6 stated he sat with Resident #64 when he ate in the dining room and Resident #64 would arrange and tell him what food was on his plate. Resident #6 also stated Resident #64 would tell him where the condiments were on the table. When asked if he like to watch TV, Resident #6 stated, I can not see, I listen to the TV. On 4/5/24 at 5:24 PM, the CNO stated she was not made aware of Resident #6's vision impairment.

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	135079	A. Building B. Wing	04/05/2024

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on observation, policy review, record review, and staff interview, it was determined the facility failed to ensure residents received proper treatment and care to maintain foot health. This was true for 1 of 1 resident (Resident #79) reviewed for foot care. This failed practice created the potential for harm should residents experience complications from their medical condition related to the lack of foot care. Findings include: Resident #79 was admitted to the facility on [DATE], with multiple diagnoses including hypertension and dementia. An annual MDS assessment, dated 3/15/24, documented Resident #79 was severely cognitively impaired. On 4/2/24 at 12:47 PM, Resident #79's feet were observed with CNA #2 and CNA #3. Resident #79's left big toenail was observed to be long, thick, and whitish with a light brownish tinge in color. It was approximately 2. 0 to 2.5 cm in length and appeared to be slightly bending upward. Resident #47's left big toenail was thick and looked like it was separating from the nail bed. On 4/4/24 at 1:54 PM, the CNO looked at Resident #79's toenails and stated, He definitely needed to see the podiatrist. When asked when the last time Resident #79 was seen by the podiatrist, the CNO stated she would ask the LMSW. The Surveyor then asked the CNO for a list of residents seen by the podiatrist in the last 12 months. On 4/5/24 at 1:18 PM, the CNO, provided a list of residents seen by the podiatrist, dated 2/7/24 and 3/13/24. Resident #79's name was not on the list.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure residents were given treatment and services to maintain or improve their ability to carry out activities of daily living. This was true for 1 of 4 residents (Resident #30) reviewed for restorative nursing services. This failure placed Resident #30 at risk for decreased range of motion, functional ability, and decreased quality of life. Findings include: The facility's Restorative Nursing policy, revised 1/20/20, documented the restorative nursing program was implemented to promote residents' abilities to adapt and adjust to living as independently and safely as possible. The policy also stated restorative services focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. The Mayo Clinic website, accessed on 4/10/24, documented Physical Therapy can build muscle strength and ease some of the symptoms of MS [multiple sclerosis]. A physical therapist or occupational therapist can teach you stretching and strengthening exercises and show you how to use devices to make it easier to perform daily tasks. Resident #30 was admitted to the facility on [DATE], with multiple diagnoses including multiple sclerosis (a long-lasting disease of the central nervous system). Resident #30's care plan, revised 9/20/20, documented Independent to eat after set-up from staff. A Physical Therapy Evaluation and Plan of Treatment, dated 1/9/24, documented Resident #30's lower extremities were assessed for AROM and PROM. The evaluation documented Patient is at baseline level and no additional skilled services required at this time. The Physical Therapy evaluation did not include assessment of Resident #30's upper extremities. On 4/2/24 at 9:44 AM, Resident #30 was observed in bed with her breakfast tray on her overbed table in front of her. Resident #30's breakfast meal looked untouched, and her head was tilted to her right side. On 4/4/24 at 9:02 AM, Resident #30's breakfast tray was delivered to her room. There was one boiled egg, two slices of bacon, two opened bottles of a chocolate drink with straws, one slice of bread, one bowl of oatmeal, and one bowl of cream of wheat. A water container with a straw containing about 600 mls of iced water was also observed on top of Resident #30's overbed table. Resident #30's head was tilted to her right side. RCM #2 then entered the room and stated she would ask for help to reposition Resident #30. (continued on next page)

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	135079	A. Building B. Wing	04/05/2024

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 9:41 AM, Resident #30's breakfast meal looked untouched. Resident #30's head was observed to be tilted to her right side. RCM #2 entered the room and stated Resident #30 requested a rest when she was helping her to eat earlier. RCM #2 then left the room. RN #2 then entered the room to administer Resident #30's medications. RN #2 assisted Resident #30 to hold the water container while she was administering her medications. When asked if Resident #30 could hold the water container by herself, RN #2 stated Resident #30 could not hold the water container by herself. Resident #30 was unable to bring the water container close to her mouth to get a sip of water without RN #2 helping her. Resident #30 was then observed to take the bottle of chocolate drink from the top of the overbed table very slowly using her right hand. She was able to drink the chocolate beverage using the straw but when about 1/8 of the chocolate drink remained, the straw did not reach the bottom of the container. Resident #30 was unable to push the straw down to the bottom of the bottle. On 4/4/24 at 9:57 AM, CNA #4 entered the room and assisted Resident #30 to eat. CNA #4 offered Resident #30 the cream of wheat but Resident #30 stated no. CNA #4 then took the breakfast tray out and stated he would get a yogurt for Resident #30. CNA #4 stated Resident #30 ate about 25% of her meal. On 4/4/24 at 10:05 AM, CNA #4 came back with a tub of yogurt and started to feed Resident #30 whose head was tilted to her right side. CNA #4 then asked Resident #30 if she would like to feed herself. Resident #30 looked at CNA #4 without moving her head and stated she would try. Resident #30 then raised her left hand very slowly and tried to hold the yogurt tub. She was unable to grasp the yogurt tub. CNA #4 then continued to feed Resident #30 the yogurt. When Resident #30 finished the yogurt, she was observed reaching for the water container using her right hand. CNA #4 advised Resident #30 to hold the water container by the handle. Resident #30 held the water container by the handle and brought it to her lap very slowly. She was unable to bring the water container to her mouth. On 4/4/24 at 10:23 AM, when asked if Resident #30 was on RNA program, RCM #2 reviewed Resident #30's record and stated she was not on a RNA program. On 4/5/24 at 4:55 PM, when asked why Resident #30 was not on a RNA program, the CNO together with PT #1 stated she had just asked PT #1 to assess Resident #30. PT #1 stated Resident #30 was able to reposition her neck to a neutral position and that she was on her baseline level. PT #1 also stated there was no change in Resident #30's ROM since the last time he assessed her. The surveyor informed PT #1 that Resident #30's head was tilted to her right side and there was no support to prevent her head from tilting to her right side. The surveyor also stated Resident #30's upper extremities were observed to be very weak and that she was unable to bring her water container to her mouth to get a sip of water without being assisted by the staff. When asked if he assessed Resident #30's ROM on her upper extremities, PT #1 stated he assessed Resident #30's lower extremities and did not assess her upper extremities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135079	A. Building B. Wing	04/05/2024

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 40733 Based on observation and resident and staff interview, it was determined the facility failed to ensure resident meals were palatable and maintained their correct temperature. This directly impacted 6 of 23 residents (#25, #42, 43, #86, #147, and #350) who were interviewed about food services, and had the potential to affect all 103 residents who dined in the facility. This failed practice had the potential to negatively affect residents' nutritional status and psychosocial well-being. Findings include: The 2022 FDA Food Code states hot food will be maintained at 135 degrees F or above. 1. During resident interviews conducted on 4/1/24 and 4/2/24, Residents #42, #43, #86, and #147 stated their food was frequently served cold. On 4/3/24 at 10:00 AM, during the Resident Council meeting, residents from the 600, 700, and 800 halls complained about the food being cold when served. On 4/2/24 at 1:30 PM, a tray from the last meal cart delivered to the 700 hall, was tested for serving temperature by surveyors. The entree was a meatball sandwich, and the meat was 121 degrees F. On 4/5/24 at 12:30 PM, the Administrator stated he was not aware of residents' concerns related to food being cold when served. 49552 2. During resident interviews conducted on 4/1/24 and 4/2/24, residents stated their food was not palatable. On 4/1/24 at 4:10 PM, Resident #6 stated, The food is so and so, sometimes it is delicious, sometimes a pig would not eat it. On 4/2/24 at 11:04 AM, Resident #350's lunch menu documented lunch was to be crusted chicken, rice pilaf, sauteed zucchini, and vanilla pudding. Resident 350's meal ticket documented she was on a regular diet. Resident 350's lunch meal was a roll, a small bowl of a light brown, thick liquid substance, and a square dessert bar. Resident #350 tasted the smooth substance in the bowl and was unable to determine what it was. On 4/4/24 at 2:53 PM, the Dietary Manager stated he was not sure what food was served to Resident #350 for her lunch on 4/2/24. He stated crusted chicken was not on the lunch menu that day. He also stated Philly cheese steak soup was the entree for that day but Resident #350 would not have received it because she did not like to eat meat, and the soup would have been replaced by another source of protein.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review and staff interview, it was determined the facility failed to ensure residents received rehabilitative services as ordered by a physician. This was true for 1 of 5 residents (Resident #147) reviewed for rehabilitative services. This failure created the potential for residents to experience decline in their physical functioning when rehabilitative services were not provided. Findings include: Resident #147 was admitted to the facility on [DATE] with multiple diagnoses including hypertension, diabetes and chronic obstructive pulmonary disease (progressive lung disease characterized by increasing breathlessness). A physician order, dated 5/11/23, included Physical Therapy Eval[uation] and Tx [Treatment] for Resident #147. Resident #147's care plan goal, revised 5/15/23, documented Resident #147 will participate in therapy resulting in functional improvements, and Occupational and Physical therapy as ordered. A handwritten Therapy Referral and Screening form, dated 5/12/23, documented Pt very diff[icult]to motivate x 3 but prior to smoke break, pt agreable [sic] to toileting .pt refuses any further - sister present states they are going to smoke now. On 4/5/24 at 3:13 PM, the Rehabilitation Director stated she assessed Resident #147 on 5/12/23 and she did not feel Resident #147 required PT/OT services. The Rehabilitation Director stated Resident #147 transferred herself independently and was not a candidate for PT/OT. When asked if the physician or the CNO were informed of her assessment findings of Resident #147, the Rehabilitation Director stated she did not inform the physician or the CNO. When asked if the CNO should have been informed of her assessment findings, the Rehabilitation Director stated she should have informed the CNO.

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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** 49552 Based on 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 2 of 8 residents (#10 and #350) observed for infection control. 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 facility's Infection Prevention and Control Program policy, revised 10/15/22, documented the facility wide infection prevention program works to prevent, identify, report, investigate, and control infections and communicable diseases. The policy further documented the facility's infection prevention and control program included processes to minimize healthcare associated infection through an organization-wide program. These processes included but were not limited to: - As necessary, and at least annually, reviewing and revising the infection control risk assessment when: - New risks identified -New services have been added -Opportunities for improvement were identified - Establishing facility wide engineering and work practice to reduce risk of exposure to and transmission of healthcare associated infections. The CDC Website for Healthcare-Associated Infections, last reviewed 7/27/22, accessed on 4/9/24, 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident # 10 was admitted on [DATE], with multiple diagnoses including type 2 diabetes and hypertension. Resident #10's record documented she had a suprapubic catheter (a hollow, flexible tube that is used to drain urine from the bladder through a surgical incision in the abdomen). Resident #10's record documented she had chronic urinary tract infections which required Gentamicin Sulfate (antiobiotic) irrigations. A physician's order, dated 8/30/23, directed staff to irrigate Resident #10's suprapubic catheter every other day with Gentamicin Sulfate using a 60 ml syringe. A physician's order, dated 2/27/24, documented Resident #10 was to be placed on Enhanced barrier precautions due to her suprapubic catheter. Staff were required to wear a gown and gloves for high-contact care (catheter care and emptying drained urine). Staff were not required to wear a gown and gloves when not performing high-contact care. On 4/4/24 11:34 AM, LPN #1 was observed irrigating Resident #10's suprapubic catheter. LPN #1 pulled the catheter off the drainage bag tubing and put the catheter tubing directly on the bed. LPN #1 did not wear a gown during flushing of the catheter. LPN #1 removed her gloves but did not wash her hands after removing gloves, before leaving room. After the procedure, LPN #1 stated enhanced barrier precautions were to be followed for wound care only and she did not need to clean the catheter entry before flushing. LPN #1 stated she needed to empty her hand, so she set the tubing for the catheter drainage bag on the bed. She stated she did not know what else to do with it. 2. Resident # 350 was admitted [DATE], with multiple diagnoses including surgical wound to her left knee and weakness. Resident #350's record documented she was to be placed on enhanced barrier precautions due to her surgical wound on her left knee. On 4/4/24 at 9:10 AM, enhanced barrier precaution signage and supplies were observed outside Resident #350's room. On 4/2/24 at 9:20 AM, LPN #3 did not put on a gown or gloves prior to flushing Resident #350 's PICC line (A long, thin tube that is inserted through a vein used to give medications directly into the bloodstream) and checking her blood pressure. On 4/2/24 at 9:22 AM, LPN #2 stated Resident #350 was on enhanced barrier precautions for the wound to her left knee. LPN #2 stated she did not need to wear a gown and gloves unless wound care or toileting of Resident #350 was to be done. On 4/2/24 at 9:24 AM, LPN #3 stated gown and gloves were only to be worn if providing wound care to Resident #350. After reviewing the enhanced barrier precaution signage on Resident #350's door, LPN #2 and LPN #3 stated they should have worn a gown and gloves to provide high contact care to Resident #350. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 11:34 AM, the IP stated the staff should have put on a gown and gloves when providing close contact care to Resident #10 and Resident #350 (or residents placed in enhanced barrier precautions).