



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P. O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

April 19, 2017

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

Provider #: 135090

Dear Mr. Roedel:

On **April 6, 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal 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.

Benjamin Roedel, Administrator  
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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 **May 1, 2017**. Failure to submit an acceptable PoC by **May 1, 2017**, may result in the imposition of penalties by **May 24, 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 **May 11, 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 **July 5, 2017**. A change in the seriousness of the deficiencies on **May 21, 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 **July 5, 2017** includes the following:

Denial of payment for new admissions effective **July 5, 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 **October 3, 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 **July 5, 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 **May 1, 2017**. If your request for informal dispute resolution is received after **May 1, 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 that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a smaller "Scott" following it.

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

DS/lj  
Enclosures

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

PRINTED: 05/04/2017  
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>04/06/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET 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 the federal recertification survey conducted at the facility from April 3, 2017 to April 6, 2017.  The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Marci Clare, RN, WCC Dennis Burlingame, RN  Survey Definitions: ADCS = Assistant Director of Clinical Services CNA = Certified Nurse Assistant DCS = Director of Clinical Services HRR = Human Resources Representative LPM = Liters Per Minute PRN = As Needed TAR = Treatment Administration Record	F 000			
F 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES  (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.  §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.  (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:	F 156		5/10/17	

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

TITLE

(X6) DATE

Electronically Signed

04/29/2017

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 156	<p>Continued From page 1</p> <p>(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -</p> <p>(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;</p> <p>(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.</p> <p>(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and</p> <p>(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.</p> <p>(ii) Information and contact information for State</p>	F 156			

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F 156	<p>Continued From page 2</p> <p>and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)</p> <p>[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for</p>	F 156			

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F 156	<p>Continued From page 3 information regarding returning to the community.</p> <p>(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:</p> <p>(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and</p> <p>(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.</p> <p>(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>(g)(16) The facility must provide a notice of rights</p>	F 156			

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F 156	<p>Continued From page 4 and services to the resident prior to or upon admission and during the resident's stay.</p> <p>(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.</p> <p>(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.</p> <p>(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;</p> <p>(g)(17) The facility must--</p> <p>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-</p> <p>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;</p> <p>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and</p> <p>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.</p>	F 156			

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F 156	<p>Continued From page 5</p> <p>(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.</p> <p>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.</p> <p>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p>	F 156			

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F 156	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure contact information for Medicare, Medicaid and the State Survey Agency was posted. This failure to provide Medicare, Medicaid and the State Survey Agency contact information affected 13 of 13 (#s 1-13) sampled residents and all other residents in the facility and had the potential for more than minimal harm if residents required assistance from any of these agencies, but did not know how to contact a representative. Findings include:</p> <p>On 4/3/17 at 3:00 pm, it was determined that contact information for Medicare, Medicaid and the State Survey Agency information, including how to contact these entities, was not posted in the facility.</p> <p>On 4/3/17 at 3:15 pm, the DCS and Social Worker said the information was not posted.</p>	F 156	<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 this plan 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>Survey Definitions: DCS = Director of Clinical Services ADCS = Assistant Director of Clinical Services HR = Human Resource MAR = Medication Administration Record TAR = Treatment Administration Record QA = Quality Assurance CNA = Certified Nursing Assistant</p> <p>F156: Corrective Action: Contact information for Medicare, Medicaid and the State Survey Agency was posted in our display case on 200 hall and in Friendship House (Secure unit) on April 3, 2017. This will allow all residents, patients, and visitors the necessary information on how to contact a representative.</p> <p>Identification: All residents and visitors are identified as</p>		

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F 156	Continued From page 7	F 156	<p>potentially being affected by this deficiency.</p> <p><b>Systemic Changes:</b> Administrator, DCS, and Social Services to verify proper information is posted for resident rights and applicable contacts.</p> <p><b>Monitor:</b> Facility Administrator, DCS, and Social Worker to verify proper contact information is available to residents and visitors:</p> <ol style="list-style-type: none"> <li>Weekly for four (4) weeks.</li> <li>Monthly for three (3) months.</li> <li>Quarterly for two (2) quarters.</li> </ol> <p>The results of these audits will be reported to the QA committee for review and further comment as indicated.</p>		
F 226 SS=E	<p>483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>483.12 (b) The facility must develop and implement written policies and procedures that:</p> <p>(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>(2) Establish policies and procedures to investigate any such allegations, and</p> <p>(3) Include training as required at paragraph §483.95,</p>	F 226		5/10/17	

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F 226	<p>Continued From page 8</p> <p>483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-</p> <p>(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.</p> <p>(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property</p> <p>(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on personnel files, policy review and staff interview, it was determined the facility failed to ensure new employee reference checks and CNA registry checks were completed for 4 of 4 employees (Employees A, B, C &amp; D) and 3 of 3 CNAs (Employees A, B &amp; C) whose employee files were reviewed. This created the potential for harm if newly-hired staff with a history of abuse and/or neglect were put into direct contact with the facility's residents. Findings include:</p> <p>The facility's current Abuse Prevention and Prohibition Program policy, dated March 2017, documented, "All potential employees will be screened prior to their first day of employment for a history of abuse, neglect, mistreatment, or exploitation of residents ... Screening includes ... State and national registry search for all Certified</p>	F 226	<p>F226: Corrective Action: To ensure the safety of our residents all new employee reference checks and CNA registry checks will be completed prior to their start date. The 4 employees identified in the Survey were pulled from the floor. Registry checks were completed on all employees 4/5/17. An audit was completed on all active employees to identify all possible incomplete documentation.</p> <p>Identification: All residents are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes:</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET 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 226	Continued From page 9 nursing assistants ... A minimum of 2 professional references ..."  1. The facility's hiring list documented Employees A and B were hired on 1/16/17, Employee C was hired on 1/17/17 and Employee D was hired on 2/20/17. Employees A, B, C and D employee personnel files were reviewed and no reference checks were found.  2. The facility's hiring list documented Employees A and B were hired on 1/16/17 and Employee C was hired on 1/17/17. Employees A, B and C nurse aide personnel files were reviewed for the State Nurse Aide Registry Verification Report on 3/28/17. The State Nurse Aide Registry Verification Report did not have any negative findings for Employees A, B, or C.  On 4/5/17 at 10:45 am, the HRR said her job duties had changed in February 2017 to include checking employee references and the CNA Registry. The HRR stated she discovered past discrepancies with employees files since that time. The HRR said there were no references for Employees A, B, C or D. She said she had checked with the CNA Registry for Employees A, B and C on 3/28/17 and found no negative findings. The HRR said each of the employees in question had been working in the facility since their dates of hire.	F 226	The Administrator and Human Resource Manager will both verify all necessary new hire paperwork is completed prior to the employees start date on all new employees.  Monitor: Facility Administrator and Human Resource Manager to complete audits on new hire paper:  1. Weekly for four (4) weeks. 2. Monthly for three (3) months. 3. Quarterly for two (2) quarters.  The results of these audits will be reported to the QA committee for review and further comment as indicated.		
F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT  (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe	F 252		5/10/17	

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F 252	<p>Continued From page 10 upon the rights or health and safety of other residents.</p> <p>§483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-</p> <p>(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to provide a clean and homelike environment when the following was observed: *Missing paint, *Missing baseboard, and *Crumbling drywall with an exposed metal flashing. This was true for 1 of 2 dayrooms, 1 of 1 dining rooms and 1 of 1 shower rooms in the Friendship House. This deficient practice had the potential for psychosocial harm for those living in an unappealing environment. Findings included:  On 4/4/17 at 8:00 am and 1:00 pm, the following</p>	F 252	<p>F252: Corrective Action: To provide a clean and homelike environment, the maintenance director fixed the exposed flashing, replaced the baseboard, and repaired the sheet rock texture with a fresh coat of paint on 4/5/17.</p> <p>Identification: 22 residents within the secure unit are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes:</p>		

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F 252	Continued From page 11 was observed: * Two (2) quarter-inch wide by two-foot long sections of wall paint was missing from the Friendship House dayroom wall next to the fireplace, -A six-inch tall by one-foot long section of baseboard was missing in the Friendship House dayroom, -A six-inch by two-foot and a six-inch by one-foot section of missing paint from the Friendship House dining area walls, and -A three-inch by one-foot section of missing plaster, exposing the metal flashing, in the Friendship House shower room corner archway.  On 4/5/17 at 2:55 pm, the Environmental Services Director was shown the missing paint, plaster and baseboard; he said each area needed to painted and/or repaired.	F 252	Housekeepers will be monitoring the entire environment as they clean, and reporting any wear or damage directly to the maintenance director. House Keeping staff in-serviced on new reporting system and what to look for to maintain proper living standards for the residents.  Monitor: Facility Administrator, DCS, and Maintenance Director will be conducting audits and walking the building to ensure a clean and homelike environment. Audits with be conducted at the following frequencies:  1. Weekly for four (4) weeks. 2. Monthly for three (3) months. 3. Quarterly for two (2) quarters.  The results of these audits will be reported to the QA committee for review and further comment as indicated.		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  (d) Accidents. The facility must ensure that -  (1) The resident environment remains as free from accident hazards as is possible; and  (2) Each resident receives adequate supervision and assistance devices to prevent accidents.  (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility	F 323		5/10/17	

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F 323	<p>Continued From page 12</p> <p>must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure harmful chemicals were secured safely. This was true for 1 of 1 shower rooms in the Friendship House unit. This failure created the potential for harm if any independently mobile, cognitively impaired resident obtained access to the unsecured chemicals. Findings include:  On 4/4/17 at 2:45 pm, the Friendship House shower room door was opened. Inside on a counter, next to the shower stall, was a full spray bottle of disinfectant cleaner. The bottle label documented the following warning: "Danger: corrosive, causes irreversible eye damage and skin burn ... Harmful if swallowed or absorbed through skin ...Wear goggles or face shield and rubber gloves ... Hazardous to humans ..."  On 4/4/17 at 3:00 pm, CNA #1 approached the shower room and said she left the door open while stocking resident rooms with items stored in the shower room. CNA #1 said the cleaner</p>	F 323	<p>F323: Corrective Action: To ensure the safety of the residents all chemicals, supplies, and any hazardous material was immediately placed in the locked cabinet within the shower room. The door to the shower was immediately closed and locked. All other shower rooms were checked to verify all other chemicals were secure, and doors were closed.</p> <p>Identification: 22 residents within the secure unit are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: CNA staff has received in-service regarding the monitoring and ensuring that all harmful chemicals are not accessible to the residents. This will be completed by May 10, 2017. LN staff will</p>		

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F 323	Continued From page 13 should not have been on the counter and then placed the cleaner inside a cabinet in the shower room. CNA #1 said there was not a key to the cabinet and that was why the door to the shower room should have been closed and locked. CNA #1 then closed the shower room door, which locked automatically when closed.  On 4/4/17 at 3:05 pm, ADCS #2 said the shower room door should have been closed and locked.	F 323	be in-serviced by May 10, 2017 that all chemicals are to be locked always when not in use.  Monitor: Facility Administrator and DCS will conduct audits to ensure that all chemicals are securely stored and not accessible to the residents. Audits to begin on 4/25/17 and to continue at the following frequencies:  1. Weekly for four (4) weeks. 2. Monthly for three (3) months. 3. Quarterly for two (2) quarters.  The results of these audits will be reported to the QA committee for review and further comment as indicated.		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS  (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:  (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and  (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments  (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who	F 328		5/10/17	

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F 328	<p>Continued From page 14</p> <p>require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.</p> <p>(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.</p> <p>(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.</p> <p>(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced</p>	F 328			

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F 328	<p>Continued From page 15</p> <p>by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure oxygen therapy was administered consistent with physician orders. This was true for 3 of 5 sampled residents (#9, #11, and #12) reviewed for use of oxygen. The deficient practice created the potential for harm if the resident received more, or less, oxygen than required to maintain homeostasis. Findings Include:</p> <p>1. Resident #9 was admitted to the facility on 9/22/15, with diagnoses that included sleep apnea.</p> <p>Physician orders, dated 9/21/15, directed staff to provide Resident #9 with oxygen at the rate of 2 LPM via nasal cannula to maintain blood-oxygen levels at 90-percent or greater, and to check the resident's blood-oxygen levels every shift.</p> <p>Resident #9's current Inadequate/Compromised Respiratory Function Care Plan, initiated 9/22/15, documented, "Oxygen use per MD order, and Oxygen levels as indicated."</p> <p>Resident #9 was observed in his room without oxygen on 4/3/17 at 12:00 pm, 4/3/17 at 1:45 pm, and 4/3/17 at 2:55 pm. At the time of the 2:55 pm observation Resident #9 and his wife both stated he only received oxygen at night at 2 LPM.</p> <p>There was no documentation that Resident #9's blood-oxygen levels were assessed for the following number of shifts each month: *November 2016 - 2 of 90 shifts. *December 2016 - 11 of 93 shifts.</p>	F 328	<p>F328: For Resident #9, #11, and #12.</p> <p>Corrective Action: Assessment completed for blood-oxygen saturation levels Orders for oxygen were transferred from the T.A.R. to the M.A.R. to allow documentation with medication pass on 4/4/17.</p> <p>Identification: All residents requiring oxygen are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: DCS, and or ADCS weekly audits of the documented O2 saturation levels, and that nursing staff are following and consistent the M.D. orders. In-service to completed on May 10, 2017 discussing location of O2 monitoring Q shift, and following M.D. orders.</p> <p>Monitor: Weekly audits conducted by the DCS, and or ADCS to be completed at the following frequencies</p> <ol style="list-style-type: none"> <li>Weekly for four (4) weeks.</li> <li>Monthly for three (3) months.</li> <li>Quarterly for two (2) quarters.</li> </ol> <p>The results of these audits will be reported to the QA committee for review and further comment as indicated.</p>		

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F 328	<p>Continued From page 16</p> <p>*January 2017 - 7 of 93 shifts. *February 2017 - 4 of 84 shifts. *March 2017 - 14 of 93 shifts.</p> <p>2. Resident #11 was admitted to the facility on 3/3/14, with diagnoses that included anxiety, atrial fibrillation, and insomnia.</p> <p>Physician orders, dated 12/24/15, directed staff to provide Resident #11 with oxygen at the rate of 2 LPM via nasal cannula as needed for comfort to maintain blood-oxygen levels at 90-percent or greater, check blood-oxygen levels every shift, and document when oxygen was utilized.</p> <p>Resident #11's current Inadequate/Compromised Respiratory Function Care Plan, initiated 9/6/12, documented oxygen was to be provided and blood-oxygen saturation rates were to be assessed per MD order.</p> <p>Resident #11 was observed in her room with oxygen at 2 LPM via nasal cannula on 4/5/17 at 9:55 am and on 4/5/17 at 11:35 am.</p> <p>There was no documentation that Resident #11's blood-oxygen levels were assessed for the following number of shifts each month:</p> <p>*January 2017 - 20 of 93 shifts. *February 2017 - 15 of 84 shifts. *March 2017 - 19 of 93 shifts.</p> <p>3. Resident #12 was admitted to the facility on 5/21/16, with diagnoses that included congestive heart failure and pleural effusion.</p>	F 328			

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 328	<p>Continued From page 17</p> <p>Physician orders, dated 5/21/16, directed staff to provide Resident #12 with oxygen at the rate of 1-3 liters per minute via nasal cannula, as needed, to maintain blood-oxygen levels at 90-percent or greater, and to check the blood-oxygen levels every shift.</p> <p>Resident #12's current Inadequate/Compromised Respiratory Function Care Plan, initiated 4/12/16, documented staff was to provide oxygen and maintain blood-oxygen level per MD order.</p> <p>Resident #12 was observed in his room with 1LPM of oxygen via nasal cannula on 4/5/17 at 10:05 am. At the time of the 10:05 am observation, Resident #12 stated his oxygen was "almost always" set between 1-2 LPM.</p> <p>There was no documentation that Resident #12's blood-oxygen levels were assessed for the following number of shifts each month:</p> <p>*January 2017 - 10 of 93 shifts. *February 2017 - 3 of 84 shifts. *March 2017 - 5 of 93 shifts.</p> <p>On 4/5/17 at 11:22 am, ADCS #1 stated the nurses should have documented the oxygen levels every shift per the physician order for Residents #9, #11, and #12.</p> <p>On 4/5/17 at 11:30 am, the DCS stated the nurses should have followed the physician orders and checked the blood-oxygen saturation levels every shift, for Residents #9, #11, and #12.</p>	F 328			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001790</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/06/2017</b>
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Marci Clare, RN, WCC Dennis Burlingame, RN</p>	C 000		
C 099	<p>02.009 CRIMINAL HISTORY AND BACKGROUND CHECK REQUIRE</p> <p>01. Criminal History and Background Check. A skilled nursing and intermediate care facility must complete a criminal history and background check on employees and contractors hired or contracted with after October 1, 2007, who have direct patient access to residents in the skilled nursing and intermediate care facility. A Department check conducted under IDAPA 16.05.06, " Criminal History and Background Checks, " satisfies this requirement. Other criminal history and background checks may be accepted provided they meet the criteria in Subsection 009.02 of this rule and the entity conducting the check issues written findings. The entity must provide a copy of these written findings to both the facility and the employee. (3-26-08)</p> <p>02. Scope of a Criminal History and Background Check. The criminal history and background check must, at a minimum, be a fingerprint-based criminal history and background check that includes a search of the following record sources: (3-26-08)</p> <p>a. Federal Bureau of Investigation (FBI); (3-26-08)</p> <p>b. Idaho State Police Bureau of Criminal</p>	C 099		5/10/17

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>04/29/17</b>
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C 099	<p>Continued From page 1</p> <p>Identification; (3-26-08)</p> <p>c. Sexual Offender Registry; (3-26-08)</p> <p>d. Office of Inspector General List of Excluded Individuals and Entities; and (3-26-08)</p> <p>e. Nurse Aide Registry. (3-26-08)</p> <p>03. Availability to Work. Any direct patient access individual hired or contracted with on or after October 1, 2007, must self-disclose all arrests and convictions before having access to residents. The individual is allowed to only work under supervision until the criminal history and background check is completed. If a disqualifying crime as described in IDAPA 16.05.06, "Criminal History and Background Checks," is disclosed, the individual cannot have access to any resident. (3-26-08)</p> <p>04. Submission of Fingerprints. The individual's fingerprints must be submitted to the entity conducting the criminal history and background check within twenty-one (21) days of his date of hire. (3-26-08)</p> <p>05. New Criminal History and Background Check. An individual must have a criminal history and background check when: (3-26-08)</p> <p>a. Accepting employment with a new employer; and (3-26-08)</p> <p>b. His last criminal history and background check was completed more than three (3) years prior to his date of hire. (3-26-08)</p> <p>06. Use of Criminal History Check Within Three Years of Completion. Any employer may use a previous criminal history and background check obtained under these rules if: (3-26-08)</p> <p>a. The individual has received a criminal history and background check within three (3) years of</p>	C 099		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001790</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/06/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</b>
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C 099	<p>Continued From page 2</p> <p>his date of hire; (3-26-08)</p> <p>b. The employer has documentation of the criminal history and background check findings; (3-26-08)</p> <p>c. The employer completes a state-only background check of the individual through the Idaho State Police Bureau of Criminal Identification, and (3-26-08)</p> <p>d. No disqualifying crimes are found. (3-26-08)</p> <p>07. Employer Discretion. The new employer, at its discretion, may require an individual to complete a criminal history and background check at any time, even if the individual has received a criminal history and background check within the three (3) years of his date of hire. (3-26-08)</p> <p>This Rule is not met as evidenced by: Based on personnel files, policy review, facility working schedule and staff interview, it was determined the facility failed to ensure fingerprint criminal history background checks were completed for 2 of 5 employees (Employee A &amp; B) within 21 days of hire. This had the potential for harm if newly-hired staff with a history of abuse and/or neglect were put into direct contact with facility's residents. Findings include:</p> <p>The facility's current Abuse Prevention and Prohibition Program policy, dated March 2017, documented, "All potential employees will be screened prior to their first day of employment for a history of abuse, neglect, mistreatment, or exploitation of residents...Screening includes...Criminal background check as outlined</p>	C 099	<p>C099: Corrective Action: All employees were pulled from the floor if they did not have fingerprints completed within the proper time frame. To ensure fingerprint criminal history background checks are completed within 21 days of hire audits employees are notified on day 7, 14, and on day 21 they will be pulled from the schedule if not fingerprints not completed.</p> <p>Identification: All residents are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes:</p>	
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Bureau of Facility Standards

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C 099	<p>Continued From page 3</p> <p>by State and/or Federal requirements."</p> <p>The facility's hiring list documented Employees A and B were hired on 1/16/17. Employees A and B employee personnel files were reviewed and no fingerprint based background check were found. Each employee's file contained a letter, dated 2/15/17, addressed to the employees and documented the need for the employees to either schedule a fingerprint appointment or to transfer their background check records to the facility.</p> <p>On 4/5/17 at 10:45 am, the HRR, said her job duties had changed in February 2017 to include checking for background checks and tht she had been discovering issues with employees files ever since. She said there were no background checks for Employees A and B when she took over and she had informed Employees A and B verbally and in writing that they needed to transfer their background check findings to the facility from their previous employer. The HRR said Employees A and B were allowed to continue to work without a background check, even after the 2/15/17 letter. The HRR said Employees A and B would be taken off the schedule and not be allowed to work until the background check issues were resolved.</p> <p>On 4/5/17 at 2:25 pm, the Scheduler provided a copy of the April 2017 work schedule which documented Employees A and B were not scheduled to work the remainder of the month. The Scheduler said the employees could be added back to the schedule once the background checks came back clear.</p>	C 099	<p>The Administrator and Human Resource Manager will both verify all necessary new hire paperwork is completed prior to the employees start date, and fingerprints are completed by day 21. Employees will be notified from the Human Resource Manager on day 7, 14, and pulled from the floor on day 21 if the fingerprint criminal history background check is not completed. (April 25, 2017)</p> <p>Monitor: Facility Administrator and Human Resource Manager to complete audits on new hire paper, specifically fingerprint criminal history background check:</p> <ol style="list-style-type: none"> <li>1. Weekly for four (4) weeks.</li> <li>2. Monthly for three (3) months.</li> <li>3. Quarterly for two (2) quarters</li> </ol> <p>The results of these audits will be reported to the QA committee for review and further comment as indicated.</p>	