



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
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3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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January 25, 2017

Benjamin Roedel, Administrator  
Shaw Mountain of Cascadia  
909 Reserve Street  
Boise, ID 83712-6508

Provider #: 135090

Dear Mr. Roedel:

On **January 13, 2017**, a survey was conducted at Shaw Mountain of Cascadia by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 6, 2017**. Failure to submit an acceptable PoC by **February 6, 2017**, may result in the imposition of penalties by **March 1, 2017**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **February 17, 2017 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **April 13, 2017**. A change in the seriousness of the deficiencies on **February 27, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **April 13, 2017** includes the following:

Denial of payment for new admissions effective **April 13, 2017**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 12, 2017**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **April 13, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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Go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **February 6, 2017**. If your request for informal dispute resolution is received after **February 6, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink, appearing to read "David Scott for". The signature is written in a cursive style with a large initial "D".

David Scott, RN,, Supervisor  
Long Term Care

DS/lj

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/13/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET</b> <b>BOISE, ID 83712</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during a complaint investigation survey completed at the facility from January 12, 2017 to January 13, 2017.  The surveyors conducting the survey were:  Teresa Kobza, RDN, LD, Team Coordinator Sheila Sizemore, RN  Abbreviations include:  ADON - Assistant Director of Nursing am - morning cm - Centimeter CNA - Certified Nursing Assistant COPD - Chronic Obstructive Pulmonary Disorder HS - Hours of sleep (bedtime) MAR - Medication Administration Record mm - millimeter PRN - As Needed PU - Pressure Ulcer RN - Registered Nurse x - Times	F 000			
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  (b) Skin Integrity -  (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-  (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 314		2/15/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/11/2017

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.

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F 314	<p>Continued From page 1 demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, observation, and record review, it was determined the facility failed to ensure pressure ulcers did not develop or worsen in the facility and that services were provided to promote the healing of pressure ulcers. This was true for 2 of 4 sampled residents reviewed for pressure ulcers (#1 and #4). This failure resulted in harm to Resident #1 when he developed a second opening on his toe. This failure also placed Resident #4 at risk of harm due to a lack of prompt and consistent treatment upon discovery of a wound on his coccyx and the lack of documentation describing the progression of the wound. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 10/10/16, with diagnoses including Type II diabetes mellitus, pressure ulcer of his right heel, peripheral neuropathy, and hypertension.</p> <p>A Nursing Admission Assessment, dated 10/10/16, documented, "...Resident admits with an (sic) stage II pressure ulcer on his right heel, he continues with use of an air bed as well as Prevalon (a type of boot that is placed on the resident to relieve pressure to the heel)." The nursing assessment stated Resident #1 was, "considered a skin risk."</p>	F 314	<p>This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited in the CMS 2567. However, the submission of the Plan of Correction is not an admission that a deficiency exists. The Plan of Correction is prepared and executed solely because it is required by federal and state law. This response and Plan of Correction does not constitute an admission or agreement by the provider of the facts alleged or set forth in the statement of deficiencies.</p> <p>The Facility drafted and presented to the QA committee in December 2016 a Performance Improvement Plan (PIP) related to Skin Integrity Management.</p> <p>For Resident #1:</p> <ul style="list-style-type: none"> <li>- A Braden Scale shall be completed to ensure all risk is identified;</li> <li>- A skin check shall be completed and then a recheck done weekly on the assigned shower/bath day and documented;</li> <li>- The Care Plan shall be reviewed and updated if indicated;</li> </ul>		

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F 314	<p>Continued From page 2</p> <p>A Braden Scale assessment (used to determine potential for skin breakdown), dated 10/10/16, documented "friction and shear" to Resident #1's skin could create a "problem."</p> <p>Resident #1's care plan, dated 10/19/16, documented he had a scab on the second right toe, measuring 0.5 by 0.3 cm.</p> <p>A Nurse's Note, dated 10/26/16 at 10:51 am, documented, "...Resident returned from wound clinic yesterday with a black boot to right foot to right heel PU (pressure ulcer). Will continue to monitor progress." There was a lack of documentation of the wound to the second right toe.</p> <p>A Nurse's Note, dated 10/29/16 at 12:16 pm, documented, "Off loading EHOB (brand name of pressure relieving boot) or equivalent approved device while in bed." The note further stated, "Double layer of tubi grip on in AM (morning) off at HS (hour of sleep)."</p> <p>A Wound Care Dressing Change document, dated 11/10/16, one month after admission, stated, "Patient has bilateral toe ulcers related to diabetes and arterial insufficiency..."</p> <p>An Office/Consultation Visit note from the wound clinic, dated 11/17/16, documented Resident #1 had a new wound to the right second toe.</p> <p>A Nurse's Note, dated 11/17/16 at 3:35 pm, documented, "Received orders from the wound clinic to cleanse right 2nd toe amd (sic) right heel with wound cleanser. Pat dry with gauze. Apply pink polymer (type of dressing) and secure with</p>	F 314	<ul style="list-style-type: none"> <li>- Weekly assessment of the wound(s) on the right toe shall be completed weekly by the facility wound nurse and documented;</li> <li>- LN shall be educated to thoroughly document the appearance of the right toe wound(s) and that the boot be worn on the right foot/positioned appropriately and not creating any rubbing, friction, and or pressure; and</li> <li>- Only the facility wound nurse shall document that a wound is resolved unless there is medical documentation from a wound clinic or medical practitioner. Once a wound has been documented as resolved, wound assessment shall continue for at least 2 weeks to ensure the wound resolution/healing is stable.</li> </ul> <p>Resident #4 is no longer in the facility and was not in the facility at the time of the complaint survey.</p> <p>For all residents that are identified at risk for skin issue based on a Braden tool:</p> <ul style="list-style-type: none"> <li>- A skin sweep shall be completed;</li> <li>- Weekly skin check shall be completed and validated by a LN on shower/bath days;</li> <li>- Braden Scale shall be completed at least quarterly based on OBRA MDS timing or as deemed appropriated based on change of condition and or LN clinical judgment;</li> <li>- Care Plans shall be reviewed and updated if indicated to ensure risk management interventions are in place</li> </ul>		

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F 314	<p>Continued From page 3 tape. Change dressings 2X (times) weekly..."</p> <p>A Nurse's Note, dated 12/14/16 at 2:02 pm, documented, "Boot is to be worn at all times per order. Boot was checked for correct placement..."</p> <p>A Nurse's Note, dated 12/15/16 at 2:37 pm, documented, "Cleanse right 2nd toe/heel with wound cleanser. Pat dry with gauze. Apply pink polymem (type of dressing). One time a day." Nurse's Notes did not include documentation of Resident #1's wound to his right 2nd toe between 11/17/16 and 12/15/16 (28 days). The Nurse's Notes did include documentation that Resident #1 wore the EHOB boot, as ordered.</p> <p>A Follow Up Questions Report, dated 12/16/16 at 9:53 am, documented the last measurement of Resident #1's right 2nd toe wound completed by the facility. It stated there was only one area on the right toe measuring 0.5 centimeters by 0.3 centimeters and the area was "Progressing toward healing/resolution."</p> <p>A Nurse's Note, dated 12/22/16 at 3:13 pm, documented, "Toe abrasion is resolved."</p> <p>A Nurse's Note, dated 1/5/17 at 2:15 am, documented Resident #1 had a small scab to the "RLE (right lower extremity) 2nd toe."</p> <p>A Wound Clinic Progress Note, dated 1/11/17, documented, "[Resident #1] has developed 2 areas of traumatic-appearing ulceration to the dorsum of the right 2nd toe. The timing and the etiology is not known by the patient or [family member]. She wondered whether it may be caused by the boot, but he has been</p>	F 314	<p>and effective in preventing pressure injuries; and - Only the facility wound nurse shall document that a wound is resolved unless there is medical documentation from a wound clinic or medical practitioner. Once wound has been documented as resolved, wound assessment shall continue for at least 2 weeks to ensure the wound resolution/healing is stable.</p> <p>All clinical staff shall receive in-service education or remediation of previous in-service education related to the Skin Prevention Program. LN supervising care staff at the bedside shall offer immediate remediation if observation is made that the Skin Prevention Program is not implemented or followed. This 1:1 remediation shall be documented as an in-service.</p> <p>The Director of Clinical Services (DCS) and or Assistant Director of Clinical Services (ADCS) shall complete weekly audits of skin checks. Immediate remediation shall take place if the audit identifies an undocumented skin check on the assigned shower/bath day. These weekly audits shall be presented to the Quality Assurance Committee (QAC) for a period of 6 months. The QAC shall review these audits and make additional recommendations as indicated.</p> <p>The DCS and or ADCS shall review skin at risk meeting notes monthly. Immediate</p>		

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F 314	<p>Continued From page 4</p> <p>predominantly in a (sic) EHOB in this seems unlikely...Largest area of ulceration to the dorsal right proximal 2nd toe measures 0.8 cm (centimeters) by 0.9 cm...There are a couple of much smaller ulcerations more distally on the toe and these are just limited skin breakdown."</p> <p>On 1/12/17 at 1:40 pm, the Assistant Director of Nursing (ADON) was observed measuring the wounds on Resident #1's right 2nd toe. The ADON said the wound on the second toe joint measured 0.2 cm by 0.1 cm, the wound below the second toe joint measured 0.5 cm by 0.5 cm. The ADON stated the wounds on the toes had been caused by the strap on the EHOB boot going across the toes. The ADON said she had asked the wound doctor twice for a different type of boot and he had refused.</p> <p>During an interview, on 1/12/17 at 4:08 pm, with the Wound Nurse and the ADON, the Wound Nurse stated that when the floor nurse documented the toe wound as resolved on 12/22/16, the toe wound had been dropped off the care plan and the weekly skin assessments. She said there were no further skin assessments of Resident #1's right 2nd toe documented since 12/16/16. The Wound Nurse stated the toe wounds should have never been resolved.</p> <p>Resident #1 was observed lying in bed on 1/13/17 at 8:10 am. There was no padding under the strap that went across the joint of his second toe.</p> <p>During an interview, on 1/13/17 at 8:15 am, the Wound Nurse stated she was unaware of the strap rubbing against Resident #1's toes. The</p>	F 314	<p>remediation shall take place if the audit identifies an undocumented skin at risk meeting. These monthly audits shall be presented to the QAC for a period of 6 months. The QAC shall review these audits and make additional recommendations as indicated.</p> <p>Facility staff responsible for the execution of this written POC include, but is not necessarily limited to:</p> <ul style="list-style-type: none"> <li>- Facility Administrator</li> <li>- DCS and ADCS</li> <li>- All Licensed nurses; and</li> <li>- All Clinical Staff.</li> </ul>		

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F 314	<p>Continued From page 5</p> <p>Wound Nurse said they only checked for proper placement, not if the strap was rubbing. She said she did not know the nursing staff felt the strap had caused the wound and was rubbing across Resident #1's toe.</p> <p>During an interview on 1/13/17 at 10:55 am, the Wound Nurse said she had now opened up a "Skin wound integrity assessment" for Resident #1's toe.</p> <p>During an interview on 1/13/17 at 1:05 pm, CNA #1 stated she told an agency nurse about the area on Resident #1's toe around 12/28/16, and the agency nurse put a Band-Aid on the toe. CNA #1 said she told another nurse on 1/7/17, who also placed a Band-Aid on Resident #1's toe.</p> <p>2. Resident #4 was admitted to the facility on 10/27/16, with diagnoses which included acute respiratory failure with hypoxia, pneumonia, and COPD.</p> <p>Resident #4's Admission Skin Assessment, dated 10/27/16, documented he had a skin abrasion located on his coccyx [tailbone], which measured 0.5 cm by 0.2 cm.</p> <p>Resident #4's Nurse's Note, dated 10/28/16 at 12:27 pm, documented he had a 5 mm (0.5 cm) by 2 mm (0.2 cm) wide, and 0.1 cm deep open area on his coccyx. The note documented the surrounding tissue was red. There was no further documentation in the Nurse's Notes describing the wound size and healing status of the area.</p> <p>Resident #4's November 2016 Physicians' Orders documented Resident #4 was to receive</p>	F 314			

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F 314	<p>Continued From page 6</p> <p>barrier cream three times a day and PRN to the abrasion on his coccyx, ordered and initiated on 10/31/16. The barrier cream was ordered 4 days after the wound was discovered by staff on 10/27/16.</p> <p>Resident #4's Risk for Skin Impairment Care Plan, initiated 10/27/16, included a goal that he would have a decreased number of risk factors for skin breakdown. Interventions included:</p> <ul style="list-style-type: none"> <li>* Resident #4 was to have a pressure reducing cushion in his wheelchair, initiated 10/27/16.</li> <li>* Staff was to notify the charge nurse if Resident #4 developed skin impairments, bruises, or rashes, initiated 10/27/16.</li> </ul> <p>The Care Plan did not include the wound to Resident #4's coccyx or the ordered treatment staff was to follow.</p> <p>Resident #4's Utilization Review, dated 11/1/16, documented he had a stage 1 pressure sore to his coccyx and barrier cream was being utilized.</p> <p>Resident #4's 10/27/16 through 11/15/16 MAR documented he did not receive the ordered treatment of barrier cream to his coccyx, 7 out of 46 opportunities. This was due to various reasons such as "other/see nurse notes," "medication not available," "medication refused," and/or the MAR was left blank. These included:</p> <ul style="list-style-type: none"> <li>* On 10/31/16 at 2:30 pm, 11/7/16 at 2:30 pm, and 11/13/16 at 2:30 pm, the MAR was left blank.</li> <li>* On 11/1/16 at 10:30 am and 2:30 pm, the MAR documented "other/see nurse notes." The</li> </ul>	F 314			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 7</p> <p>subsequent Nurse's Notes did not contain documentation of why the treatment was not given.</p> <p>* On 11/2/16 at 2:30 pm, the MAR documented "medication not available."</p> <p>* On 11/7/16 at 10:30 am, the MAR documented "medication refused."</p> <p>Resident #4's Utilization Review, dated 11/8/16, documented he had a stage 1 pressure sore to his coccyx and barrier cream was being utilized. The Utilization Review documented the pressure sore was nearly resolved.</p> <p>On 1/13/17 at 1:25 pm, RN #1 and the ADON stated when a wound was discovered the facility protocol instructed staff to get orders for a treatment that day and initiate the treatment. In addition, staff was to update the care plan to include what the skin impairment was, the location of the wound, measurements of the wound, and any treatment plans for the wound. The ADON stated when nurses assessed wounds or re-evaluate them, they were to document the progression of the wounds in the Nurse's Notes section. The wounds would also be documented during the facility's Utilization Reviews. RN #1 stated Resident #4's Nurse's Notes did not contain documentation after 10/28/16, of measurements and the healing progression of his coccyx wound or the reasons wound treatments were not completed. Documentation of Resident #4's coccyx wound was not completed consistent with the facility's protocols. The ADON could not recall what the wound looked like upon admission. RN #1 and the ADON stated they did not know the reason treatment was initiated 4 days after the wound</p>	F 314			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/13/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET</b> <b>BOISE, ID 83712</b>		
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F 314	Continued From page 8 was discovered.  The facility did not ensure Resident #4's wound was consistently re-evaluated and assessed by nursing staff. The facility failed to ensure Resident #4's wound and related treatments were included in his care plan and descriptions of the wound were consistently documented. In addition, the facility failed to ensure after the discovery of the wound to Resident #4's coccyx, treatment was ordered timely and provided consistently per physicians' orders.	F 314			



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

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May 19, 2017

Benjamin Roedel, Administrator  
Shaw Mountain of Cascadia  
909 Reserve Street  
Boise, ID 83712-6508

Provider #: 135090

Dear Mr. Roedel:

On **January 13, 2017**, an unannounced on-site complaint survey was conducted at Shaw Mountain of Cascadia. The Complaint was investigated during a Complaint Investigation Survey conducted January 12, 2017 to January 13, 2017.

Immediately after entering the facility, the survey team conducted a general tour of resident's rooms and common areas. Throughout the survey, four individual residents and all residents in general, were observed for quality of care, signs of distress, and quality of life issues. In addition, facility staff were observed as they provided care, interacted with residents and responded to residents' needs and requests.

The clinical records of the identified resident and three other residents were reviewed for quality of life, quality of care, physician services, and discharge planning issues. Specifically, pressure ulcer and wound management, discharge planning, and physician rounding was reviewed. The facility's grievance files and Incident and Accident reports were reviewed.

Interviews were conducted with multiple individual residents. Several direct care staff, including nurses and nursing aides, were also conducted, as well as with the Assistant Director of Nursing Services, Social Worker, Wound Nurse, and the physician. The interviews included questions about discharge planning, physician services, and quality of life and quality of care issues.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007286**

ALLEGATION #1:

Nursing staff did not follow physician's orders for treatment of a wound which progressed into a Stage III pressure ulcer.

FINDINGS:

Based on interviews with residents and record reviews there were concerns with staff not providing necessary cares and services for specialized wound care needs.

The clinical record documented the facility received orders on March 9, 2016 from the wound clinic for the care and treatment of a deep tissue injury to the identified resident's fifth toe. The facility did not start the prescribed treatment until March 18, 2016, which was nine days after the treatment was ordered. The clinical record documented the identified resident received three scheduled treatments before discharge. The record documented the identified resident's deep tissue injury progressed into a Stage III pressure ulcer.

Based on interviews and record reviews the allegation was substantiated through the previous survey results.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility did not arrange Home Health services for the identified resident upon discharge from the facility.

FINDINGS #2:

Residents interviewed did not voice any concerns about not receiving discharge planning.

The Licensed Social Worker stated if identified residents' needed Home Health the facility would obtain physician orders and arrange for those services.

The identified resident's clinical records contained an order for Home Health and a note which documented a Home Health agency visited the family after the identified resident was discharged from the facility.

Based on observation, interviews, and record review, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Benjamin Roedel, Administrator  
May 19, 2017  
Page 3 of 4

ALLEGATION #3:

The physician would not address, or speak to the responsible party, about the identified resident's blood sugars.

FINDINGS:

Residents interviewed did not voice any concerns about physicians' management of their diabetes.

The physician stated if an identified resident's diabetes was uncontrolled, the facility would manage the blood glucose the best they could and attempt to obtain outside help from the identified resident's primary physicians. The physician stated if the identified resident's responsible party was present during rounds, the physician would discuss any concerns with them.

The Assistant Director of Nursing Services stated if the identified resident's responsible parties requested to speak with the physician, it would be documented in the clinical record.

The identified resident's clinical records contained documentation the resident and the identified resident's responsible party were present while the physician discussed blood glucose concerns and diabetes management on March 16, 2016, after a request had been made on March 15, 2016. The record did not contain documentation that the identified resident's responsible party requested to speak with the physician around the time frame of March 9, 2016.

Based on observation, interviews, and record review, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

David Scott, R.N., Supervisor  
Long Term Care

DS/lj