IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON– 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

July 10, 2017

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

Provider #: 135090

Dear Mr. Roedel:

On **June 16, 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.) **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.

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 **July 20, 2017**. Failure to submit an acceptable PoC by **July 20, 2017**, may result in the imposition of civil monetary penalties by **August 12, 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*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy(ies):

- A civil money penalty.

- Denial of Payment for New Admissions effective September 16, 2017.

In addition, we must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 16, 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.

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

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 **July 20, 2017**. If your request for informal dispute resolution is received after **July 20, 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,

David Scott, RN, Supervisor
Long Term Care

DS/lj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135090		C 06/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAW MOUNTAIN OF CASCADIA	909 RESERVE STREET BOISE, ID 83712

(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 A Complaint Investigation survey was conducted at the facility from June 6, 2017 through June 9, 2017 and June 15 through June 16, 2017. The surveyors conducting the survey were: Edith Cecil, RN team leader Linda Kelly, RN Susan Costa, RN Nina Sanderson, LSW BSW Laura Thompson, RN Acronyms include: ABX - Antibiotics ADLs - Activities of Daily Living ADCS - Assistant Director of Clinical Services AM - morning BG - Blood Glucose CCRO - Compliance/Clinical Resource Officer C-diff - Clostridium difficile cm - centimeters CNA- Certified Nursing Assistant D/C - discontinue DM - type II - Diabetes Mellitus type II DNS - Director of Nursing Services ED - Emergency Department EMS - Emergency Medical Services/Paramedics ER - Emergency Room IV - Intravenous(ly) LN - Licensed Nurse LPN - Licensed Practical Nurse L - Left LUE - Left Upper Extremity MAR - Medication Administration Record MDS- Minimum Data Set mg - milligram	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/20/2017

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 000	Continued From page 1 mg/dl - milligram/deciliter ml - milliLiter MR - Medication Refused NN - Nurse's Notes NP - Nurse Practitioner PASARR - Pre-Admission Screening and Resident Review PD - Police Department POA - Power of Attorney PM - afternoon PT/INR - Protime/International Normalized Ratio R - Right RN - Registered Nurse SQ - subcutaneous SW - Social Worker TS - Therapy Staff UM - Unit Manager W/C- wheelchair	F 000		
F 151 SS=D	483.10(b)(1)(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL (b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. (b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. (b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced	F 151		8/5/17

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F 151	Continued From page 2 by: Based on interview and record review, it was determined the facility failed to ensure a resident was able to exercise their right to access the police department [PD] and emergency medical services [EMS] without fear of reprisal. This was true for 1 of 1 residents (#20) sampled for initiating contact with the PD and EMS. The deficient practice created the potential for harm when Resident #20 was not allowed to return to the facility after her surrogate decision maker accessed emergency response personnel due to the discovery of multiple large bruises on Resident #20. Findings include: Resident #20 was admitted to the facility on 6/7/16 with diagnoses which included dementia and congestive heart failure. Resident #20 had two daughters involved with her care. On 6/14/17 at 1:15 pm during a family interview, Daughter #2 reported she had been visiting Resident #20 on 6/9/17 when she noticed several large bruises on the resident. Daughter #2 stated she ended her visit before the facility nursing staff had assessed the bruises, so she returned the following morning (6/10/17) to find out what the facility had determined. Daughter #2 stated LPN #1, who was on duty that morning, did not know about the bruising. Daughter #2 stated LPN #1 came briefly into Resident #20's room and looked at some of the bruises, but did not measure them or examine the resident for possible pain or injuries related to the bruising. During the interview Daughter #2 stated she called Daughter #1, who was Resident #20's Power of Attorney [POA], and following that	F 151	This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor□s findings or conclusions are accurate, that the findings constitute deficiency, or that the scope and severity regarding the deficiency are correctly applied. Survey Definitions: Daily as used in monitors = Monday □ Friday LN = Nurse ADL = Activities of Daily Living FSBG = Finger Stick Blood Glucose DCS = Director of Clinical services ADCS = Assistant Director of Clinical Services F 151 Resident #20 is not at the facility. For all other residents at the facility, the facility shall ensure they are able to exercise their rights without fear of reprisal. During the resident council meeting in July, residents will be advised of their right to exercise their rights without fear of reprisal.	

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F 151	Continued From page 3 discussion asked LPN #1 to have Resident #20 seen by a physician. Daughter #2 stated LPN #1 stated she did not feel that was necessary, the facility had started a "skin sheet" and would conduct an investigation. Daughter #2 stated she called Daughter #1 again, and the two decided the bruising may indicate Resident #20 had been abused. The daughters decided to call the police. The daughters expressed concern that they had "done something wrong" in calling law enforcement because, "That's when everything [with the facility] went downhill." On 6/16/17 at 8:55 am, LPN #1 stated she recalled Daughter #2 asking if it would be acceptable for the family to call the police on 6/10/17, and told her it would be "OK." On 6/15/17 at 9:35 am, ADCS #1 stated she had been the nurse on call the morning of 6/10/17. ADCS #1 stated after EMS had taken Resident #20 to the hospital, she [ADCS #1] called both the ED and Daughter #1 to inform them that Resident #20 could not return to the facility from the ED that day, in part because Daughter #2 had "over-reacted" to the bruising on Resident #20. On 6/15/17 at 8:15 am, the Ombudsman stated she attended a care conference for Resident #20 at the facility on 6/12/17. The Ombudsman stated the Administrator's statements to Resident #20 and her family during that conference left her with the impression that Resident #20 was not allowed to return to the facility on 6/10/17 because her family had called the police and had them come into the facility.	F 151	The Resident Right documents appearing in the admission agreement and in policy and procedure shall be reviewed and revised as needed. The policy will be reviewed by the Quality Assurance committee after the initial review for their comment and approval. All facility staff shall be educated related to Resident Rights and how to support them in exercising their rights without fear of reprisal. After staff is educated random interviews shall be conducted that validate staff understand the Resident Rights and how to support them in exercising their rights without fear of reprisal. These interviews shall be conducted weekly for 1 month, then monthly for 6 months. If a staff member is not able to answer questions posed in the interview, there shall be immediate remediation with the staff 1:1. The results of these interviews and all remediation provided shall be presented to the QA committee on a monthly basis for review and additional comment as appropriate. Responsible: Administrator and all department heads and all staff.	

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F 151	Continued From page 4 On 6/15/17 at 4:00 pm, the Administrator stated since Resident #20's family "demanded" that she be taken to the ED for evaluation of the bruising, the facility considered the resident discharged.	F 151		
F 156 SS=D	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: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (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. (C) A list of names, addresses (mailing and	F 156		8/5/17

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F 156	Continued From page 5 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 (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. (ii) Information and contact information for State 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.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage;	F 156		

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F 156	Continued From page 6 [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (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)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (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 information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (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	F 156		

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F 156	Continued From page 7 service programs, and the Medicaid Fraud Control Unit; and (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. (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. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (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. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in	F 156		

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F 156	Continued From page 8 writing; (g)(17) The facility must-- (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- (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; (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 (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. (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. (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. (ii) Where changes are made to charges for other	F 156		

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F 156	Continued From page 9 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. (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. (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. 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. This REQUIREMENT is not met as evidenced by: Based on staff and family interview and record review, it was determined the facility failed to ensure a resident or surrogate decision had the name and contact information for the attending physician. This was true for 1 of 20 residents (#20) sampled for Resident Rights. The deficient practice created the potential for harm when Resident #20's surrogate decision maker did not know how to contact the physician to discuss the concerns related to the bruises, pain, and potential injury. Findings include: Resident #20 was admitted to the facility on	F 156	F 156 Resident #20 is not at the facility. For all other residents at the facility, the facility shall ensure they are aware of who their treating physician is and how they may contact the physician independently. During the resident council meeting in July, residents will be advised they will receive a letter identifying who their primary treating physician is and how to	

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F 156	Continued From page 10 6/7/16, with diagnoses which included dementia and congestive heart failure. Resident #20 had two daughters involved in her care. Resident # 20's annual MDS assessment, dated 5/31/17, documented she had severely impaired cognition, delusions, wandered and was at risk of elopement from the facility. Resident #20's record documented physician visits from Physician A or Physician A's Nurse Practitioner on 2/2/17, 3/22/17, and 4/4/17. On 5/26/17, Resident #20 was seen by Physician B. Resident #20's June 2017 Physician's Recapitulation orders documented her physician was Physician B. On 6/10/17, Resident #20's nurse's notes documented Daughter #2 called the police, who then called paramedics due to concerns with bruising on Resident #20. On 6/14/17 at 1:15 pm, Resident #20's two daughters said after they discovered Resident #20's bruising, they were concerned she had further injuries, and requested the facility have her evaluated by a physician. The daughters stated they did not feel the facility had responded to that request, and called the police. On 6/15/17 at 3:15 pm, the Director of Nursing stated Resident #20's daughters could have called the physician themselves if they felt the facility was not responding sufficiently to their requests. On 6/16/17 at 8:35 am, Resident #20's Daughter #1, who was the resident's Power of Attorney	F 156	contact the physician directly. If the resident is not able to understand this information the residents surrogate shall receive the letter. All resident records shall be audited to ensure the primary treating physician listed in the medical record is correct. If necessary, corrections to the medical record shall be made immediately during the audit. Moving forward quarterly we will be discussing and confirming the resident/family is aware of who the attending physician is and there contact information. The results of this audit and the number of corrections made shall be reported to the QA committee for review and further comment if indicated. All facility records shall be audited every quarter for 3 quarters to ensure the primary treating physician listed and correct contact information is in the medical record is correct, and resident/family is aware at quarterly care conferences. If necessary, corrections to the medical record shall be made immediately during the audit. The results of these audits and the number of corrections made shall be reported to the QA committee for review and further comment if indicated. Responsible: Administrator, medical records	

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F 156	Continued From page 11 stated when the resident was first admitted to the facility approximately a year prior, the facility suggested it would be easier on the resident to be seen by the in-house physician. Daughter #1 stated she had agreed to this suggestion, and was provided Physician A's name and contact information. However, Daughter #1 stated she was informed a "couple of months ago" that the physician would be changing. Daughter #1 stated that she had not been informed of the new physician's name, or how to contact that individual. Daughter #1 stated she looked through her file of all the documents she had received from the facility, but could only find the information for the previous physician. When given Physician B's name, Daughter #1 stated, "I have no idea who that is."	F 156		
F 157 SS=E	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 157		8/5/17

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F 157	Continued From page 12 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on resident, family member, and staff interview; observation; and record review, it was determined the facility failed to ensure physicians and/or residents' interested parties were notified of accidents resulting in injury, out of range lab values, refusals of care, multiple bruise of unknown origin, and significant changes in residents' clinical conditions. This was true for 5	F 157	F 157 For residents #2, 4, and 7 the facility shall ensure that appropriate notifications are made to family or surrogates and/or that physicians are consulted with changes in condition that present an opportunity for involvement from family and/or physician.	

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F 157	Continued From page 13 of 13 (#2, #4, #7, #12 and #20) sampled residents. This deficient practice had the potential to result in missed opportunities for medical intervention and family involvement. Findings include: 1. Resident #12 was admitted to the facility on 3/3/14, with diagnoses of DM Type II [Diabetes Mellitus adult onset] and dementia. Additional diagnoses included insomnia, irregular heartbeat, and anxiety disorder. A fall investigation report dated 5/22/17 documented Resident #12 fell on that date. The investigation report stated Resident #12 experienced a fall by rolling out of bed. The investigation report documented a thud was heard and the responding CNA ran to Resident #12's room and found her on the floor. She was documented as lying on her left side facing the bed. Resident #12 was reported to state "I rolled out of bed." A nursing progress note, dated 5/22/17 at 3:30 am, described Resident #12's fall. It included documentation of swelling on her chin and the left side of her lower jaw. The progress note documented a message for Resident #12's physician was left in the communication box, and Resident #12's Interested Party would be called in the morning. The message to Resident #12's physician on 5/22/17 at 3:30 am stated, "At 00:35 [12:35 am] resident rolled out of bed. Found lying on her left side. She has some swelling on her chin and L [left] lower jaw. Ice pack applied. States "I broke my jaw." Jaw feels the same on both sides. Has	F 157	Resident #12 and 20 are no longer at the facility. For Resident #2 and #4, the LN on duty at the time of the FSBG that were out of range shall be identified and remediated on a 1:1 bases related to the necessity to notify the physician as outlined in the physician order. All licensed nursing staff shall be educated related to the medical necessity of following sliding scale coverage orders with emphasis on physician notification as outlined in the specific order. The facility's policy related to the management of sliding scale coverage order as well as hyper/hypoglycemic protocols shall be reviewed and revised if appropriate. Revisions to the protocol shall be approved by the medical director. This reviewed protocol shall be presented to the QA committee for review and further comment as indicated. The FSBG record and appropriate application of the sliding scale coverage order shall be audited daily for 30 days. Failure to initiate appropriate application of the sliding scale coverage order shall be immediately corrected and the LN remediated on a 1:1 basis. The results of this daily audit and all remediation shall be reported to the QA committee for review and further comment as appropriate.	

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F 157	Continued From page 14 some bruises/abrasion L [left] knee, R [right] knee & L[left] elbow and LUE [left upper extremity]. Please check face. Neuro checks initiated." Resident #12's nursing progress note, dated 5/22/17 at 6:38 am, documented her son and daughter-in-law were notified of the fall via telephone. The note did not document whether the family was notified of Resident #12's swelling or other injuries after the fall. Resident #12's nursing progress note, dated 5/22/17 at 1:30 pm, documented she was evaluated by a Nurse Practitioner and X-rays were ordered. A nursing progress note, dated 5/22/17 at 4:36 pm, documented an X-ray revealed a fracture of Resident #12's lower mandible [jaw]. A nursing progress note, dated on 5/22/17 at 5:21 pm, documented Resident #12's Interested Party requested she be transported to a hospital for evaluation. She did not return to the facility. On 6/8/17 at 3:30 pm, the Assistant Director of Clinical Services [ADCS] #3 stated the policy for physician notification was to call the physician for all fall resulting in injury. She stated Resident #12's physician should have been contacted by phone right away, rather than a written message left in the communication box. 2. Resident #7 was admitted to the facility on 4/1/17, after being hospitalized for a urinary tract infection. Additional diagnoses included chronic renal disease, DM Type II, and weakness. Her	F 157	Following the initial 30-day daily review, the FSBG level shall be audited weekly for one month for the appropriate application of the sliding scale coverage order. Failure to initiate appropriate application of the sliding scale coverage order shall be immediately corrected and the LN remediated on a 1:1 basis. The results of this weekly audit and all remediation shall be reported to the QA committee for review and further comment as appropriate. Following the weekly audits, the FSBG level shall be audited monthly for 2 months for the appropriate application of the sliding scale coverage order. Failure to initiate appropriate application of the sliding scale coverage order shall be immediately corrected and the LN remediated on a 1:1 basis. The results of this monthly audit and all remediation shall be reported to the QA committee for review and further comment as appropriate. All residents in the facility that have FSBG and sliding scale coverage orders shall be audited weekly for 1 month for the appropriate application of the sliding scale coverage order. Failure to initiate appropriate application of the sliding scale coverage order shall be immediately corrected and the LN remediated on a 1:1 basis. The results of this weekly audit and all remediation shall be reported to the QA committee for review and further comment as appropriate.	

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F 157	Continued From page 15 record included a hospital Discharge Summary dated 4/1/17. The Medications Ordered/ Recommended to be Continued section of the Discharge Summary, included Heparin (5,000 units/ml) 1 ml [milliliter] injected subcutaneously [under the skin] every 12 hours. Resident #7's Medication Administration Record [MAR] included an order for Heparin 1 ml subcutaneously every 12 hours. The order date on the MAR was 3/31/17, start date 4/1/17, and did not include an end date. Resident #7's MAR documented "MR" [Medication Refused] of Heparin from 5/24/17 to 6/6/17, except 1 dose administered the evening of 6/3/17. A total of 24 doses were refused. A Progress Note, dated 5/31/17, stated "Fax sent to Dr.[name] requesting end date on heparin injections." The Progress Note did not include information to Resident #7's physician that from 5/24/17 to 5/31/17, she had refused all heparin injections A copy of a fax dated 5/31/17, was provided by the DNS on 6/8/17 at 3:30 pm. The fax stated: "Heparin injection - This was continued after her hospital stay in March. We need an end date please! Thank you." The information on the fax to the physician did not include documentation that Resident #7 had refused the heparin since 5/24/17. A copy of the return fax from the physician to the facility was provided by the Administrator on 6/9/17 at 3:45 pm. The return fax sheet documented it was received by the physician on	F 157	Thereafter, the FSBG level shall be audited monthly for 2 months for the appropriate application of the sliding scale coverage order. Failure to initiate appropriate application of the sliding scale coverage order shall be immediately corrected and the LN remediated on a 1:1 basis. The results of this monthly audit and all remediation shall be reported to the QA committee for review and further comment as appropriate. For resident #4 related to Coumadin. A new Coumadin order was written on 7/12/2017 with a PT/INR ordered on 7/17/2017. The facility□s policy and procedure related to Coumadin administration and tracking with PT/INR shall be reviewed and revised if appropriate. Revisions to the policy and procedure shall be approved by the medical director. This reviewed policy and procedure shall be presented to the QA committee for review and further comment as indicated. All licensed nursing staff shall be educated related to the medical necessity of following the policy and procedure related to Coumadin administration and PT/INR tracking orders with emphasis on physician notification as outlined in the specific order. The anti-coagulation record and appropriate application of the PT/INR	

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F 157	Continued From page 16 6/5/17. The return fax was dated at the top of the form as being transmitted on 6/9/17 at 10:42 am, from the physician to the facility. The return fax included a note that was hand written and stated: "Please D/C [discontinue] Heparin injections." The note was signed by a physician on 6/5/17. On 6/8/17 at 12:30 pm, Resident #7 stated "I haven't had the heparin injections in quite a while. It is a medication for someone in the hospital that has had surgery. I did not have surgery. I don't think I need it. Actually, I thought it was discontinued because they [the nursing staff] don't even offer it anymore." On 6/8/17 at 12:35 pm, LPN #2 stated Resident #7 had refused the heparin injections so she stopped asking her about them. On 6/8/17 at 3:30 pm, ADCS #3 was unable to find documentation that Resident #7's physician was notified by phone, or by return fax confirmation, of her refusals of heparin. 3. On 6/8/17 at 2:30 pm, the DNS provided a copy of a form titled "Critical Lab Values." The form included instructions of: "Please call the Provider On-Call to inform of the abnormal lab value." The form included: - Glucose less than 50 mg/dl [milligram/deciliter]. - Glucose greater than 400 mg/dl. - Pro time greater than 30 seconds [a test that measures the time in seconds required for blood to clot] - INR [international normalizing ratio] greater than 4.0 minutes [the result of a PT test must be converted into standard units, the INR is the	F 157	order shall be audited daily for 30 days. Failure to initiate appropriate response to critical PT/INR levels shall be immediately corrected and the LN remediated on a 1:1 basis. The results of this daily audit and remediation shall be reported to the QA committee for review and further comment as appropriate. Following the initial 30 day daily review, the anti-coagulation log shall be audited weekly for one month for the appropriate application of the sliding scale coverage order. Failure to initiate appropriate response to critical PT/INR levels shall be immediately corrected and the LN remediated on a 1:1 basis. The results of this daily audit and remediation shall be reported to the QA committee for review and further comment as appropriate. Following the weekly audits, the anti-coagulation log shall be audited monthly for 2 months for the appropriate response to critical PT/INR levels. Failure to initiate appropriate response to critical PT/INR levels shall be immediately corrected and the LN remediated on a 1:1 basis. The results of this daily audit and remediation shall be reported to the QA committee for review and further comment as appropriate. For resident #7 as documented in the 2567L the heparin was discontinued on 6/9/2017. The order to discontinue was documented on a return fax notification from the physician.	

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F 157	Continued From page 17 standard unit used] The following residents had abnormal lab values and their medical records did not include documentation of physician notification: a. Resident #4 was admitted to the facility on 1/23/17, for skilled nursing related to chronic respiratory failure. Additional diagnoses included DM Type II and long term anticoagulant use. * A physician's order, dated 5/12/17, documented Resident #4's dose of Coumadin was increased on that date from 5 mg to 6 mg daily. Resident #4's Coumadin Anticoagulant Record documented her PT/INR was checked on 5/15/17 with results of 25.1 and 2.1. The Coumadin Anticoagulant Record documented a repeat PT/INR test was completed on 5/22/17 at 5:52 am, with results of 51.4 and 4.3. Resident #4's record did not include documentation that her physician was called to report the abnormal results. An NP order, dated 5/22/17 at 1:10 pm, instructed facility staff to hold the Coumadin and recheck the PT/INR the following day. On 6/8/17 at 3:30 pm, ADCS #3 stated abnormal labs were to be reported to the physician. She stated PT/INRs were performed by the night shift staff and results were placed in a log that included each resident who was on anticoagulation therapy. She stated the usual routine was to put the results in the anticoagulation log, the physician or their representative would review the results, and orders would be provided. The ADCS #3 stated	F 157	The facility□s policy and procedure related to fax notifications to physicians shall be reviewed and revised if appropriate. Revisions to the policy and procedure shall be approved by the medical director. This reviewed policy and procedure shall be presented to the QA committee for review and further comment as indicated. Additionally, the policy and procedure related to physician notification when a resident refuses treatment shall be reviewed and revised if appropriate. Revisions to the policy and procedure shall be approved by the medical director. This reviewed policy and procedure shall be presented to the QA committee for review and further comment as indicated. All licensed nursing staff shall be educated related to the medical necessity of following the policy and procedure related to fax notifications to physicians orders with emphasis on the thoroughness of the information presented in the physician notification as outlined in the specific order. Additionally, LN shall be re-educated on their responsibility to notify the primary physician when a resident refuses treatment. All residents who refuse treatment ordered by the physician shall be placed on the 24-hour report. (The facility uses PCC which has a 24-hour report that can be populated.) This 24-hour report shall	

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F 157	Continued From page 18 all abnormal result should be reported to the physician on call. She stated Resident #4's record documented the physician/NP was not notified for greater than 7 hours. * Resident #4's record documented daily BG [blood Glucose] monitoring. The month of May 2017, her BG results ranged from 182 to 460. Resident #4's record had an order for Insulin 10 units subcutaneously to be administered every morning. Additionally, she received Metformin 500 mg orally twice daily, am and pm. Her record did not include parameters with which to notify her physician of low or elevated BG values. Resident #4's MAR documented the BG level of 460 the morning of 5/13/17. Resident #4's record did not include documentation her physician was informed of the elevated BG of 460. On 6/8/17 at 3:30 pm, ADCS #3 stated Resident #4's elevated BG of 460 should have been reported to her physician. She stated each resident with diabetes should have specific and individual parameters for when to notify the physician. She reviewed Resident #4's record and was unable to find specific parameters. She referred to the form Critical Lab Values, and stated the elevated BG of 460 should have triggered a call to Resident #4's physician. On 6/8/17 at 11:20 am, the Medical Director reviewed Resident #4's record, and stated he would expect to be notified for a BG level of over 400. b. Resident #2 was admitted to the facility on 5/8/17 with multiple diagnoses, including type 1	F 157	be audited daily by nursing leadership related to treatment refusals. Nursing leadership shall assess the treatment refusals and take appropriate nursing action based on the refusal. Physician notification shall be made as outlined in the facility policy and procedure and this notification shall be documented by nursing leadership in the nursing progress notes. The above activity shall be audited weekly for 30 days. Failure to assess the treatment refusal and take appropriate nursing action based on the refusal shall be immediately remediated. The results of these weekly audits and all remediation shall be presented to the QA committee for review and further action as appropriate. Following the weekly audits, monthly audits shall be completed for 2 month. Failure to assess the treatment refusal and take appropriate nursing action based on the refusal shall be immediately remediated. The results of these weekly audits and all remediation shall be presented to the QA committee for review and further action as appropriate. Responsible party: Administrator, DCS, ADCS, nursing supervisors	

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F 157	Continued From page 19 diabetes and end stage renal disease. A 5/15/17 admission MDS assessment documented Resident #2 had intact cognition and a diagnosis of diabetes for which she received insulin. Resident #2's clinical record documented a 5/8/17 order for insulin Aspart solution by subcutaneous injection [SQ] per the following sliding scale: * 0-60 = no units of insulin, give juice and call physician * 61-200 = 0 units * 201-261 = 5 units * 262-320 = 7 units * 321-400 = 9 units * 401-402 = 11 units and call physician * If 400 or greater, give 11 units and call physician On 5/17/17, Resident #2's insulin Apart per sliding scale order was changed to: * 0-150 = no units of insulin, give juice and call physician * 151-200 = 2 units * 201- 250 = 4 units * 251-300 = 6 units * 301-350 = 8 units * 351-400 = 10 units and call physician * If 60 or less, give juice and call physician and if 400 or greater, give 10 units and call physician. There was no documentation in Resident #2's clinical record that a physician was notified when his BG level was 60 or less on:	F 157		

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F 157	Continued From page 20 * 5/15/17 at 3:20 am, it was 41 * 5/20/17 at 12:20 pm, it was 60 * 5/25/17 at 12:30 pm, it was 52 There was no documentation in Resident #2's clinical record that a physician was notified when his BG was 400 or greater on: * 5/11/17 at 7:16 am, it was 490 * 6/6/17 at 9:30 pm, it was 454 On 6/8/17 at 3:05 pm, ADCS #1 reviewed Resident #2's clinical record, including the MARs for May and June 2017, a log of BG results, and progress notes. The ADCS said she did not find documentation of physician notification when Resident #2's BG results were outside the established parameters. 5. Resident #20 was admitted to the facility on 6/7/16 with diagnoses which included dementia and congestive heart failure. Resident #20's annual MDS assessment, dated 5/31/17, documented she had severely impaired cognition, delusions, wandered and was at risk of elopement from the facility. The MDS documented Resident #20 required assistance for bed mobility, transfers, dressing, toilet use, and hygiene; and supervision with ambulation. The MDS documented resident had no physical or verbal aggression towards others. A "Skin Event" form in Resident # 20's record documented bruises were discovered to the resident's right wrist (5.3 x 4 cm), right upper arm (6.5 x 17 cm), left upper arm (5.4 x 3.3 cm), right	F 157		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAW MOUNTAIN OF CASCADIA	909 RESERVE STREET BOISE, ID 83712

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F 157	Continued From page 21 hip (5.2 x 10.8 cm); and a scab (0.6 x .05 cm) was discovered to her left elbow, all on 6/9/17 at 9:20 pm. On 6/15/17 at 10:30 am, ADCS #3 stated she assisted with the assessment of the bruising when it was reported, but presumed LPN #2 notified the physician since he was the nurse in charge of Resident #20's care that shift. On 6/15/17 at 2:20 pm, LPN #4 stated "believe I put a note [the physician's facility mail box] for him to look at when he came in ...I think the physician comes in on Mondays, and this happened on a Friday. If I put a note in there, he would have seen it Monday." LPN #2 stated, "Maybe [ADCS #3] called him." On 6/16/17 at 8:55 am, LPN #1 stated she was Resident #20's nurse on the morning of 6/10/17. LPN #1 stated she notified the physician of Resident #20's bruising after the family called the police. LPN #1 stated the physician agreed the resident could go to the hospital for evaluation at that time. The facility did not provide evidence the physician was notified of Resident #20's bruising for over 12 hours after it was first discovered	F 157		
F 201 SS=G	483.15(c)(1)(i)(ii) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT (c) Transfer and discharge (1) Facility requirements (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-	F 201		8/8/17

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F 201	Continued From page 22 (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to	F 201		

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F 201	Continued From page 23 discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to permit a resident to remain in the facility after family discovered multiple large bruises, asked to have the nature of the bruises evaluated by a physician, and summoned emergency services when the facility did not respond to this request. The resident was subsequently evaluated at the emergency department [ED] and found to be medically stable to return to the facility. This was true for 1 of 1 Residents (#20) sampled for involuntary discharge. Resident #20 was harmed when the facility refused to allow the resident to return after evaluation in the ED, causing the resident to be discharged to a private home without adequately trained or otherwise prepared caregivers, medications, medical equipment, or follow-up care. Findings include: Resident #20 was admitted to the facility on 6/7/16, with diagnoses which included dementia and congestive heart failure. Resident #20 had two daughters involved with her care. Resident #20's annual MDS assessment, dated 5/31/17, documented she had severely impaired cognition, delusions, wandered, and was at risk of elopement from the facility. The MDS documented Resident #20 required assistance for bed mobility, transfers, dressing, toilet use, and hygiene; and supervision with ambulation. The MDS documented Resident #20 had no	F 201	F 201 Resident #20 is no longer at the facility. For all residents at the facility, the facility shall ensure that if a resident is sent out to the emergency department for evaluation and deemed medically stable to return to the facility as a result of that emergency room evaluation, the facility shall facilitate the return to the facility following discharge from the emergency room. The facility policies related to admit, transfer, and discharge shall be reviewed and revised if appropriate. Revisions to the policy and procedure shall be approved by the medical director. This reviewed policy and procedure shall be presented to the QA committee for review and further comment as indicated. All LN and facility staff that may be involved in admit, transfer, discharge situations shall be educated in the facility policies related to admit transfer and discharge. After staff is educated random interviews shall be conducted that validate staff understand the admit transfer, and	

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F 201	Continued From page 24 physical or verbal aggression towards others. Resident #20's care plan, Nurse's Notes, and Social Services progress notes for January through June of 2017, did not include documentation regarding family interference with Resident #20's care. Resident #20's Nurse's Notes documented a "Monthly head to toe assessment" on 5/25/17 at 12:16 am. No bruising or other skin abnormalities were documented. The next entry in the Nurse's Notes was dated 6/8/17 at 1:50 pm and documented, "Shower not given as there were time constraints." A "Skin Event" form in Resident #20's record documented bruises were discovered on her right wrist (5.3 x 4 cm), right upper arm (6.5 x 17 cm), left upper arm (5.4 x 3.3 cm), right hip (5.2 x 10.8 cm); and a scab (0.6 x .05 cm) was discovered on her left elbow, all on 6/9/17 at 9:20 pm. The form was signed and dated on 6/14/17. On 6/9/17, Resident #20's Nurse's Notes documented: * 9:39 pm: "Received call from resident's daughter, [Name of Daughter #1], who was concerned about new bruises found on resident's right upper arm, left upper arm, and right hip area. Resident's daughter wanted to know the cause of the bruises - resident has had no recent falls..." * 9:44 PM: "Noted bruise on right wrist. Upon further assessment other bruises were noted on both right and left underarms. Noted bruising on her right hip..."	F 201	discharge policies and procedures. These interviews shall be conducted weekly for 1 month, then monthly for 6 months. If a staff member is not able to answer questions posed in the interview, there shall be immediate remediation with the staff 1:1. The results of these interviews and all remediation provided shall be presented to the QA committee on a monthly basis for review and additional comment as appropriate. During the week of July 11th, the facility Administrator meet with a preceptor on 4 separate occasions to re-educate related to the following: 1) the regulatory requirements at F201, 2) how the acute hospital perceived the communications between the nurse on duty on June 10th, and 3)survey management. During the week of July 11th and the week of July 24th the Cascadia Director of Compliance and Clinical Resource met with the Facility Administrator to provide coaching and reinforcement regarding the requirements to investigate an injury of unknown origin. The Cascadia Director of Compliance and Clinical Resource along with the Facility Administrator and the DCS reviewed and revised the Abuse Prohibition Program to ensure all language was regulatory. The medical director reviewed and approve this revised policy and it was presented to the QA committee and adopted by the QA committee.	

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F 201	Continued From page 25 No further entries were documented in Resident #20's record until the following morning. On 6/10/17, Resident #20's Nurse's Notes documented: * 10:55 am [Late entry]: "Staff alerted that [police department] was in the facility and investigating bruising on resident's hip and underarms. Attempted to evaluate resident and [Daughter #2] declined said the police would investigate...Paramedics called and took resident to the ER for evaluation..." * 11:09 am [Late entry]: "Resident was discharged to the ED..." * 11:30 am [Late entry]: "Called [Daughter #1] that before the resident returns to facility we would have to meet with family and facility administrator based on families [sic] concerns with bruising and facilities [sic] concerns for [Daughter #2's] impediment in care of resident." There was no documentation as to when the "late entries" were added to Resident #20's record. Resident #20's 6/10/17 Nurse's Notes continued: * 2:16 pm: "Received call from ED physician and ED [nurse's name and title]. Discussed concerns around ability to provide sufficient care with [Daughter #2's] impediment on care. ED states there are no significant injuries. Will hold resident until a meeting can be facilitated about resident's care." * 2:42 pm: "[Daughter #2 asked] to have a confidential conversation regarding the bruises on her mother's arms, wrists, and hips. She	F 201	Additional Cascadia Clinical Resource has worked with the Facility Administrator and the clinical staff on July 20 and the week of July 31st to support the Administrator in making operational the POC for this citation. The Cascadia Vice-President worked with the Administrator in a coaching fashion the week of July 12, July 19, and July 26, 2017 specifically focusing on root cause analysis and alternative decision making and best practices. Ongoing support will be provided by the Director of Operations and/or the Director of Compliance and Clinical resource. This support will be done at least 2 weeks out of the month. Additionally, Clinical Resource will be in the building supporting the POC activity and then post credible allegation of compliance to ensure the POC remains operational through follow up survey. Once the facility clears the survey, ongoing support will occur at least monthly. Responsible party: Administrator, DCS, ADCS, Social Service, Admissions, and clinical staff Date:	

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F 201	Continued From page 26 stated she was going to talk with the Ombudsman and she was not angry but insisted that the bruises be investigated." * 5:59 pm: "[Daughter #2] then stated she was taking pictures of the bruises and she stated she had called the Boise police and she was waiting for them states she wanted to have it investigated very well that is why she called the police. Police arrived and [officer's name] states that police protocol is to call the paramedics for an eval[uation]. Paramedics arrived and then transported the resident to the [ED]." Resident #20's ED Triage notes from 6/10/17 at 12:46 pm documented, "Patient arrives via EMS [emergency medical services] with c/o [complaint of] possible abuse at her nursing home. Patient's daughter reportedly called the police after finding 'bruises on the patient's arms and hip' ...patient herself is a poor historian. She was unable to reliably tell EMS how she got the bruises; she first stated 'I was ganged up on' and then 'It's from all the tests they do.' She was able to stand with minimal assistance...[Facility nurse's name] also called to give...report...She states the facility will not be able to take the patient back until 'we have a meeting with the patient's family to discuss her care...'" In terms of "tests," Resident #20's record documented she most recently had labs drawn on 8/15/16. An ED Plan of Care note for Resident #20, on 6/10/17 at 2:38 pm, documented, "...the [facility] nurse reports that [Resident #20] currently lives in a secured dementia facility. The nurse also reports that the...daughter is very disruptive and	F 201		

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F 201	Continued From page 27 they [the facility] had to call the police. EMS reports that they found bruises up her bilateral arms, right forearm, and right flank...I spoke with [facility nurse's name] who reports they will not be able to take the patient back until after a care conference occurs with their administrator/DNS [Director of Nursing] and herself to discuss ongoing care needs. She [the facility nurse] reports [Resident #20] resides on their locked memory care unit with a history of wandering and exit seeking behavior...also...has struck out at staff...I met with [Daughter #2] who reports that she visits 2-3 times/week...with her sister on alternate days...[Resident #20] is not noted to be on an anticoagulant...she reports the police were involved due to 'the large bruises' and 'concern for excessive use of force' used when [Resident #20]...'tried to escape at night.' She reports the police recommended involving EMS who recommended the ED visit for evaluation. [Daughter #2] reports their goal in reporting to police was to have an 'accurate documentation of what this is'...[Daughter #2] reports she and her sister were leaning towards taking [Resident #20] home to care for her unless she can stay here because [Daughter #2] understood from [Daughter #1] that the facility said [Resident #20] could not return there. I clarified the accuracy of this within the caveat that [Facility nurse] explained being a care conference clarifying goals of care would need to happen first..." Resident #20's ED Plan of Care notes from 6/10/17 at 3:17 pm documented, "Met with [Daughter #1 and Daughter #2]. [Daughter #1] clarified that she was told they were not able to return [Resident #20] to facility until a care conference was done ...I reviewed with them my	F 201		

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F 201	Continued From page 28 discussion with the ED MD that there is no medical findings to support admission at this time..." On 6/14/17 at 1:15 pm, Resident #20's Daughter #1 and Daughter #2 reported they had Resident #20 home with them since the ED visit on 6/10/17, and were "exhausted." The daughters reported Resident #20 was complaining of constant pain from her bruises, was sleeping poorly, and not as mobile as she had been prior to the onset of the bruising. The daughters stated Resident #20 was requesting her walker, which was still at the facility, and the daughters were concerned if they returned to the facility it would not be given to them because of the way the resident had been discharged. The daughters expressed concern that they had "done something wrong" in calling law enforcement because, "That's when everything [with the facility] went downhill and now [Resident #20] can't get the help she needs. We won't be able to keep this up for much longer. [Resident #20] always needs someone who can be awake to keep an eye on her, so we are each taking 12 hour shifts." The daughters reported the following timeline of events: * Daughter #2 reported she was in the facility, sitting with Resident #20 in the dining room prior to the dinner meal on Friday, 6/9/17 as it was customary for her to assist the resident with her meals several times weekly. Daughter #2 stated Resident #20 was wearing a long-sleeved shirt. At approximately 4:45 pm, Daughter #2 stated she saw a bruise on Resident #20's right wrist, "peeking out from under her sleeve." Daughter #2 stated she notified LPN #2, who stated the	F 201		

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F 201	Continued From page 29 bruise looked old, although had not been reported to him when he came on duty. LPN #2 stated he would look at the bruise later. * Daughter #2 stated that after Resident #20 had finished her meal, she again asked LPN #2 to assess the resident's bruised wrist. LPN #2 responded that he was busy supervising the dining room, and then had to pass medications. LPN #2 instructed Daughter #2 to go ahead and take Resident #20 to her room and get her ready for bed, and he would assess the bruise later. * Daughter #2 did as instructed and took Resident #2 to her room at 6:15 pm, and as she was undressing Resident #20 discovered a second bruise, this one on the resident's right upper arm. Daughter #2 reported this bruise to LPN #2, who again told Daughter #2 to continue assisting Resident #20 to get ready for bed, and the RN would assess the bruises later. At 6:20 PM, Daughter #2 discovered a third bruise and skin tear on Resident #20's left elbow, then a fourth and fifth bruise on the resident's left upper arm. Daughter #2 again reported these findings to LPN #2, who again stated he would assess the bruises later. When Daughter #2 returned to assist Resident #20, the resident was verbalizing pain and having difficulty maintaining a standing position, both of which were unusual for the resident. Daughter #2 then assisted Resident #20 to change her Attends, and discovered a sixth "very large bruise" on the resident's right hip. Daughter #2 alerted LPN #2 of the sixth bruise, and was told the bruises would be assessed later that evening when other work had been completed and a second staff person was available. Daughter #2 remembered the bruises	F 201		

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F 201	Continued From page 30 as large, in places on her body (upper arms, around her wrist, and on her hip) that suggested to her that the resident had been engaged in struggle and thought the bruises may have been the result of facility staff handling Resident #20 with "excessive force." * Daughter #2 stated she was not the Resident #20's POA [Power of Attorney], but Daughter #1 was. Daughter #2 stated the facility expressed sometimes they felt she interfered with care decisions, so she decided not to press the issue further at that time. Daughter #2 left the facility, drove home to charge her phone, then called Daughter #1 to inform her of Resident #20's bruises and that the facility had not assessed the bruises at the time Daughter #2 left the facility. * Daughter #1 stated Daughter #2 called her at approximately 9:00 pm on 6/9/17 to report she had found 6 bruises on Resident #20. Daughter #1 stated in her mind's eye she saw small bruises on extremities where the resident may have bumped into furniture, but did not imagine bruises in the locations or of the size ultimately discovered. Daughter #1 told Daughter #2 she would call the facility to find out what the results of the evaluation of the bruises were. * Daughter #1 stated she called the facility shortly after 9:00 pm and talked to ADCS #3. ADCS #3 assured Daughter #1 she would go evaluate the bruises, and called back at approximately 9:30 to report there was no need to be concerned, and the bruises had likely resulted from the pillows in Resident #20's wheelchair. * On Saturday, 6/10/17, Daughter #2 went to the	F 201		

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F 201	Continued From page 31 facility at approximately 10:00 am to follow up on the evaluation of Resident #20's bruising. Daughter #2 stated she continued to be troubled by the size, number, and locations of the bruising. Daughter #2 approached LPN #1, who was the nurse caring for Resident #20. LPN #1 told Daughter #2 that the facility had started a "skin sheet" and would be investigating the cause of the bruising, so there was no need to worry. Daughter #2 stated she asked LPN #1 to have Resident #20 evaluated by a physician to rule out abuse as a potential cause of the bruising, and to assess for further internal injuries or fractures associated with the bruising. Daughter #2 stated LPN #1 told her she did not think that was necessary. Daughter #2 stated she began to wonder if the facility was trying to "sweep the cause of the bruises under the rug," so took pictures of Resident #20's injuries with her cell phone so they would be accurately documented. * Daughter #2 stated that at that point, she felt she needed to consult with Daughter #1, who was Resident #20's POA. Daughter #2 stated she exited the memory care unit where Resident #20 resided each time she spoke on the phone with Daughter #1, as the nature of their conversations was private, and potentially upsetting to Resident #20. * Daughter #1 stated she remembered Daughter #2 calling her the morning of 6/10/17, and being upset about the extent of Resident #20's bruising. Daughter #1 stated she began to understand the bruising was more severe than she had previously imagined, and agreed she would like Resident #20 evaluated by a physician for abuse and/or other injuries. Daughter #1 stated since	F 201		

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(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 201	Continued From page 32 the facility had declined to have Resident #20 evaluated by a physician, they weren't sure how to proceed to get that done on their own. After discussion, the daughters decided if this discovery was made in the community, the police would be called. Daughter #1 stated it seemed reasonable to them at the time that calling the police was the best option given the facility's response to their request to have the resident seen by a physician. Daughter #1 told Daughter #2 to check with the facility to see if it was acceptable for them call the police. * Daughter #2 stated after this discussion, she approached LPN #1 and asked if it would be "OK" to call the police. Daughter #2 stated LPN #1 told her there was no problem with them calling the police, and went back to her work. Daughter #2 then called the police. * Daughter #1 stated within approximately 30 minutes, she was contacted by a police officer on site at the facility with Resident #20. Daughter #1 stated the police officer agreed the bruising was "significant," and as such police policy was to summon EMS. Daughter #1 stated she gave permission to have EMS called. Daughter #1 stated that a few minutes later, a paramedic called and requested permission to transport Resident #20 to the ED for evaluation. Daughter #1 stated, "I asked him if he thought that was really necessary and he told me, 'If it were my mom, she'd already be there by now.' Daughter #1 stated that based on this statement from the paramedic, she gave consent for Resident #20 to be evaluated at the ED, and set out from her home to meet the resident there.	F 201		

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F 201	Continued From page 33 * Daughter #1 stated that while she was driving to the hospital to meet Resident #20, ADCS #1 called from the facility and told Daughter #1 that since the facility did not think the resident required evaluation at the ED, the facility's position was that Resident #20's family had chosen to discharge her. Daughter #1 stated that since the discharge was the "family's choice" and not a medical necessity, the facility considered the resident officially discharged and she would not be able to return to the facility that day. Daughter #1 stated ADCS #1 told her the facility would only be willing to readmit the resident after the family met with the Administrator, DNS, and herself to discuss care concerns. Daughter #1 stated she was "stunned and confused" by the call, but more focused on making sure the resident did not have underlying injuries related to her bruising, and that the resident had not been abused. * Daughter #1 stated that when she saw Resident #20's bruising for the first time in the ED, she "agreed completely" with Daughter #2's concerns and insistence that the resident be evaluated by a physician. * Daughter #1 stated the ED was unwilling to confirm or refute whether Resident #20 had been abused, but did find that the resident had not sustained internal injuries or fractures related to the bruising. Daughter #1 stated the ED informed them the resident did not meet criteria for admission to the hospital, and the facility had declined to let the resident return. Daughter #1 stated they had "no choice" but to take Resident #20 home and try to care for her until they could meet with the facility on Monday, 6/12/17.	F 201		

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F 201	Continued From page 34 * Daughter #1 stated that between 6/10/17 and 6/12/17, Resident #20 complained almost constantly of pain related to her bruises, and was less independent with her mobility due to her pain levels. * Daughter #1 stated that by 6/12/17, they were exhausted trying to care for Resident #20 with just 2 family members, and called the Ombudsman first thing that morning to request she attend a conference with family and the facility to facilitate the resident's readmission. Daughter #1 stated she lived in a community quite some distance from the facility, and there was no one else to care for Resident #20 in their absence, so they decided the most prudent action was to bring the resident with them to the facility for the conference. Daughter #1 stated she presumed, since the facility had been the resident's home for the past year, there would be no problem with Resident #20 returning to her room in the facility that day. Resident # 20 was present when the facility met with the family and Ombudsman. * Daughter #1 stated, as POA, that she expected the facility would apologize for their response to the discovery of Resident #20's bruising, and discuss the results of their investigation into the root cause of the bruising during the meeting. Daughter #1 stated, "Instead, it was like an interrogation of my sister and me. Like we were on trial. The Administrator told us [Resident #20] no longer had her bed at the facility and was no longer considered a resident. He [the Administrator] told us that he didn't appreciate us throwing an allegation of abuse around, or calling	F 201		

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F 201	Continued From page 35	F 201		

those people [police and EMS] in. He said he could really get in trouble with the state, have to do lots of paperwork, and cost the facility their licensing because [Daughter #2] had alleged abuse...he tried to make my sister a scapegoat because of how she responded to finding all those big bruises on [Resident #20]."

* Daughter #1 stated the Administrator then asked to speak with her privately, away from Daughter #2. Daughter #1 stated the purpose of that conversation was to inform her that since Daughter #2 had made an abuse accusation against the facility, no other facilities would be willing to accept Resident #20 for admission. Daughter #1 stated based on that, the Administrator said he was willing to consider letting Resident #20 back into the facility on the condition that Daughter #2 did not visit Resident #20 unless she was accompanied by another family member.

* Daughter #1 stated she was becoming frightened for Resident #20's well-being, and ashamed that the family's response to the bruising may have jeopardized the facility's willingness to care for her. Daughter #1 stated she felt that she did not have a choice other than to go along with whatever the facility requested, so she agreed to the condition.

* Daughter #1 stated that after she agreed to the condition, the facility said they still could not let Resident #20 stay there because they did not have the proper paperwork. The Administrator told Daughter #1 the family would have to take the Resident #20 back to the ED to get "orders and a PASARR [Pre-Admission Screening and

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F 201	Continued From page 36 Resident Review]." Daughter #1 stated once at the ED, there became a problem with the ED providing the PASARR. The ED called the facility to discuss the barrier, and the facility told them Resident #20 would not be able to come back. Daughter #1 stated, "We had to take [Resident #20] home with us again. We don't have her walker, we don't have her medications, and we are absolutely exhausted. We don't know where to turn or what to do." On 6/15/17 at 8:15 am, the Ombudsman stated she was contacted by Resident #20's daughters on the morning of 6/12/17 regarding the above situation, and they requested that she meet them at the facility for the care conference later that morning. The Ombudsman stated the Administrator, SW [Social Worker], and DNS [Director of Nursing] were at the conference. The Ombudsman stated the Administrator told Resident #20 and her daughters that the resident would not be allowed to return to the facility and implied that decision had been made because the police had been called. The Ombudsman stated the daughters were "upset with the news" because "they just wanted an investigation, and it felt like the bruising was being minimized by the facility." The Ombudsman stated the Administrator had asked to meet with her privately, and told her Daughter #2 was the "problem." The Ombudsman stated some of the Administrator's comments and insinuations caused her concern. The Ombudsman stated the Administrator did require the family agree to supervised visits for Daughter #2 as a condition of readmission, and that she felt Daughter #1 agreed to this "out of desperation." The Ombudsman described the situation and	F 201		

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F 201	Continued From page 37 conference as, "such a shock." On 6/15/17 at 9:35 am, ADCS #1 stated she had been the "nurse on call" on 6/10/17, and was notified at some point during the morning that the police were in the building. ADCS #1 determined the police had been called by Resident #20's family related to bruises that had been discovered. ADCS #1 stated Daughter #2 was present in the facility. ADCS #1 stated Daughter #2 had a "long-standing history" of interfering with Resident #20's cares, and interfered with facility cares that morning. ADCS #1 was not aware of any documentation or other evidence of Daughter #2's "interference" since Resident #20 was admitted to the facility approximately a year prior, but said there was documentation at the time of Resident #20's admission that Daughter #2 had been Resident #20's caregiver in the community, and had not given Resident #20 her antipsychotic medication as she thought it made Resident #20 drowsy. ADCS #1 stated Daughter #2 interfered with care in two ways on the morning the police were called. The first was Daughter #2 did not allow ADCS #1 to complete a skin assessment after the police were called, stating that she was not going to allow anyone from the facility to look at the resident until the police arrived. The second was as Resident #20 was sitting on the gurney being attended by the paramedics at 11:45 am, LPN #1 asked if Resident #20 would like her noon dose of Tylenol before going to the hospital. Resident #20 did not respond, but Daughter #2 declined on the resident's behalf. ADCS #1 confirmed that she had called both the ED and Daughter #1 to tell them Resident #20 could not return to the facility that day because, "[Daughter #2] completely	F 201		

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F 201	Continued From page 38 over-reacted to the situation" and because of that "I wasn't sure if we [the facility] could meet [Resident #20's] needs." ADCS #1 could not state which needs Resident # 20 had that the facility could not meet. ADCS #1 stated she thought the hospital would admit the resident due to this development, and keep her in the hospital until the facility could meet with the family. ADCS #1 was unable to identify the date the resident was considered discharged. ADCS #1 stated after Resident #20 left the facility, she started an abuse investigation. On 6/15/17 at 9:55 am, the SW stated her first awareness of the event was an email she had on Monday, 6/12/17, notifying her of a care conference with Resident #20's family, as the police had been called and the resident removed from the facility due to an allegation of abuse. The SW stated she was also informed that Daughter #2 had "caused a commotion and was so emotional she had caused disruption in the [memory care unit]." The SW stated the conference was facilitated by the Administrator. The SW stated the Administrator informed Resident #20 and her family in the conference that he was concerned about Daughter #2's reaction to the bruising, and he did not want Resident #20 to return to the facility. The SW stated the Administrator told Resident #20 and her family she had "lost her bed" and was no longer considered a resident at the facility. The SW stated Resident #20's family was very concerned about the resident's bruising. The SW stated historically Resident #20's family, including Daughter #2, was not unusually disruptive to the resident's care or the overall environment. The SW stated Resident #20's family needed	F 201		

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F 201	Continued From page 39 guidance at times as to care options or the grievance process, but were receptive to such guidance. On 6/15/17 at 10:30 am, ADCS #3 stated she had been working on evening shift on a different unit on 6/9/17. ADCS #3 stated she received a call from Daughter #2 at approximately 9:00 pm, with a concern about Resident #20's bruising. ADCS #3 stated the bruises had not yet been assessed, so she went to assist with the assessment. ADCS #3 stated she recalled at that time finding bruising on Resident # 20's right upper arm that was "fairly large," a bruise to the resident's right wrist, and a bruise to her left arm. ADCS #3 stated there was also a bruise to Resident # 20's right hip that she recalled as "about 2 inches" in diameter, however the resident's Attends was not removed for the bruise to be visualized or measured in its entirety. ADCS #3 surmised at the time that the bruising had come from the cushion in Resident #20's wheelchair. ADCS #3 stated she had no further interaction with Resident #20 or her family until a care conference on Monday, 6/12/17. ADCS #3 stated she recalled the Administrator told Resident #20 and her family during the care conference that she was no longer a resident in the facility and had "lost her bed." On 6/15/17 at 11:55 am, the police officer who responded to Daughter #2's call on 6/10/17, stated he found Resident #20 with what he would consider "severe bruising," and in his training the most important thing to do was to rule out further injuries. The police officer stated the family consented to summoning EMS, and upon EMS recommendation Resident #20 was taken to the	F 201		

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F 201	Continued From page 40 hospital. The police officer stated, "They were saying we were disrupting the unit, but that didn't make sense to me, because we were in her room or just outside her room in the hall. We were sensitive to where we were." On 6/15/17 at 2:20 pm, LPN #2 stated he was on duty when Daughter #2 started noticing bruising on Resident #20. LPN #2 stated though Daughter #2 reported several instances of new bruising, he was occupied with other, more pressing duties, and it was not until after 9:00 pm when the bruises were assessed. LPN #2 stated he had worked with Resident #20 for quite some time, and was very familiar with Daughter #2. LPN #2 stated Daughter #2 made "odd" requests at times, but was not disruptive to Resident #20's care. LPN #2 stated in his experience, Daughter #2 was not problematic in her demeanor on the unit, either prior to, or on, that night. On 6/15/17 at 3:15 pm, the DNS stated she was informed on Saturday morning, 6/10/17, that Resident #20's family had summoned the police, and that Daughter #2 had been "walking back and forth on the floor, disrupting the unit." The DNS stated when she found out Resident #20 was being transported to the hospital, she informed ADCS #1, who was the nurse on call that day, that there would have to be a care conference when the resident returned to the facility to discuss Daughter #2's behavior. The DNS stated she was under the presumption that the resident was going to be "held for observation" at the hospital until such a conference could be arranged. On 6/15/17 at 4:00 pm, the Administrator stated	F 201		

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F 201	Continued From page 41 Daughter #2 had created disruption on the memory care unit on the morning of Saturday, 6/10/17. The Administrator stated he was not present at the facility until after Resident #20 had been transported to the hospital and her family had left the premises. The Administrator stated the family "demanded" Resident #20 needed to go to the hospital, so the physician wrote the order and the resident was discharged. The Administrator stated he assessed the other residents in the memory care unit were not safe because of Daughter #2, and he made the "executive director privilege" decision to not accept the resident back that day. The Administrator stated he believed ADCS #1 and the hospital "struck a bargain" that Resident #20 would be kept under observation at the hospital until the facility could arrange a conference the following work week. The Administrator stated he learned when Resident #20 and her family came to the care conference on 6/12/17, that the resident had been home with her daughters since 6/10/17. The Administrator stated he initially declined to have Resident #20 return to the facility, but was able to work out an arrangement with Daughter #1 that Daughter #2 would only have supervised visits. The Administrator stated at that point, since the facility considered Resident #20 discharged, he instructed the family to take Resident #20 back to the ED to obtain orders and other admission paperwork. The Administrator stated the ED was unable to provide a PASARR for Resident #20, so the facility did not allow her to come back. On 6/16/17 at 8:55 am, LPN #1 stated she had been the nurse on duty on 6/10/17. LPN #1 stated she had received report that morning that	F 201		

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F 201	Continued From page 42 Resident #20 had been restless during the night, and had "high activity the past couple of days." LPN #1 did not recall being told of Resident # 20's bruising, so had not done an assessment. LPN #1 stated she was approached at one point by Daughter #2 due to concerns with Resident #20's bruising, and went to the room to "observe" the bruising. LPN #1 stated she did not do a formal assessment at that time, but checked the resident's record and saw that a "skin sheet" had been opened. LPN #1 stated no measurements were documented on the skin sheet at that time. LPN #1 informed Daughter #2 of this, and that the skin sheet would be "completed" later that day. LPN #1 stated Daughter #2 had an "excited" manner about her, requesting further evaluation of the bruises. LPN #1 stated she offered to "eyeball" the bruises, but Daughter #2 became more excited, going in and out of the building. LPN #1 described the impact of Daughter #2's behavior that morning as, "It wasn't unusual or a big deal." LPN #1 stated when Daughter #2 requested further evaluation of the bruising, "I didn't call the physician. I didn't even consider it. When I saw the 'skin sheet' had been started, I just presumed someone else had already let the physician know and there was nothing else to be done." Resident #20 was harmed when she was involuntarily discharged from the facility. Resident #20's family discovered several large bruises on her, and requested she be evaluated for further injuries and to rule out abuse. Resident #20's family summoned emergency responders and had her taken to the ED when the facility failed to respond to this request. The facility's refusal to allow Resident #20 to return to	F 201		

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F 201	Continued From page 43 the facility resulted in her being discharged to her daughter's home without medications, medical equipment, or follow-up care, and without enough caregiver support to sustain the arrangement safely. The facility reaffirmed the decision by telling Resident #20 and her family two days later at a care conference that she had "lost her bed" and was "no longer considered a resident."	F 201		
F 203 SS=D	483.15(c)(3)-(6)(8) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE (c) (3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (b)(5) of this section. (c) (4) Timing of the notice. (i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 203		8/8/17

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F 203	Continued From page 44 (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or (E) A resident has not resided in the facility for 30 days. (c) (5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how	F 203		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAW MOUNTAIN OF CASCADIA	909 RESERVE STREET BOISE, ID 83712

(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 203	Continued From page 45 to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. (c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. (c)(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the	F 203		

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F 203	Continued From page 46 facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on family member and staff interview and record review, it was determined the facility failed to provide written notice before involuntarily discharging a resident; failed to provide such notification 30 days in advance; and failed to ensure the resident and resident's representative were notified of their appeal rights. This was true for 1 of 1 Residents (#20) sampled for involuntary discharge. The deficient practice created the potential for harm when Resident #20 was discharged from the facility due to her family choosing to have bruising evaluated at the emergency department [ED]. Findings include: Resident #20 was admitted to the facility on 6/7/16, with diagnoses which included dementia and congestive heart failure. Resident #20 had two daughters involved with her care. On 6/14/17 at 1:15 pm, Resident #20's daughters reported they had been caring for the resident at home since 6/10/17. Daughter #2 stated she had discovered multiple large bruises on Resident # 20 on 6/9/17, which she reported to both the facility and to Daughter #1, who was Resident #20's Power of Attorney. Daughter #1 reported that when the facility had failed to have Resident #20 evaluated for further internal injuries or fractures associated with the bruising by the morning of 6/10/17, the family elected to have the resident transported to the ED for evaluation. Daughter #1 stated that while she was en route	F 203	F 203 Resident #20 is no longer at the facility. For all residents at the facility, the facility shall ensure that if a resident is discharged involuntarily, the required 30-day advance notification of discharge with rationale for the involuntary discharge and appeal language is provided to the resident and all other appropriate individuals. All residents discharged involuntarily shall be reviewed at the monthly QA meeting for review and comment/additional interventions as indicated. This practice shall be conducted in perpetuity. The facility policies related to discharge and specifically involuntary discharge shall be reviewed and revised if appropriate. Revisions to the policy and procedure shall be approved by the medical director. This reviewed policy and procedure shall be presented to the QA committee for review and further comment as indicated. All LN and facility staff that may be involved in discharge and specifically involuntary discharge situations shall be	

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F 203	Continued From page 47 to the ED to meet the resident there, she received a phone call from ADCS #1 at the facility, and was informed that since the facility did not feel evaluation at the ED was medically necessary, the facility considered the resident to be discharged. Daughter #1 stated ADCS #1 informed her at that time Resident #20 would not be able to return to the facility that day. ED notes from the 6/10/17 visit documented the ED was also informed Resident #20 would not be able to return to the facility that day. The ED notes documented after the ED had ruled out further injuries or fractures, and had determined Resident #20 did not meet the criteria to be admitted to the hospital, they confirmed with the facility that the resident would be unable to return. On 6/15/17 at 9:15 am, ADCS #1 confirmed she had called both the ED and Daughter #1 on 6/10/17 after Resident #20 had left the facility via ambulance, to inform them that the resident would be unable to return to the facility until after a care conference was held, which would be at least 2 days later. ADCS #1 stated she was under the impression that the ED would admit Resident #20 for observation until the conference could be held. On 6/15/17 at 4:00 pm, the Administrator stated he made the "executive director privilege decision" to discharge Resident #20, as the facility considered Daughter #2's reaction to the discovery of the bruising to be disruptive to the other residents in the facility, and because Daughter #2 had refused to allow facility staff to examine the resident after the police had been	F 203	educated in the facility policies related to discharge. After staff is educated random interviews shall be conducted that validate staff understand discharge policies and procedures with special emphasis on the involuntary discharge process. These interviews shall be conducted weekly for 1 month, then monthly for 6 months. If a staff member is not able to answer questions posed in the interview, there shall be immediate remediation with the staff 1:1. The results of these interviews and all remediation provided shall be presented to the QA committee monthly for review and additional comment as appropriate. Responsible party: Administrator, DCS, ADCS, Social Service, Admissions, and clinical staff	

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F 203	Continued From page 48 called. The Administrator stated there was not a written notice of discharge, but per his assessment Daughter #2 placed Resident #20's safety at significant enough risk to warrant immediate discharge. The Administrator was unable to identify specific clinical or behavioral issues displayed by Daughter #2, aside from entering and exiting the unit that morning, that placed Resident #20 at risk.	F 203		
F 208 SS=D	483.15(a)(1)-(7) PROHIBITING CERTAIN ADMISSION POLICIES (a) Admissions policy. (1) The facility must establish and implement an admissions policy. (2) The facility must- (i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and (ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits. (iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property. (3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or	F 208		8/5/17

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F 208	Continued From page 49 continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources. (4) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,- (i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term ''nursing facility services'' so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and (ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident. (5) States or political subdivisions may apply	F 208		

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F 208	Continued From page 50 stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid. (6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility. (7) A nursing facility that is a composite distinct part as defined in § 483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and family, staff, and Ombudsman interview, it was determined the facility required a resident to waive her rights as a condition of readmission. This was true for 1 of 1 Resident (#20) sampled for admission practices. The deficient practice created the potential for harm if the resident experienced fewer family visits as a result of facility-imposed restrictions. Findings include: Resident #20 was admitted to the facility on 6/7/16, with diagnoses which included dementia and congestive heart failure. Resident #20 had two daughters involved with her care. Resident # 20's annual MDS assessment, dated 5/31/17, documented she had severely impaired cognition, delusions, wandered and was at risk of	F 208	F 208 Resident #20 is no longer at the facility. For all other residents, the facility shall ensure that admission procedures and/or practices do no limit or waive the residents ability to freely exercise any of their rights including rights to unlimited visitation from family. During the resident council meeting in July, residents will be advised of their right to exercise their rights with emphasis on the admission process and their right to family visitation. The facility policies related to admission	

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F 208	Continued From page 51 elopement from the facility. The MDS documented Resident #20 required assistance for bed mobility, transfers, dressing, toilet use, and hygiene; and supervision with ambulation. The MDS documented Resident #20 did not display physical or verbal aggression towards others. On 6/14/17 at 1:15 pm, Resident #20's two daughters reported the facility declined to allow the resident to return to the facility after an evaluation at the emergency department [ED] on 6/10/17, following the discovery of several large bruises on her. The daughters reported they met with the facility on 6/12/17, and facility agreed to readmit Resident #20 on the condition that Daughter #1 supervised all visits from Daughter #2. Daughter #1, who served as Resident #20's Power of Attorney stated, "They made me feel like I didn't have any other choice. I know my sister [Daughter #2] sometimes 'vents,' which is why I'm the POA. But in asking for supervision for her visits, they were deflecting their responsibility for determining where those bruises came from." On 6/15/17 at 8:15 am, the Ombudsman stated she had been present for the meeting on 6/12/17, when the facility Administrator told Resident #20 and her daughters the only way she could be readmitted was to agree to restricted/supervised visits for Daughter #2. On 6/15/17 at 4:00 pm, the Administrator confirmed he told Resident #20 and her daughters supervised visits for Daughter #2 were a condition of the facility's willingness to readmit Resident #20. The Administrator stated this was because Daughter #2 had a history of interfering	F 208	and specifically family visitation shall be reviewed and revised if appropriate. Revisions to the policy and procedure shall be approved by the medical director. This reviewed policy and procedure shall be presented to the QA committee for review and further comment as indicated. The Resident Right documents appearing in the admission agreement and in policy and procedure shall be reviewed and revised as needed. The policy will be reviewed by the Quality Assurance committee after the initial review for their comment and approval. All facility staff shall be educated related to the admission process and procedures with emphasis on family visitation. After staff is educated random interviews shall be conducted that validate staff understand the admission process and procedures especially as this related to family visitation. These interviews shall be conducted weekly for 1 month, then monthly for 6 months. If a staff member is not able to answer questions posed in the interview, there shall be immediate remediation with the staff 1:1. The results of these interviews and all remediation provided shall be presented to the QA committee on a monthly basis for review and additional comment as appropriate. Responsible party: Administrator, DCS, ADCS, Social Service, Admissions, and clinical staff Date:	

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F 208	Continued From page 52 with Resident #20's care, and had "over-reacted" to the presence of the bruises on Resident #20. However, the facility did not provide documented evidence of Daughter #2's interference, prior to the bruises being discovered on 6/9/17.	F 208		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving	F 225		8/5/17

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F 225	Continued From page 53 abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to conduct a thorough investigation to establish the cause of injuries of unknown origin, and failed to establish a policy that all injuries of unknown origin are investigated to rule out abuse. This was true for 1	F 225	F 225 Resident #20 is no longer in the facility. For all residents at the facility, the facility shall ensure that all injuries of unknown	

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F 225	Continued From page 54 of 6 residents (# 20) sampled for adverse events. The deficient practice created the potential for harm when the facility ruled out staff abuse as the cause of bruising to a resident without conducting a thorough investigation. Findings include: a.Resident #20 was admitted to the facility on 6/7/16, with diagnoses which included dementia and congestive heart failure. Resident #20 had two daughters involved with her care. Resident #20's annual MDS assessment, dated 5/31/17, documented she had severely impaired cognition, delusions, wandered, and was at risk of elopement from the facility. The MDS documented Resident #20 required assistance for bed mobility, transfers, dressing, toilet use, and hygiene; and supervision with ambulation. The MDS documented Resident #20 had no physical or verbal aggression towards others. Resident #20's Nurse's Notes [NN] documented a "Monthly head to toe assessment" on 5/25/17 at 12:16 am. No bruising or other skin abnormalities were documented. The next entry in the Nurse's Notes was dated 6/8/17 at 1:50 pm and documented, "Shower not given as there were time constraints." A "Skin Event" form in Resident #20's record documented bruises were discovered on her right wrist (5.3 x 4 cm), right upper arm (6.5 x 17 cm), left upper arm (5.4 x 3.3 cm), right hip (5.2 x 10.8 cm); and a scab (0.6 x .05 cm) was discovered on her left elbow, all on 6/9/17 at 9:20 pm. The form was signed and dated on 6/14/17.	F 225	origin are thoroughly investigated prior to any conclusion being made as to cause of the injury. The facility□s Abuse Prohibition Program shall be thoroughly reviewed related to the language used in the policy and procedure related to the thorough investigation of injures of unknown origin. Appropriate revisions shall be made as indicated to ensure the policy language is compliant with federal regulations. Revisions to the policy and procedure shall be approved by the medical director. This reviewed policy and procedure shall be presented to the QA committee for review and further comment as indicated. All investigations related to injuries of unknown origin shall be reviewed at the monthly QA meeting for review and comment/additional interventions as indicated. This practice shall be conducted in perpetuity. All facility staff shall be educated related Abuse Prohibition Program with emphasis on thorough investigation of injuries of unknown origin. After staff is educated random interviews shall be conducted that validate staff understand the admission process and procedures especially as this related to family visitation. These interviews shall be conducted weekly for 1 month, then monthly for 6 months. If a staff member is not able to answer questions posed in the interview, there shall be immediate	

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F 225	Continued From page 55 On 6/16/17, the facility's Incident Summary as received on the Long Term Care Portal documented, "Family reported bruising located on bilateral underside [of] arms to nurse. Skin check was initiated and bruising confirmed and located right under arm, right hip, right wrist, and scab on left elbow...Resident's daughter wanted to know the cause of the bruises. ADCS [#3] reported to daughter that resident had no recent falls, and evening shift staff were questioned and denied any adverse events...skin assessment was completed...Both nurses did not suspect any abuse with the above findings...A skin check was completed 6/8/17 by [LPN #3]. There were no skin impairments. A shower was completed on 6/8/17 by [CNA #5], there [was] no bruising observed that day. Staff on 6/8/17 did not observe any bruising to the resident or any changes in behaviors...The bruising was brought to the attention of the facility by the family after having the resident out of the facility in their care and at a physician appointment. The resident was transported by the family in the family's private vehicle...On 6/12/17, the facility expected to hold a care conference with the family...During the meeting daughters...began undressing the resident to expose bruising...observed grabbing arms, pulling resident up in her wheelchair..." The facility's investigative documentation included: *A Weekly Skin Check form, which documented LPN #3 checked a box on 6/8/17 at 12:36 pm to verify Resident #20's skin check was done, with "no new skin issues." *An undated written statement from LPN #3	F 225	remediation with the staff 1:1. The results of these interviews and all remediation provided shall be presented to the QA committee monthly for review and additional comment as appropriate. Responsible party: Administrator, DCS, ADCS, Social Service, clinical staff, and all facility staff Date:	

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F 225	Continued From page 56 which documented, "...I was [Resident #20's] nurse days prior to the discovery of bruising on [the resident's] upper arms. There was no injury noted on Thursday the 8th of June when I left for 2 days off. Resident was doing nothing unusual, however everything she does is unusual." The facility's investigation did not include clarification of that statement. *A written statement from CNA #5, dated 6/15/17, which documented, " I gave her [Resident #20] a shower on Thursday the 8th. The nurse [LPN #3] checked her skin and there was nothing on her skin." The investigative documents offered no explanation as to the discrepancy between the CNA's statement on 6/15/17 and the entry in Resident #20's NN from 6/8/17 which documented the resident had not been showered due to "time constraints." *A written statement from LPN #2, dated 6/16/17, who had been Resident #20's nurse the evening the bruises were discovered. The statement addressed how the bruises came to the attention of LPN #2, but did not address whether events occurred on the shift which may have contributed to the bruising, or rule out they occurred that shift. *A written statement from ADCS #3, which documented, "...Spoke with [CNA #7]...who had worked night shift the previous night...he reported [Resident #20] was very anxious that night and frequently going into/out of the bathroom. He did not provide cares as resident is female cares only, however there was another CNA [CNA #8] in the room with [Resident #20] who reported that resident was having 'a rough evening.' [CNA #7]	F 225		

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(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 225	Continued From page 57 reported that resident was rubbing her arms a lot that night. Asked [CNA #7] to write a witness statement..." The facility's investigation did not include interviews or written statements from CNA #7 or CNA #8. *A written statement from the facility's Social Worker [SW], who reported that she had seen Resident #20 sitting in her room in a wheelchair with Daughter #1 present earlier in the day on 6/9/17. The statement documented the resident's daughter was in the process of dressing Resident #20 to take her to a physician's appointment. The statement documented that the resident was wearing a slip and a camisole, and from her perspective, the SW did not notice bruises on the resident's arms. It is not clear from the statement whether the SW was able to visualize the resident's underarms, where the bruising was present, from her perspective. The facility's investigation did not document a clarifying interview with the SW. On 6/15/17 at 9:55 am, the SW stated that she did not see any bruising on Resident #20 at that time, but her perspective was from behind Resident #20, and she did not have a clear view of the resident's underarms. The facility's investigation did not include documentation of an interview, or a written statement from Daughter #1, who got the resident dressed and took her to the physician's appointment on 6/9/17. On 6/16/17 at 8:55 am, Daughter #1 stated she knew the facility felt that the bruising had occurred either while she was dressing Resident #20 on the morning of 6/9/17, or during the outing to the physician's appointment. Daughter	F 225		

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F 225	Continued From page 58 #1 stated, "They implied that at the care conference we had on Monday [6/12/17], but they never asked me about it." Daughter #1 stated Resident #20 had a history of discomfort when lifting her arms over her head to dress, but preferred to wear "dusters" [house dresses]. Daughter #1 stated she had modified all of Resident #20's dusters so they fastened up the back. Daughter #1 stated she was able to dress and undress Resident #20 by simply sliding the garment up her arms, and while dressing Resident #20 that morning, would have neither lifted her arms nor seen her underarms. Daughter #1 she recalled the SW in the room that morning, but the SW was standing behind Resident #20, and since the resident did not lift her arms it would have been "impossible" for the SW to see Resident #20's underarms. Daughter #1 stated it was not uncommon for her to take Resident #20 on outings to physician's appointments, and while the resident could be very confused at times she prided herself on still being able to get in and out of the car by herself. Daughter #1 stated had the facility asked her, she could have told them nothing unusual happened that day. Resident #20 was able to get into and out of the vehicle herself, and required no hands-on assistance. The appointment that day was at the podiatrist, where they lowered the chair so Resident #20 could just "slide on," raised it during treatment, then lowered it again so the resident could "slide off." Daughter #1 stated she was aware the facility thought she and her sister were "rough" when trying to show the facility the bruising during the care conference on 6/12/17, but stated the "real problem" is the facility did not want to see the bruising. Daughter #1 stated, "They were trying to minimize it. They didn't want	F 225		

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F 225	Continued From page 59 to take responsibility for where the bruises came from." On 6/15/17 at 4:00 pm, the Administrator stated the SW's lack of observation of bruising on 6/9/17, combined with the facility's observations of the "rough treatment" Resident #20 received when her daughters were "undressing" the resident at the care conference on 6/12/17, contributed to the facility's findings the resident had not been abused in the facility, and instead the bruises had occurred either while Daughter #1 was dressing the resident, or while the resident was out with her daughter to the physician's appointment. The facility's investigation did not include: *An interview with Resident #20 at the time the bruises were discovered. *Clarification regarding whether Resident #20 had her shower and skin check completed on 6/8/17, given the conflicting documentation in the resident's nurse's notes and staff statements. *An interview with Resident #20's Daughter #1, who dressed the resident the morning of 6/9/17 and took her out to a podiatry appointment. *Interviews with all staff who may have had knowledge of the cause of the bruises, including CNA #s 7 and 8. *Clarification of LPN #3's statement that everything Resident #20 did was "unusual." *A statement from LPN #2 to conver not just the reporting of the bruises, but any unusual occurrences with Resident #20 on the shift the bruises were reported. *Interviews with Resident #20's roommate, or other residents receiving care from the same caregivers as Resident #20.	F 225		

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F 225	Continued From page 60 b. Policy The facility's Abuse Prevention and Prohibition Program, revised March 2017, documented, "Unexplained injuries are promptly and thoroughly investigated by the Director of Nursing Services and/or other staff person appointed by the Administrator, to ensure that resident safety is not compromised and action is taken whenever possible, to avoid future occurrences." The Policy documented, "Based on the determinations of the Nursing Staff, Attending Physician and/or Medical Director, the Administrator decides whether to undertake an investigation of the injury... If the Administrator determines the injury should be investigated, he/she may designate a member of the Facility management team to serve as the incident Investigator." The program did not identify how the facility would identify which injuries of unknown origin the facility would investigate. The Centers for Medicare and Medicaid Services [CMS] defined an "Injury of Unknown Source" to be present when the injury was not observed or the resident could not explain the injuries and the injury is suspicious because of its extent, location, number of injuries or incidence of injuries over time. On 6/15/17 at 4:00 pm, the Administrator stated Resident #20's injuries were "potentially" of unknown origin. The Administrator could not explain the policy's provision for the administrator deciding whether to undertake an investigation of an injury of unknown origin or how the provision met regulatory requirements.	F 225		

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F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and	F 280		8/8/17

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F 280	Continued From page 62 cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 280		

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F 280	Continued From page 63 assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure residents' care plans were revised to reflect their current behavioral status, level of assistance required for activities of daily living [ADLs], and toileting needs. This was true for 1 of 20 residents (#20) sampled for care plan revision and had the potential to cause harm if residents did not receive appropriate care and interventions due to outdated and/or incomplete care plan information. Findings include: Resident #20 was admitted to the facility on 6/7/16 with diagnoses which included dementia and congestive heart failure. Resident # 20's annual Minimum Data Set [MDS] assessment, dated 5/31/17, documented she had severely impaired cognition, delusions, wandered and was at risk of elopement from the facility. The MDS documented Resident #20 required assistance for bed mobility, transfers, dressing, toilet use, and hygiene; and supervision with ambulation. The MDS documented resident had no physical or verbal aggression towards others. a. The Activities Care Plan, revised 7/18/16, documented Resident #20 enjoyed religious activities, Christian services program and music, "some" television, socializing and table top activities. The care plan included 36 "System Generated" activities which included: sports, computer activity, men's club activity, reading and writing activity, television activity, and movie and video activity. The care planned activities	F 280	F 280 Resident #20 is no longer in the facility. For all other residents, the facility shall ensure that care plans are reviewed and revised appropriate to accurately reflect current behavioral status and/or issues, assistance required with ADLs, and toileting needs. The facility□s policy related to care planning shall be reviewed and reviewed and revised if appropriate. Revisions to the policy and procedure shall be approved by the medical director. This reviewed policy and procedure shall be presented to the QA committee for review and further comment as indicated. All clinical staff responsible for ensuring that care plans are reviewed and revised to accurately reflect current behavioral status and/or issues, assistance required with ADLs, and toileting needs shall be re-educated related to the timing of care plan revisions and the need for accurate person-centered care plans. All care plans for active residents shall be audited by MDS, Social Services, and ADCS's to ensure care plans accurately reflect current behavioral status and/or issues, assistance required with ADLs, and toileting needs. Corrections shall be	

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F 280	Continued From page 64 were not resident-specific. b. The Resident Care Standards Care Plan, dated 6/7/16, documented Resident #20 preferred "female caregivers only." The "Resident Care" Care Plan documented she wanted "female caregiver" and the "Activities" Care Plan documented she was involved in "men's group" which contraindicated each other. c. The Problematic Manner/Ineffective Coping/Anxious Behavior Care Plan, dated 6/7/16, documented Resident #20's "anxious behavior" was repetitive verbalization of 'Praise Jesus Praise the Lord.' The care plan did not identify how the verbalization was harmful or distressing to the resident. The Problematic Manner/Ineffective Coping/ Wandering and Elopement Risk Care Plan, dated 6/7/16, documented staff was to redirect Resident #20 with calling her family or singing religious songs. Resident #20's Problematic Manner Care Plans contraindicated each other. The facility identified on the "Anxious Behavior" care plan Resident #20 verbalized 'Praise Jesus Praise the Lord,' and staff was to redirect her and provide a different activity. With the "Wandering" Care Plan staff was to sing religious songs with her. Resident #20 was discouraged for verbalizing 'Praise Jesus Praise the Lord,' and then when she wandered she was encouraged to sing religious songs. d. Resident # 20's annual MDS assessment,	F 280	made to care plans immediately during this audit to ensure they accurately reflect current behavioral status and/or issues, assistance required with ADLs, and toileting needs. The results of this audit with details about the corrections required shall be presented to the QA committee for review and further comment as appropriate. For a period of 6 months, all active resident who have MDS completed during a month shall have the care plan audited to ensure they accurately reflect current behavioral status and/or issues, assistance required with ADLs, and toileting needs. Corrections shall be made to care plans immediately during this audit to ensure they accurately reflect current behavioral status and/or issues, assistance required with ADLs, and toileting needs. The results of this audit with details about the corrections required shall be presented to the QA committee for review and further comment as appropriate. Responsible party: Administrator, MDS, DCS, ADCS, Social Service, Activities, Dietary, and any other staff involved in the care planning process. Date:	

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F 280	Continued From page 65 dated 5/31/17, documented she required limited assistance of one staff member for her toileting needs. The Urinary or Bowel Incontinence Care Plan, dated 6/7/16, documented Resident #20 required one person of "intermittent supervision and physical assist for safety" with her toileting needs. On 6/16/17 at 8:35 am, Resident #20' daughters stated the resident was a "deeply religious" person, who took comfort in "praying in tongues." The daughters stated the staff did not always understand what the resident was doing when this occurred, and thought it was something they needed to stop because they presumed she was "cussing." The daughters stated Resident was also a "deeply private" person, and preferred limited interaction with peers. The daughters confirmed Resident #20 preferred female caregivers, and preferred female peers when interacting with others. On 6/16/17 at 11:15 am, the Administrator stated the facility had reviewed Resident #20's care plan, and felt it was fine. The Administrator stated the facility had not seen the "system generated" interventions in the care plan, and that the computerized care plan program they were using was new to the facility.	F 280		
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 281		8/8/17

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F 281	Continued From page 66 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure medications were administered, neurological assessments completed, and intravenous [IV] antibiotics administered, assessment of bruises were completed timely and included visualization of all reported areas of injury consistent with accepted standards of practice. This was true when: a) Administration of heparin and insulin was not provided consistent with physicians' orders and current standards of practice for 2 of 12 sampled residents (#7 and #12). b) Neurological assessments were not performed after residents experienced unwitnessed falls for 2 of 5 residents (#10 and #14) reviewed for falls. c) An IV antibiotic was not dated, timed, or initialed, and it was unknown when the IV tubing was put into use for 1 of 1 resident (#2) reviewed for IV medications. d) The size location of bruises was not documented and a visual assessment of all reported bruises was performed in a timely manner for 1 of 1 resident (#20). These failures created the potential for more than minimal harm if residents were to receive the wrong amount of insulin, suffer adverse effects related to not receiving heparin injections,	F 281	F 281 Residents # 10, 12, 14 and 20 are no longer at the facility. Resident #2 is no longer on IV antibiotics. For resident #2 and for all residents that receive IV therapy the facility shall ensure that physician orders related to the frequency of tubing change is followed. Additionally, IV tubing when changed shall be tagged with the date and time of the change and the initials and credential of the LN changing the tubing. When an IV medication of any type is hung, the medication bag is tagged with the date and time it was hung and the initial and credential of the LN hanging the medication. All LN shall be re-educated to the professional standard related to following physician orders, tagging IV tubing appropriately when changed and the frequency with which the tubing is changed. All residents receiving IV treatments/medications shall be audited daily by ADCS's and RN supervisor to ensure the tagging of tubing and IV medication administration is taking place.	

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F 281	Continued From page 67 neurological changes went undetected and untreated, IV antibiotics were administered incorrectly and/or the IV tubing was in use too long, or resident bruising was not accurately assessed. Findings include: 1. Resident #12 was admitted to the facility on 3/3/14, with diagnoses of DM Type II [Diabetes Mellitus adult onset] and dementia. Resident #12's Medication Administration Record [MAR] included an order for insulin, dated 10/13/15, for Lantus Solution 100 units/ml [milliliters]. Inject 15 units subcutaneously [under the skin] in the morning and Lantus insulin 10 u q-am [units every morning]. The MAR documented 2 orders of different doses of insulin. It was unclear which dose was to be administered. The monthly recapitulated orders were the same as the MAR, and were signed by Resident #12's physician and acknowledged by ADCS #3 on 5/9/17. On 6/9/17 at 3:30 pm, the ADCS #3 stated Resident #12 received 15 units of Lantus insulin every morning. She reviewed the recapitulated orders and MAR. The ADCS #3 stated the order was unclear, and should have been clarified and rewritten to include only the 15 unit dose of insulin. She provided a copy of the order for insulin, dated 10/12/15, which stated "Change Lantus to 15 units sub-q [subcutaneously] once daily." ADCS #3 stated the order was probably not transcribed correctly, and continued to include Resident #12's previous dose of Lantus [10 units]. She stated the orders should have been noted and clarified.	F 281	Variances shall be immediately remediated with the LN involved on a 1:1 basis. These daily audits and any remediation activity shall be documented and reported to the QA committee monthly for review and further comment. This shall be done for 6 months. For resident #7 as documented in the 2567 the heparin was discontinued on 6/9/2017. For resident #7 and for all resident at the facility the policy and procedure related to physician notification when a resident refuses treatment shall be reviewed and revised if appropriate. Revisions to the policy and procedure shall be approved by the medical director. This reviewed policy and procedure shall be presented to the QA committee for review and further comment as indicated. For all residents on heparin the facility shall ensure that physician orders related to heparin are reviewed and any variances, conflicts and/or duplications are resolved. Additionally, during the monthly medication recapitulation process, the LN doing the physician order recapitulation gives attention to heparin orders to ensure the correct orders are carried over to the new month. The facility□s policy and procedure related to monthly physician recapitulation process shall be reviewed and revised as appropriate. Revisions to the policy and	

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F 281	Continued From page 68 2. Resident #7 was admitted to the facility on 4/1/17, after being hospitalized for a urinary tract infection. Additional diagnoses included chronic renal disease, DM Type II, and weakness. Her record included a hospital Discharge Summary dated 4/1/17. The Medications Ordered//Recommended to be continued section of the Discharge Summary included Heparin (5,000 units/ml) 1 ml injected subcutaneously every 12 hours. Resident #7's MAR included an order for Heparin 1 ml SQ every 12 hours. The start date on the MAR was 4/1/17 and did not include an end date. Resident #7's MAR for May and June 2017 documented she refused heparin 28 times during the period 5/24/17-6/6/17. Resident #7's Progress Notes did not include documentation to explain her refusals of heparin injections. A Progress Note entry, dated 5/31/17, stated, "Fax sent to Dr.[name] requesting end date on heparin injections." A copy of the fax, dated 5/31/17, was provided by the DNS on 6/8/17 at 3:30 pm. The fax stated: "Heparin injection- This was continued after her hospital stay in March. We need an end date please! Thank you." The information on the fax to the physician did not include documentation that Resident #7 had refused the heparin since 5/24/17. The Administrator provided a copy of a returned fax from the physician to the facility on 6/9/17 at	F 281	procedure shall be approved by the medical director. This reviewed policy and procedure shall be presented to the QA committee for review and further comment as indicated. All clinical staff responsible for completing the monthly physician orders recapitulation process shall be re-educated to the process. For all physician order recapitulations, a 10% random sample shall be audited by Director of Clinical Services or Designee to ensure the recapitulation process ensured the accurate carry over of physician orders. Errors identified during this random audit shall be corrected immediately and the LN completing the initial orders recapitulation shall be remediated on a 1:1 basis. Additionally, if more than 2 recaps are found to be in error the audit sample shall be expanded to 20%. This monthly audit shall be conducted for a period of 6 months. Each monthly audit and any corrections made and/or expansion of the sample shall be reported monthly to the QA committee for further review and/or comment. For resident #7 and for all resident receiving insulin the facility shall ensure that physician orders related to insulin are reviewed and any variances, conflicts and/or duplications are resolved. Additionally, during the monthly medication recapitulation process, the LN doing the physician order recapitulation	

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F 281	Continued From page 69 3:45 pm. The fax was dated as being transmitted from the physician to the facility on 6/9/17 at 10:42 am. On 6/8/17 at 12:30 pm, Resident #7 stated, "I haven't had the heparin injections in quite a while. It is a medication for someone in the hospital that has had surgery. I did not have surgery. I do not think I need it. Actually, I thought it was discontinued because they [the nursing staff] don't even offer it anymore." On 6/8/17 at 12:35 pm, RN #3 stated Resident #7 had refused the heparin so Resident #7 was no longer asked about it. RN #3 said a couple weeks ago she passed the information on to the other shift, which was to notify the physician, and had not pursued it further. Resident #7's Heparin injections were not administered as ordered, the staff stopped offering the injections before the medication was discontinued, her physician was not informed of her refusal of the medication and her request to discontinue it. 3. Resident #14 was admitted to the facility on 5/12/17, with diagnoses including Alzheimer's dementia, unspecified dementia with behavioral disturbances, and collapsed vertebra in the lumbar region, cataract, anxiety disorder, repeat falls, and difficulty walking. A Care Plan, dated 5/12/17, documented Resident #14 was at risk for falls related to her acute medical condition, cognitive impairment, gait disturbance, weakness, history of falls, impaired balance, short term memory loss, and	F 281	gives attention to insulin orders to ensure the correct orders are carried over to the new month. The facility□s policy and procedure related to monthly physician recapitulation process shall be reviewed and revised as appropriate. Revisions to the policy and procedure shall be approved by the medical director. This reviewed policy and procedure shall be presented to the QA committee for review and further comment as indicated. For all residents requiring neurological assessments related to an unwitnessed fall the facility shall ensure that neurological assessments are completed as outlined in the facility□s policy Neurological Assessments Level III. This policy was initiated in 2011 and revised in 2012. This policy shall be reviewed and revised if appropriate. Revisions shall be reviewed and approved by the Medical Director. Then the revised policy shall be presented to the QA Committee for further review and/or comment. If no revision is deemed necessary, the Medical Director shall review the policy and procedure to validate the guidance remains appropriate. All clinical staff responsible for completing neurological assessment shall be re-educated related to the specifics of this policy and how it relates to unwitnessed falls and/or head injuries.	

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F 281	Continued From page 70 unsteady gait. On 5/18/17 at 6:30 pm, a Fall/Post Fall Assessment was completed following an unwitnessed fall on that date. Documentation of neurological assessments following the fall was not found in Resident #14's medical record. On 5/28/17 at 10:00 am, a Fall/Post Fall Assessment was completed following an unwitnessed fall on that date. Documentation of neurological assessments following the fall was not found in Resident #14's medical record. A Fall/Post Fall Assessment, dated 6/6/17 at 1:10 am, was completed following an unwitnessed fall with injury on that date. Resident #14 was transferred for emergency care and returned to the facility with diagnoses of left orbital fracture, maxillary sinus fracture, eyebrow laceration, and a closed head injury [concussion]. Discharge Instructions from the emergency department [ED] provided symptoms to monitor for and instructed Resident #14 to rest from both physical and cognitive activities. The Discharge Instructions documented, "Return to the ER if altered mental status, focal weakness or numbness, double or blurred vision develop. Return immediately if condition worsens, for new symptoms, or any concerns." Documentation that these symptoms were monitored was not found in Resident #14's medical record. On 6/8/17 at 4:30 pm, the DNS stated she had not found a facility policy for neurological assessments. The DNS stated an initial neurological assessment is completed and then	F 281	All unwitnessed falls and/or falls with head injuries shall be audited by the ADCS's or RN supervisor within 24 hours of the event to ensure neurological assessments were initiated as indicated. LN that do not initiate neurological assessments as directed in the policy shall be immediately remediated on a 1:1 bases. All unwitnessed falls and/or falls with head injuries 24-hour audits and remediation activities shall be reported to the QA Committee for 6 months. For all residents with new bruising that is initially assessed and specifically bruises of unknown origin a thorough assessment of the bruising shall be completed when the clinical staff has first knowledge of the bruising. Assessment of the bruising requires a full body skin check to ensure all bruising has been identified. This full body skin check requires the removal of clothing and incontinence products. All bruises are measured and a thorough description is documented via a skin event assessment record. All clinical staff responsible for completing skin assessment shall be educated related to the specifics of this policy and how it relates to bruising of unknown origin, documenting, measuring, and completing a thorough assessment. Responsible party: Administrator, MDS,	

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F 281	Continued From page 71 the nursing staff use critical nursing judgment. On 6/8/17 at 5:15 pm, the Compliance/Clinical Resource Officer [CCRO] provided an undated Falls Management Program policy and procedure which documented, "When a resident falls the following steps are completed: ...a neurological evaluation if the resident hit their head or if the fall is not witnessed." The CCRO said the facility did not have guidelines or a policy and procedure on how frequently neurological assessments are done. 4. Resident #10 was admitted to the facility on 5/13/17, with multiple diagnoses including respiratory failure, Clostridium difficile [C-diff] infection, and deconditioning. On 5/23/17, the resident was transferred to a hospital for acute care. Resident #10's admission MDS assessment, dated 5/19/17, documented moderate cognitive impairment, extensive assistance by 2 people for bed mobility, transfers and toileting, a history of falls, and oxygen use. A 5/16/17 Fall/Post Fall Assessment documented Resident #10 had an unwitnessed fall at 5:40 am. Resident #10 was found next to his bed and said that he rolled out of bed. He denied hitting his head and "no redness or bumps were noted." In the assessment's Recommendations / Plan section, ADCS #1 documented on 5/23/17 that Resident #10 was "unable to recap actual events". On 6/8/17 at 3:50 pm, ADCS #1 was asked to provide neurological assessments related to	F 281	DCS, ADCS, Social Service, Activities, Dietary, and any other staff involved in the care planning process.	

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F 281	Continued From page 72 Resident #10's unwitnessed fall on 5/13/17. ADCS #1 said she did not agree that neurological assessments were needed when the resident was able to say what had happened and she was not sure they were done. On 6/8/17 at 4:30 pm, the DNS said she had not found a policy for neurological assessments. She said that an initial neurological assessment is completed then nurses use their critical judgment after that. On 6/8/17 at 4:50 pm, the CCRO said the facility did not have a neurological assessment policy "per se" but they were still looking. On 6/8/17 at 4:55 pm, the DNS said Resident #10's neurological status was not assessed after the unwitnessed fall on 5/13/17. On 6/8/17 at 5:15 pm, the CCRO provided an undated Falls Management Program policy and procedure, which documented, "When a resident falls the following steps are completed: ...a neurological evaluation if the resident hit their head or if the fall is not witnessed." The CCRO said the facility did not have guidelines or a policy and procedure on how frequently neurological assessments are done. She said they "default" to the Lippincott Manual of Nursing Practice, 10th Edition, and the Lippincott Nursing Procedure, 7th edition located in the receptionist office, which is open 24 hours a day, or on Hall 300. 5. Regarding IV medications and IV tubing, the Clinical Nursing Skills & Techniques, 8th edition, 2014, by Perry, Potter and Ostendorf, documented, "Note date and time when IV tubing	F 281		

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F 281	Continued From page 73 and solution were last changed" and "Place time label on side of container and label with time hung, time of completion...If using plastic bags, mark only on label and not container." The Lippincott Manual of Nursing Practice, 9th edition, 2010, by Wolters Kluwer Health/Lippincott, Williams & Wilkins, documented, "Intermittent administration tubing should be changed every 24 hours" and "Label new tubing with the date, the time it was hung, and your initials." Resident #2 was admitted to the facility on 5/8/17, with multiple diagnoses including type 1 diabetes, status post total hip replacement with infection and removal of prosthetic, and an unstageable left heel pressure ulcer. Resident #2's 5/15/17 admission MDS assessment documented intact cognition and that IV antibiotics were administered 7 of 7 days. Resident #2's care plan documented an "actual infection" as a focus area on 5/8/17. The intervention included medications per physician orders. Resident #2's current physician orders included: * IV tubing change every 24 hours for intermittent infusion every night shift on 5/8/17. * Ceftriaxone 2 grams, 1 vial in 100 milliliters [mL] of D5W [5% dextrose in water], infuse IV over 30 minutes every night shift for infection, beginning 5/24/17. On 6/6/17 at 7:10 am, Resident #2 was observed in his wheelchair in his room. Resident #2 said	F 281		

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F 281	Continued From page 74 he was getting ready to go out for Hyperbaric therapy. An empty 100 ml bag of D5W labeled as ceftriaxone 2 grams, with IV tubing attached to it was observed hanging from an IV pole in the room. The IV pump was off. The IV tubing was not connected to Resident #2. The label on the IV antibiotic bag did not have the date or time it was hung or the initials of the person who hung it; and, the IV tubing was not dated or timed. On 6/6/17 at 1:10 pm, Resident #2 was observed in his wheelchair in his room. He said he was getting ready to go out for a wound care appointment. The same empty IV bag and IV tubing were observed hanging from the IV pole. The label on the bag documented the pharmacy filled the medication on 5/30/17. On 6/6/17 at 1:20 pm, ADCS #1 entered Resident #2's. ADCS #1 said she did not know when the IV bag with ceftriaxone was hung. She said the IV bag and IV tubing should have the hang date, time, and initials of the staff who hung it. She said she would discard the empty IV bag and tubing right away. The facility's policy and procedure for intermittent administration of IV medications was requested. On 6/6/17 at 2:00 pm, ADCS #1 provided an Administration Set Tubing Changes policy and procedure, which documented, "All tubing is labeled with start and change date and time." 6. Resident #20 was admitted to the facility on 6/7/16, with diagnoses, which included dementia and congestive heart failure. Resident #20's annual MDS assessment, dated	F 281		

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F 281	Continued From page 75 5/31/17, documented she had severely impaired cognition, delusions, wandered, and was at risk of elopement from the facility. The MDS documented Resident #20 required assistance for bed mobility, transfers, dressing, toilet use, and hygiene; and supervision with ambulation. The MDS documented Resident #20 had no physical or verbal aggression towards others. On 6/9/17, Resident #20's nursing notes documented bruises were reported to the resident's right upper arm left upper arm, and right hip area. The documentation did not include the number, size, or appearance of the bruises. A "Skin Event" form in Resident #20's record documented bruises were discovered on her right wrist (5.3 x 4 cm), right upper arm (6.5 x 17 cm), left upper arm (5.4 x 3.3 cm), right hip (5.2 x 10.8 cm); and a scab (0.6 x .05 cm) was discovered on her left elbow, all on 6/9/17 at 9:20 pm. The form was signed and dated on 6/14/17, 5 days after the report of the bruises. On 6/14/17 at 1:15 pm, Resident #20's daughter stated she had been the person to discover the bruising, and the bruise on the hip documented on the facility's skin sheet was one of two bruises she found on the resident's hip when she helped the resident change her Attends. Resident #20's daughter stated the facility's documentation did not account for the larger of the two bruises on Resident #20's hip/buttock. On 6/15/17 at 10:30 AM, ADCS #3 stated she had assessed Resident #4's bruises on 6/9/17, along with LPN #2. ADCS #3 stated she did not recall a second or larger bruise when the	F 281		

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F 281	Continued From page 76 assessment was completed. ADCS #3 stated they did not remove Resident #20's Attends when measuring the bruise to her right hip, but instead "just moved it around so we could visualize the area." On 6/15/17 at 2:20 pm, LPN #2 stated he assessed Resident #20's bruises with ADCS #3 at approximately 9:00 pm on 6/9/17. LPN #2 stated he did not recall the bruise to Resident #20's right hip to be "that large," and did not recall seeing a second bruise. LPN #2 stated Resident #20 was lying in her bed when the bruises were assessed, and her Attends were not removed so the skin could be fully visualized during the assessment.	F 281		
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including	F 309		8/8/17

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F 309	Continued From page 77 but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff and physician interview, review of resident records and facility policy, it was determined the facility failed to: a) Ensure timely treatment for a resident that fell with resulting injury b) Ensure antibiotics were administered as ordered c) Ensure abnormal blood glucose levels were treated d) Ensure the policy for diabetic management provided direction for hyperglycemia management. This was true for 2 of 5 residents (#2 and #12) reviewed for falls, incidents and diabetic management. Resident #12 was harmed when she fell out of bed and fractured her jaw. Nursing interventions for pain management were not effective, her physician was not consulted	F 309	F 309 Resident #12 is no longer in the facility. For resident #2 and all other residents the facility will ensure timely treatment for residents that fell resulting in injury, ensure antibiotics are administered as ordered, ensure abnormal blood glucose levels are treated, and ensure the policy for diabetic management provides direction for hyperglycemia management. For all other residents, the facility will ensure that pain management is provided to residents who require such services with scheduled and or PRN pain regimen. Following the administration of pain medication, the nurse will evaluate for effectiveness in a timely manner, and as	

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F 309	Continued From page 78 regarding the fall or of ineffective pain management interventions, which resulted in unnecessary pain and suffering. Resident #2 was at risk for more than minimal harm when interventions for hypoglycemia were not consistently implemented and an antibiotic was not consistently administered as ordered. This had the potential to result in adverse complications for any resident that experienced untreated hyperglycemia. Findings include: 1. Resident #12 was admitted to the facility on 3/3/14, with diagnoses of DM Type II [Diabetes Mellitus adult onset] and dementia. Additional diagnoses included insomnia, irregular heartbeat, and anxiety disorder. A fall investigation report documented Resident #12 fell on 5/22/17 at 12:35 am. The report documented at a "Thud" was heard, the responding CNA ran to Resident #12's room and found her on the floor. She was described as lying on her left side facing the bed. Resident #12 was reported to state "I rolled out of bed." A nursing progress note, dated 5/22/17 at 1:01 am, documented Resident #12 was complaining of left jaw pain and she was medicated with morphine 15 mg orally, at that time. The note documented the medication was effective at relieving her pain. Resident #12's Medication Administration Record [MAR] documented her pain prior to administration of the morphine, as 6, on a pain scale of 1-10, with 10 being the worst pain. A nursing progress note, dated 5/22/17 at 1:31	F 309	needed implement further interventions including consult physician for ineffective pain management. The facility□s policy and procedure related to pain assessment and management shall be reviewed and revised as appropriate. Revisions to the policy and procedure shall be approved by the medical director. This reviewed policy and procedure shall be presented to the QA committee for review and further comment as indicated. All clinical staff responsible for completing the pain assessment and management shall be re-educated to the process. This pain assessment and management audit shall be conducted by the ADCS's and RN supervisor. These audits will be completed every other day for 30 days for correct documentation, timeliness, and effectiveness. A 10% random sample shall be audited to ensure the recapitulation process ensured the accurate carry over of pain assessment and management. Errors identified during this random audit shall be corrected immediately and the LN completing the initial orders recapitulation shall be remediated on a 1:1 basis. Additionally, if more than 2 errors are discovered during the audit the sample shall be expanded to 20%. Following the initial 30-day review period, pain assessment and management will be	

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F 309	Continued From page 79 am, 30 minutes after the morphine was administered, documented Resident #12 was "repeatedly yelling out "Help me!" even after needs met." The progress note and her MAR documented she was medicated with lorazepam 1 mg for anxiety at 1:31 am. A nursing progress note, dated 5/22/17 at 3:30 am, described Resident #12's fall. It included documentation of swelling on her chin and left side of lower jaw. The progress note documented a superficial abrasion on Resident #12's left knee, small bruises on her left knee, right knee, left upper arm and left elbow. The progress note documented a note for Resident #12's physician was left in the communication box, and her Interested Party would be called in the am. A nursing progress note, dated 5/22/17 at 4:12 am, documented Resident #12 was anxious since rolling out of bed, and did not calm down for any length of time. It stated staff attempted to feed her pudding and after 2 bites she refused to eat. The progress note stated Resident #12 was, "Yelling so much she get [sic] mucous in the back of her throat that was suctioned." A nursing progress note, dated 5/22/17 at 6:38 am, documented Resident #12's Interested Party was notified of her fall. The progress note documented Resident #12's Interested Party was assured that a message was left to have the physician check on her. The message to Resident #12's physician on 5/22/17, stated "At 00:35 [12:35 am] resident rolled out of bed. Found lying on her left side. She has some swelling on her chin and L [left]	F 309	audited weekly for one-month for correct documentation, timeliness, and effectiveness. A 10% random sample shall be audited to ensure the recapitulation process ensured the accurate carry over of pain assessment and management. Errors identified during this random audit shall be corrected immediately and the LN completing the assessment and evaluation recapitulation shall be remediated on a 1:1 basis. Additionally, if more than 2 errors are discovered during the audit the sample shall be expanded to 20%. Following the weekly audits, pain assessment and management will be audited monthly for 3-month for correct documentation, timeliness, and effectiveness. A 10% random sample shall be audited to ensure the recapitulation process ensured the accurate carry over of pain assessment and management. Errors identified during this random audit shall be corrected immediately and the LN completing the assessment and evaluation recapitulation shall be remediated on a 1:1 basis. Additionally, if more than 2 errors are discovered during the audit the sample shall be expanded to 20%. Resident #2 is no longer on IV antibiotics. The LN on duty at the time the IV antibiotic was not administered shall be identified and remediated on a 1:1 bases related to the necessity to administer antibiotics as ordered.	

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F 309	Continued From page 80 lower jaw. Ice pack applied. States "I broke my jaw." Jaw feels the same on both sides. Has some bruises/abrasion L [left] knee, R [right] knee & L [left] elbow and LUE [Left upper extremity]. Please check face. Neuro checks initiated." A nursing progress note, dated 5/22/17 at 12:31 pm, approximately 12 hours after her fall, documented Resident #12 received an additional dose of lorazepam for anxiety. Resident #12's nursing progress note, dated 5/22/17 at 1:30 pm, documented she was evaluated by a Nurse Practitioner and X-rays were ordered. A nursing progress note, dated 5/22/17 at 4:36 pm, documented an X-ray revealed a fracture of Resident #12's mandible [jaw]. A nursing progress note, dated on 5/22/17 at 5:21 pm, documented Resident #12's Interested Party was notified of the X-ray results and made the decision to send Resident #12 to the ER for evaluation and treatment. The note documented the NP was notified and an order was received for non-emergent transport of Resident #12 to a hospital ED. A nursing progress note, dated 5/22/17 at 5:45 pm, documented Resident #12 was administered Morphine 15 mg 1 tablet. Resident #12's MAR documented her pain level prior to administration of the morphine, as 10, on the 1-10 pain scale. Resident #12 was transported to the hospital and did not return to the facility.	F 309	All licensed nursing staff shall be re-educated related to the medical necessity and professional standards of practice, specifically following physician orders with emphasis on ensuring antibiotics are administered as ordered. The facility□s policy related to the antibiotic administration shall be reviewed and revised if appropriate. Revisions to the protocol shall be approved by the medical director. This reviewed protocol shall be presented to the QA committee for review and further comment as indicated. All residents receiving antibiotics shall be audited daily by clinical leadership to ensure the antibiotics administration is taking place. Variances shall be immediately remediated with the LN involved on a 1:1 basis. These daily audits and any remediation activity shall be documented and reported to the QA committee monthly for review and further comment. This shall be done for 6 months. For Resident #2, the LN on duty at the time of the FSBG that were out of range shall be identified and remediated on a 1:1 bases related to the necessity to consistently implement interventions and recheck the FSBG after interventions. All licensed nursing staff shall be educated related to the medical necessity	

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F 309	Continued From page 81 On 6/8/17 at 3:30 pm, Assistant Director of Clinical Services [ADCS] #3 stated Resident #12's clinical record indicated she was medicated for pain and anxiety twice after her fall. The ADCS stated Resident #12's MAR included orders for Morphine 15 mg as needed for "moderate pain." She stated the Morphine order was previously in place "as needed for moderate pain," prior to Resident #12's fall. She stated Resident #12's MAR documented she also received fentanyl as a continuous pain medication via topical patch. ADCS #3 stated Resident #12's pain level documented was 10 of 10 prior to her transfer to the hospital. She stated the NP or physician were not called about Resident #12's injuries at the time of her fall. She confirmed there was a delay of approximately 13 hours before Resident #12 was evaluated by a physician or NP. 2. Resident #2 was admitted to the facility on 5/8/17, with multiple diagnoses including Type 1 diabetes, status post total hip replacement with infection and removal of prosthetic, and an unstageable left heel pressure ulcer. Resident #2's 5/15/17 admission MDS assessment documented his cognition was intact and he received insulin and antibiotics 7 of 7 days prior to the assessment. a. Resident #2's care plan documented a focus on the risk for hyper/hypoglycemia on 5/8/17. Interventions were to encourage him to report signs of hyper/hypoglycemia, and to provide medications as ordered.	F 309	and professional standards of practice, emphasis on consistently implementing interventions when FSBG are out of range, and rechecking FSBG after interventions. The facility□s policy related to the management of hypo/hyperglycemia protocols shall be reviewed and revised if appropriate. Revisions to the protocol shall be approved by the medical director. This reviewed protocol shall be presented to the QA committee for review and further comment as indicated. Out of range FSBG shall be audited by the ADCS's and RN supervisor to identifying if appropriate interventions were implemented, and recheck FSBG after interventions. Failure to initiate appropriate interventions shall be immediately corrected and the LN remediated on a 1:1 basis. The results of this daily audit and all remediation shall be reported to the QA committee for review and further comment as appropriate. Following the initial 30-day daily review, the out of range FSBG level shall be audited weekly for one month for the appropriate intervention and recheck. Failure to initiate appropriate intervention and recheck shall be immediately corrected and the LN remediated on a 1:1 basis. The results of this weekly audit and all remediation shall be reported to the QA committee for review and further	

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F 309	Continued From page 82 Resident #2's Progress Notes and log of BG results, both dated 5/10/17 to 6/8/17, and Medication Administration Records [MARs] for May and June 2017, documented his BG level was 60 or less on: * 5/16/17 4:56 am - Resident awoke "around" 3:20 am and said he felt "shaky." His BG level was 41. Resident #2 ate a 1/2 sandwich and drank orange juice. He slept after that. At 4:40 am, an hour and 20 minutes later, his BG was 68. He drank more orange juice with a package of sugar in it but said he could not eat the rest of the sandwich. There was no documented evidence Resident #2's BG level was rechecked 15 minutes after he ate half of the sandwich and drank orange juice. * 5/20/17 at 12:20 pm - BG 60. There was no documented evidence interventions were implemented or that Resident #2's BG level was rechecked. The next BG level was documented 4 1/2 hours later at 4:50 pm and was 175. On 6/8/17 at 3:05 pm, Assistant Director of Clinical Services (ADCS) #1 reviewed Resident #2's Progress Notes and BG log records. She said the BG should have been rechecked on 5/16/17. The facility's diabetes management policy was requested at that time. Later in evening on 6/8/17, the Director of Nursing Services (DNS) provided a Nursing Care of the Resident with Diabetes Mellitus policy, dated 6/2012 as revised/reviewed. The policy documented the following: * Asymptomatic and responsive resident with	F 309	comment as appropriate. Following the weekly audits, the out of range FSBG level shall be audited monthly for 2 months for the appropriate intervention and recheck. Failure to initiate appropriate intervention and recheck shall be immediately corrected and the LN remediated on a 1:1 basis. The results of this monthly audit and all remediation shall be reported to the QA committee for review and further comment as appropriate. To ensure the policy for diabetic management provides direction for hyperglycemia management, the facility□s policy related to the management of hyper/hypoglycemic protocols shall be reviewed and revised as appropriate. Revisions to the protocol shall be approved by the medical director. This reviewed protocol shall be presented to the QA committee for review and further comment as indicated. All licensed nursing staff shall be educated related to the policy for diabetic management providing direction for hyperglycemic management. Responsible party: Administrator, MDS, DCS, ADCS, Social Service, Activities, Dietary, and any other staff involved in the care planning process.	

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F 309	Continued From page 83 hypoglycemia - give an oral form of rapidly absorbed glucose, recheck BG in 15 minutes; if still hypoglycemic, repeat the oral glucose and recheck the BG in 15 minutes; if no improvement, notify the physician. * Symptomatic but responsive resident with hypoglycemia who is able to swallow - give an oral form of rapidly absorbed glucose, recheck BG in 15 minutes; repeat juice if indicated, recheck BG in 15 minutes. * Symptomatic but responsive resident with hypoglycemia who is unable to swallow - administer oral glucose paste to the buccal mucosa, intramuscular Glucagon, or IV 50% dextrose (per facility protocol), recheck BG in 15 minutes; repeat intervention if indicated and recheck BG in 15 minutes; if no improvement, notify physician. The facility did not consistently implement interventions or recheck the BG after interventions when Resident #2 experienced hypoglycemia. The facility policy titled "Nursing Care of the Resident with Diabetes Mellitus," revised 6/2012, stated the purpose of the guideline [policy] included recognition, management and documentation for the treatment of complications commonly associated with diabetes. The policy stated "Hyperglycemia is not the same as having diabetes." The policy provided detailed management of hypoglycemia, however, it did not include assessment or management of hyperglycemia.	F 309		

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F 309	Continued From page 84 The Medical Director reviewed the policy on 6/8/17 at 11:20 am. He stated the policy should direct the staff to contact the resident's physician for a BG level less than 70 or greater than 400. He stated he would expect to be called for BG outside of the parameters except in cases of hospice, or other specified parameters. He stated "It would be reasonable to add a statement to the policy to notify the physician for BG over 400." b. Resident #2's care plan documented a focus area for actual infection with Enterococci and serratia on 5/8/17. Interventions included medications per physician orders on 5/8/17. Resident #2's active orders documented a 5/24/17 order for an antibiotic, ceftriaxone 2 grams, 1 vial in 5% dextrose in water 100 miliLiters, infuse IV over 30 minutes every night shift to treat the infection. On 6/6/17 at 1:10 pm, Resident #2 was observed in his room. He said said his IV antibiotic was not administered "last night because it did not come from the pharmacy." On 6/6/17 at 1:20 pm, ADCS #1 said she was unaware Resident #2's IV antibiotic was not administered or that it was not available. Resident #2's June 2017 Medication Administration Record [MAR] included the order for ceftriaxone by IV every night shift. In the space to document administration of the medication on 6/5/17 was "NN" and someone's initials. Chart Codes/Follow Up Codes at the bottom of the MAR documented "NN" meant "Other/See Nurse Notes."	F 309		

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F 309	Continued From page 85 Resident #2's Progress Notes, dated 6/6/17 at 12:48 am, documented the IV antibiotic was not available. It documented that the pharmacy provider was called and the nurse was told the antibiotic would be shipped to the facility in the morning. On 6/6/17 at 4:05 pm, ADCS #1 said 7 doses of ceftriaxone were received from the pharmacy for Resident #2's initially. The ADCS said she did not know the number of doses received after that and she would review pharmacy receipts and/or call the pharmacy provider. On 6/6/17 at 7:45 pm, ADCS #1 provided pharmacy delivery records for Resident #2's ceftriaxone which documented 7 doses were delivered to the facility on 5/23/17, 3 doses were delivered on 5/30/17 and 4 doses were delivered on 5/31/17. The pharmacy delivery records documented enough doses of Resident #2's ceftriaxone were available for daily administration through 6/6/17. However, the IV antibiotic was not administer on 6/5/17 as ordered.	F 309		
F 312 SS=E	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure	F 312	F 312	8/5/17

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F 312	Continued From page 86 residents were provided assistance with bathing consistent with their needs. This was true for 4 of 12 residents (#1, #7, #12, and #20) residing in the facility sampled for bathing. The lack of bathing care could lead residents to experience embarrassment, isolation, decreased sense of self-worth, skin breakdown, or otherwise compromise their physical and/or psychosocial well-being. Findings include: Residents were not consistently bathed as follows: a. Resident #1 was admitted to the facility on 5/7/16 with diagnosis of a cerebral vascular accident (stroke) which resulted in hemiparesis [inability to move one side of the body]. Resident #1's annual Minimum Data Set [MDS] assessment, dated 4/17/17, documented he required total staff assistance for bathing and had severe cognitive impairment. Resident #1's current Care Plan directed staff to provide him with 2 showers each week. Resident #1's clinical record, reviewed for showers/bathing between 5/8/17-6/5/17, documented Resident #1 received a shower on 5/29/17. The clinical record documented Resident #1 refused a shower on 5/25/17 and 6/5/17. No other documentation of showers for these dates were provided. b. Resident #7 was admitted to the facility on 4/1/17, after being hospitalized for a urinary tract infection. Additional diagnoses included chronic renal disease, DM Type II [Diabetes Mellitus adult	F 312	Resident #12 and #20 are no longer in the facility. For residents #1 and #7, and for all residents in the facility, the facility shall ensure that these residents receive baths/showers consistent with their needs. All staff shall be re-educated in the importance of hygiene, specifically regularly scheduled baths/shower, and the lack of bathing care could compromise their physical and or psychosocial well-being. Education will also emphasis on when a resident refuses a bath/shower, to re-approach later, and/or offer bath/shower at a different time to accommodate the resident□s needs. The DCS shall review/audit bath schedules weekly for 1 month to ensure they provided baths for residents as care planned and scheduled. The results of these audits shall be reported to the QA Committee for review and further comments. Following this the bath schedules shall be reviewed/audits 2 times/month for 4 months. The results of these audits shall be reported to the QA Committee for review and further comments. Responsible party: Administrator, MDS, DCS, ADCS, Social Service, Activities, Dietary, and any other staff involved in	

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F 312	Continued From page 87 onset], and weakness. Resident #7's Activities of Daily Living [ADL] care plan stated she required 1 person to provide physical assistance with bathing. The care plan did not state how frequently Resident #7 was to bathed. Resident #7's clinical record included dates of her showers, including offers to shower and refusals. Her record documented a span of 11 days between showers, from 5/15/17 to 5/26/17. The documentation did not include offers to bathe or refusals of bathing during the 11 day period. c. Resident #12 was admitted to the facility on 3/3/14, with diagnoses of DM Type II and dementia. Additional diagnoses included insomnia, irregular heartbeat, and anxiety disorder. Resident #12's ADL care plan stated she required 1 person to provide extensive to total assistance with bathing. The care plan did not state how frequently Resident #7 was to bathed. Resident #12's clinical record included dates of bathing, including offers of bathing and refusals. Her record documented a span of 7 days between bathing from 5/1/17 to 5/8/17, and 11 days between bathing from 5/11/17 to 5/22/17. The documentation did not include offers to bathe or refusals of bathing during those periods. On 6/8/17 at 3:30 pm, ADCS #3 stated the records of Residents #1, #7, and #12 did not include evidence bathing was offered between the dates specified above. She stated the facility	F 312	direct care / ADL□s.	

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F 312	Continued From page 88	F 312		
	had a twice weekly routine for resident bathing. She stated the resident was allowed to refuse a bath/shower, but that should be documented and offered at another time. d. Resident #20 was admitted to the facility on 6/7/16, with diagnoses which included dementia and congestive heart failure. Resident #20's annual MDS assessment, dated 5/31/17, documented she had severely impaired cognition, required assistance for bed mobility, transfers, dressing, toilet use, and hygiene; and supervision with ambulation. The MDS documented Resident #20 had no physical or verbal aggression towards others. On 5/18/17 at 11:00 am, Resident #20's Nurse's Notes [NN] documented, "unable to take shower due to staffing issues." On 6/8/17 at 1:50 pm, Resident #20's NN documented, "Shower not given as there were time constraints."			
F 323 SS=G	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	F 323		8/8/17

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F 323	Continued From page 89 or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (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 observations, staff interview, review of clinical records and incident/accident reports, it was determined the facility failed to ensure residents received sufficient supervision, toileting assistance, resident repositioning as care planned, and care plan updates to prevent falls and injuries for 2 of 5 residents (#12 and #14) reviewed for falls. As a result: a) Resident #12, was harmed when she fell and sustained a fractured jaw, as well as, abrasions and bruising to both legs, left elbow and arm. b) Resident #14, was harmed when she fell and sustained a closed head injury and facial fractures. Findings include: 1. Resident #12 was admitted to the facility on 3/3/14, with diagnoses of DM Type II [Diabetes Mellitus adult onset] and dementia. Additional	F 323	F 323 Resident #12 and 14 are no longer in the facility. For all residents in the facility, the facility shall ensure that all care staff are sufficient in number deployed in such a fashion as to meet the assessed needs of all residents for sufficient supervision, toileting assistance, resident repositioning as care planned, and care plan updates to prevent falls and injuries. The Administrator and DCS shall review the daily staffing assignments to ensure there is sufficient resource available to meet the assessed needs of all residents. To ensure that staff were appropriately deployed and responsive to assessed and/or immediate resident need, the Administrator and DCS shall randomly	

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F 323	Continued From page 90 diagnoses included insomnia, irregular heartbeat, and anxiety disorder. Resident #12's MDS assessment, dated 5/1/17, documented she required extensive assistance with transfers, ambulation, bed mobility, and toileting. Resident #12's care plan revised on 8/25/16, identified her as at risk for falls and having behavior related to insomnia and dementia. Interventions included: - Bed mobility - 2 person assistance, sit-to-stand for transfer on and off the commode, toileting upon rising, before and after meals, at bedtime and every 2 hours and as needed. Additional interventions included a "High/Low" bed in lowest position, wearing of nonskid slippers with transfers and nonskid socks while in bed. - Resident #12's care plan revised on 8/25/16, included interventions related to skin integrity, which documented Prevalon boots [pressure reduction] were to be worn at all times except during transfers and she was to be repositioned in her bed every 1-2 hours. Her care plan documented a pressure reduction air mattress with bolsters was initiated on 3/31/16. A fall investigation report, dated 5/22/17, documented the following: - The fall investigation report documented Resident #12 fell on 5/22/17 at 12:35 am. The investigation report documented a thud was heard, the responding CNA ran to Resident #12's room and found her on the floor. The	F 323	interview a 10% sample of residents. To ensure the needs of residents with impaired cognition and/or communication are audited, the Administrator and/or DCS shall contact responsible parties and/or surrogates with the same interview. If the results of these interviews indicate 2 or more residents/surrogates with negative responses the sample size shall be doubled. This sample interviewing shall be done two times every month for 6 months. The results of these interviews shall be reported to the QA Committee for further review and/or comment as appropriate. The DCS shall review/audit bath schedules weekly for 1 month to ensure that staff were sufficient in number and appropriately deployed to ensure they provided baths for residents as care planned and scheduled. The results of these audits shall be reported to the QA Committee for review and further comments. All staff shall be inserviced related to the best practices to follow when a resident declines a scheduled bath. Residents who repeatedly decline baths a scheduled shall be reassessed to ensure the bath schedule offered is person-centered and meets the goals of the resident. Everytime a resident declines a bath the CNA shall inform the appropriate Licensed Nurse for their follow up. This is documented in PCC by the ADCS.	

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F 323	Continued From page 91 investigation report documented Resident #12 was lying on her left side facing the bed. The resident was reported to state "I rolled out of bed." - The fall investigation report documented the last time Resident #12 was toileted was 5/21/17 at 4:46 pm, approximately 8 hours prior to her fall. She was documented as being incontinent of urine when she was found on the floor. - The fall investigation included a section titled "Re-Creation of Last 3 Hours Before Fall." The statement was incomplete and stated "Worked with two CNA's. First CNA checked on [Resident #12] around [time left blank] and I checked on her around 11:15 pm. She was laying on [right] side and sleeping." - The fall investigation included a section titled "Fall Huddle." The statement, unsigned, documented, "May benefit from bolster mattress or 2nd bed cane." Resident #12's current care plan documented an air mattress with bolsters was initiated on 3/31/16. - The fall investigation included a section titled "ROOT CAUSE OF THIS FALL" which documented the following contributing factors: * amount of assistance in effect * Assistive/protective device * Medication * Medical status/Physical condition/Diagnoses * Toileting status * Vision or hearing - The fall investigation described initial	F 323	For all residents the facility assesses for fall risk at the time of admission. This initial assessment is completed within the first 8 hours post admit. The facility shall adopt the "4 Ps and Frequent Checks" tool as fall prevention methodology. All staff shall be inserviced in the use of this tool. Residents who experience a fall shall have a root cause analysis completed within 24 hours of the fall. A post fall huddle is completed at the site of the fall as part of this root cause analysis. Members of the huddle include ADCS, therapy, a CNA, floor nurse, and the DCS and/or the RN supervisor. In this huddle the 4 Ps are discussed, the environment is assessed, and a medication regimen review is completed. If necessary, the consulting pharmacist is asked to complete the medication regimen review. The primary physician is always notified of the fall but will also be consulted as determined appropriate by the post-fall huddle related to further assessment of potential medical changes. The therapy department shall complete a post fall screening after every fall. Therapy shall document the screen and any recommendations as a result of the screen in PCC. The ADCS documents the post fall huddle analysis and recommendations in PCC. The care plan is updated as appropriate Every fall is reviewed in the falls meeting weekly. A follow up note is made in PCC	

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F 323	Continued From page 92 interventions to prevent future falls: "Left note for ADCS [Assistant Director of Care Services] for poss[ible] bolster or 2nd bed cane for visual boundary." A nursing progress note, dated 5/22/17 at 3:30 am, described Resident #12's fall. It included the following documentation: "At 00:35 [12:30 am] resident rolled out of bed. Found lying on her left side. She has some swelling on her chin and L [left] lower jaw. Ice pack applied. States "I broke my jaw." Jaw feels the same on both sides. Has some bruises/abrasion L [left] knee, R [right] knee & L[left] elbow and LUE [Left upper extremity]. Nursing progress notes dated 5/22/17 at 4:36 pm, documented the X-ray revealed a fracture of her lower mandible [jaw]. A nursing progress note, dated on 5/22/17 at 5:21 pm, documented Resident #12's Interested Party requested she be transported to a hospital for evaluation. She did not return to the facility. On 6/8/17 at 3:30 pm, ADCS #3 stated Resident #12's fall investigation recommended an air mattress with bolsters and her care plan documented she had one since 3/31/16. ADCS #3 stated it was unclear what kind of footwear, if any, Resident #12 was wearing at the time of the fall. She confirmed the care plan documented Prevalon boots were to be worn, but her clinical record did not include documentation whether they were used. ADCS #3 stated Resident #12's care plan directed staff to assist her with repositioning and toileting frequently, and she should have not had an 8 hour delay of toileting.	F 323	related to this meeting and additional recommendations and/or risk management strategies from this meeting. Care plan is updated at indicated. The RN supervisor shall complete an audit twice monthly validating the root cause analysis was completed, the post-fall huddle took place, a therapy screen was completed, the care plan was updated appropriately, and that recommendations were acted upon. The results of these audits are reported to the facility Administrator for review and further action if indicated. The facility Administrator shall report these audits and any additional recommendations from this audit to the QA committee. The QA committee shall determine the timeframe for these audits but they shall be done initially for no less than 6 months. Responsible party: Administrator, DCS, Clinical leadership, therapy, and appropriate designees Date:	

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F 323	Continued From page 93 ADCS #3 stated Resident #12's care plan interventions of bed position, the air mattress with bolsters, footwear type and resident repositioning every 1-2 hours would not be documented on a treatment record or other document. She stated "If it is care planned, they should be doing it." The facility failed to ensure Resident #12 received the care and services necessary to protect her from falls. 2. Resident #14 was admitted to the facility on 5/12/17, with diagnoses of Alzheimer's dementia, unspecified dementia with behavioral disturbances, collapsed vertebra in the lumbar region, cataract, anxiety disorder, repeat falls, and difficulty walking. The Nursing Admission Assessment, dated 5/12/17, documented Resident #14 had poor balance, an unsteady gait, weakness, required assistive devices, had a fall in the last month, had a fall in the last 2-6 months, and had a fall resulting in a hip fracture 1 1/2 years ago. The Nursing Admission Assessment noted Resident #14 was a high fall risk. Interventions put in place included 15 minute checks for the first 72 hours, a red leaf [indicating high fall risk], a high low bed with bolster sheet, and a pressure sensitive call light. The MDS assessment for Resident #14, dated 5/26/17, documented she required extensive assistance of one staff for transfers.	F 323		

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F 323	Continued From page 94 A Care Plan for impaired coordination, dated 5/12/17, directed staff to provide Resident #14 a one person assistance with constant guidance and physical assistance for transfers, and one person assistance with ambulation using a 4-wheeled walker. Resident #14's Fall Risk Care Plan, completed on 5/12/17, documented she was at risk for falls due to her acute medical condition, cognitive impairment, gait disturbance, weakness, history of falls, impaired balance, short term memory loss, and unsteady gait. Interventions included every 15 minute checks [no end date provided], Red fall risk, commonly used items within easy reach, high-low bed, [no position for height provided], perimeter mattress, reinforce with her the need to call for assistance, resident to wear nonskid shoes/slippers/socks, not leaving her unsupervised in room while she was up in her wheelchair; if she is awake please take out to an area of high visibility for closer supervision, and to seat her in an area of high visibility for supervision. A Fall/Post Fall Assessment, dated 5/18/17 at 6:30 pm, was completed Resident #14's unwitnessed fall from a wheelchair at the side of her bed. The Preventative Plan, the Social Service portion, and the RN follow up portion of the assessment were not completed. The Care Plan identified a revision date of 5/22/17 for high low bed and nonskid shoes/slippers. Both interventions were initiated on 5/12/17. No new interventions were noted. A Fall/Post Fall Assessment, dated 5/28/17 at 10:00 am, was completed for Resident #14's	F 323		

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F 323	Continued From page 95 unwitnessed fall from a wheelchair. Resident #14 was in a "common area" of the facility watching TV. The assessment documented Resident #14's wheelchair brakes were on. The RN recommended anti-roll back brakes for Resident #14's wheelchair as an intervention. Resident #14's current Care Plan did not reflect the recommendation. The Care Plan identified new interventions, dated 5/31/17, which directed staff to encourage Resident #14 to use handrails or assistive devices properly and to adjust bed height and leave the bed in the lowest position when in bed. A Fall/Post Fall Assessment, dated 6/6/17 at 1:10 am, was completed when Resident experienced an unwitnessed fall from bed. The assessment documented Resident #14's bed was at normal height and her wheelchair was next to the bed. Resident #14 was transferred to the hospital and returned to the facility with diagnoses of left orbital fracture, maxillary sinus, eyebrow laceration, and closed head injury [concussion]. Resident #14 participated in Physical Therapy from 5/13/17 to 6/7/17. Each Treatment Encounter Note documented Resident #14's precautions as being dementia, fall risk, and poor safety awareness. There was no Physical Therapy documentation or assessment of the three falls. There was no Physical Therapy documentation or assessment that placing Resident #14's high low bed in the lowest position would be the safest intervention to prevent falls. A Nursing Progress note, completed by ADCS #1, dated 6/7/17, documented per "night shift	F 323		

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F 323	Continued From page 96 aide reports resident slept all night without waking since starting Melatonin." On 6/8/17 at 10:55 am, Certified Nursing Assistant [CNA] #4 stated the communication section of the electronic medical system had updates for CNA's to see facility wide. CNA #4 stated there were no specific times specified to check on Resident #4. CNA #4 said, "everybody works together, not just me." CNA #4 was not aware of updates on Resident #14. CNA #14 said, "Physical Therapy put Resident #14 in bed 10-15 minutes ago." Resident #14 was lying in bed and appeared to be asleep. CNA #5 was asked if the bed was in the lowest position. CNA #5 pressed the control for the bed to lower until it stopped. CNA #5 stated, "It was in a low position, but not the lowest." On 6/8/17 at 11:30 am, the DNS stated changes in resident care are provided on the electronic communication screen. Staff is to review at the beginning of their shift to note any new interventions they need to be aware of. The DNS was not able to find communication to staff providing care to Resident #14 following the recent fall with injury. On 6/8/17 at 12:30 pm, Therapy Staff #1 stated at 10:45 am the door to Resident #14's room was closed and the call light was on. Therapy Staff #1 found Resident #14 standing by the bed. Therapy Staff #1 stated she assisted Resident #14 with toileting and then to bed. Therapy Staff #1 stated Resident #14 was not to transfer independently because she is a fall risk. Therapy Staff #1 stated she knew it was communicated that the bed was to be in the lowest position and she thought it	F 323		

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F 323	Continued From page 97 was.	F 323		
F 353 SS=F	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353		8/5/17

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F 353	Continued From page 98 (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of all residents. The deficient practice created the potential for harm when there was a delay in assessment of a resident who required female staff. The facility also failed to provide fresh drinking water for 4 of 12 sampled residents (#2, #3, #6 and #7) and 4 random residents (#16, #17, #18, and #19.) The lack of sufficient staffing had the potential to affect all residents who lived in the facility. This failure created the potential for psychosocial and physical harm if call lights were not answered in a timely manner and care needs were not addressed. Findings include: 1. Resident #20 was admitted to the facility on 6/7/16, with diagnoses which included dementia and congestive heart failure. Resident #20 had two daughters involved with her care. Resident #20's annual MDS assessment, dated 5/31/17, documented she had severely impaired cognition, delusions, wandered, and was at risk	F 353	F 353 Resident #7 and 20 are no longer in the facility. For all residents in the facility, the facility shall ensure that all care staff are sufficient in number deployed in such a fashion as to meet the assessed needs of the all residents. Additionally, to the extent reasonably possible, the facility shall ensure that gender specific requests for staffing are accommodated. Residents in the facility that have gender specific staff requests shall be identified and the deployment of staffing in the unit shall be made to reasonably accommodate the gender specific request. The Administrator and DCS shall review the daily staffing assignments to ensure there is sufficient resource available to meet the assessed needs of all residents.	

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F 353	Continued From page 99 of elopement from the facility. The MDS documented Resident #20 required assistance for bed mobility, transfers, dressing, toilet use, and hygiene; and supervision with ambulation. The MDS documented Resident #20 had no physical or verbal aggression towards others, and did not reject care. Resident #20's care plan dated 6/7/16, and in effect on 6/9/17, documented the resident preferred female caregivers only. Resident #20's Nurse's Notes [NN] for 6/9/17 documented the resident's daughter began to notice bruises on the resident beginning at 5:00 pm. The NN documented the bruises were not assessed until 9:20 pm. On 6/15/17 at 2:20 pm, LPN #2 stated he had been on duty the evening of 6/9/17. LPN #2 identified three barriers to assessing Resident #20's bruising in a timely manner. The first was, at the time the bruises were discovered, as the only licensed nurse scheduled to work in the memory care unit, he had to stay in the dining room to supervise the evening meal. Once he had completed that assignment, LPN #2 stated he had to complete his medication pass. The second reason was that there was another resident who had an "incident" that night and his attention was consumed with that matter. The third reason LPN #2 cited for the delay in the assessment of Resident #20's bruising was that she required a female attendant, and two of the three staff members, including himself, assigned to the memory care unit that evening were male. LPN #2 stated he did not feel this was a barrier to sufficient staffing for the unit, as he would	F 353	To ensure that staff were appropriately deployed and responsive to assessed and/or immediate resident need, the Administrator and DCS shall randomly interview a 10% sample of residents. To ensure the needs of residents with impaired cognition and/or communication are audited, the Administrator and/or DCS shall contact responsible parties and/or surrogates with the same interview. If the results of these interviews indicate 2 or more residents/surrogates with negative responses the sample size shall be doubled. This sample interviewing shall be done two times every month for 6 months. The results of these interviews shall be reported to the QA Committee for further review and/or comment as appropriate. The DCS shall review/audit bath schedules weekly for 1 month to ensure that staff were sufficient in number and appropriately deployed to ensure they provided baths for residents as care planned and scheduled. The results of these audits shall be reported to the QA Committee for review and further comments. Following this the bath schedules shall be reviewed/audits 2 times/month for 4 months. The results of these audits shall be reported to the QA Committee for review and further comments. The DCS or clinical leadership designee shall ensure daily that fresh water is	

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F 353	Continued From page 100 typically ask a female nurse working in other areas of the facility to assist with residents who preferred "female caregivers only." LPN #2 stated he had not requested a female staff member assess Resident #20's bruises after they were initially reported because he was so busy with his other duties he hadn't realized how much time had passed. LPN #2 stated he was "about to" contact ADCS #3 to ask for her help when she arrived on the unit to assess Resident #20's skin. 2. Staff Interviews: On 6/15/17 at 10:30 am, ADCS #3 stated she was working as a cart nurse on another unit in the facility on the evening of 6/9/17. ADCS #3 stated she first became aware of Resident #20's situation when her daughter called at approximately 9:00 pm to ask to have the resident's bruises evaluated. ADCS #3 stated the delay caused by not involving a female staff member earlier was "too long." On 6/6/17 at 2:00 pm, a day shift CNA #7 stated she worked at the facility for 7 months. She stated the facility was short of staff in mid-May, they had to hire temporary staff. The CNA stated staffing was better at the current time but the facility did not have shower aides, and when they were short staffed, showers were not provided. On 6/8/17 at 7:55 am, CNA #6 stated her duties on night shift included answering lights, turning and changing residents. She stated often the CNA staffing was 2 CNA's for 3 halls - 100, 200, and 300. She stated they were to have 3 CNAs. CNA #6 stated it was "rough" when they worked with only 2 CNA's on those nights, and	F 353	provided to all residents during waking hours (the AM and PM shifts). Hydration rounds shall be conducted on the AM and PM shift and a daily report of these rounds related to residents having fresh water shall be given to the Administrator for his review. The Administrator shall sign off on these hydrations audits. These audits shall be presented to the QA Committee for a period of 3 months for further review and comment. The Administrator or designee shall do a weekly call bell audit for 1 month to ensure that staff are sufficient in number and deployed efficiently to provide for timely response to call lights. The results of these audits shall be reported to the QA Committee for review and further comments. Following this the call bell audit shall be completed 2 times/month for 4 months. The results of these audits shall be reported to the QA Committee for review and further comments. The facility has been and continues to be actively recruiting clinical staff. The Administrator shall keep a weekly log of applications received, interviews conducted, and employment offers extended. If the facility must use agency staffing, the staffing need shall be projected out far enough to get consistent staffing from agencies to the extent possible.	

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F 353	Continued From page 101 sometimes residents only got changed once during the shift. She said responding to call lights was the priority. CNA #6 stated that although residents were identified as 2 person assists, the CNA staff would have to provide the care alone, because they could not find anyone to assist them. She stated there was no use talking to the upper management, "They know how we feel." 3. Fresh drinking water was not consistently provided to residents. a. On 6/6/17 at 1:10 pm, Resident #2's water mug was observed almost full of water, no ice. The resident said the water mug had not been changed since "last night." b. Resident #3's water mug was observed almost full, without ice, on 6/6/17 at 10:40 am, 10:50 am, 1:00 pm, 2:30 pm, 4:00 pm and 4:10 pm. At 4:00 pm, Resident #3 demonstrated that he could reach the water mug and said, "Cold is always better, but if I need a drink, this will do." Resident #3's water mug was again observed almost full, without ice, on 6/7/17 at 7:30 am, 9:25 am, and 9:30 am. At 9:30 am, Resident #3 said he "always" liked cold water better but he would drink it warm when he needed to quench his thirst. c. Resident #6's water mug was observed 1/2 full, without ice, on 6/6/17 at 10:50 am. The resident said his water had not been "freshened" so far that day. Resident #6's water mug was observed still 1/2 full later that day at 1:00 pm, 1:25 pm, 4:00 pm, and 4:10 pm.	F 353	The Administrator shall report monthly to the QA Committee about recruiting activity and present the log related to applications, interviews, and offers. Additionally, the Administrator shall present to the QA Committee the number of agency staff used during the month and the percentage of consistency. This reporting shall be done consistently for a period of 6 months. At that time, the QA Committee shall determine whether further reporting is required. Responsible party: Administrator, DCS, Clinical leadership, and appropriate designees	

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F 353	Continued From page 102 d. On 6/6/17 at 8:00 am, Resident #18 had a mug half full of water at bedside. On 6/7/17 at 3:30 pm, the mug appeared at the same level as the previous day. Resident #18 stated, "I freshen my water, usually once a day." "Yes, I like ice, but I have no way of getting it." e. On 6/6/17 at 8:00 am, a water container was not observed in Resident #19's room. On 6/7/17 at 3:35 pm, Resident #19 stated he gets water out of the sink in his room. When asked if he liked cold ice water, Resident #19 stated, "Yes, I get that once in awhile." f. On 6/6/17 at 7:55 am, a full mug of water was on a bedside table in Resident #16's room. On 6/7/17 at 3:45 pm, Resident #16 stated she had a glass of water with her lunch. She stated she did not receive fresh water on the date of the interview. A cup half full of water was on a table near her. Resident #16 said, "it is warm." g. On 6/6/17 at 7:55 am, Resident #17 had a full mug of water at bedside. On 6/7/17 at 3:45 pm, Resident #17 stated she had not received fresh water on the date of the interview. h. On 6/8/17 at 1:30 pm, when asked about replenishment of fresh drinking water, Resident #7 stated, "I have my mug; they refill it when I ask them to." On 6/7/17 at 4:00 pm, a CNA who worked the evening shift, stated fresh mugs and ice water were passed to residents on nightshift and freshened each shift. The CNA said "We don't always have time for that though, I think we could use more staff."	F 353		

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	135090		C 06/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 353	Continued From page 103 On 6/8/17 at 2:30 pm, CNA #8 stated fresh water was provided only when residents asked for it. CNA #8 stated she did not feel that there was enough CNA staff to meet the resident's needs, especially after dinner when they all want to go to bed at the same time. 4. Staffing and timecards were reviewed for the evening and night shift of 5/21/17. The facility had a secure unit which, (according to the DNS) scheduled 1 LN and 2 CNA's for evening and night shifts. On 5/21/17 for the 2-10 pm shift, 3 LN's and 7 CNAs worked. After providing for staffing for the secure unit, the staff was reduced to 2 LN's and 5 CNA's. The facility census on 5/21/17 was 75. On 5/21/17 for the 10:00 pm to 6:00 am shift, 2 LN's and 4 CNAs worked. The census was 75. To meet the staffing needs for the secure unit reduced the main facility to 2 CNAs and 1 LN for approximately 53 residents, of which half required 2 person assistance for toileting and repositioning. On 6/8/17 beginning at 8:30 am, the Administrator, Compliance/Clinical Resource Officer, and DNS met with the survey team. The Administrator stated the facility was currently not admitting residents, as the census of 75 and the current staffing was at max capacity. He stated the goal for staffing was to always include an LN and 2-3 CNAs on the secure unit. He stated the facility used a lot of agency staff, and described their efforts to recruit new employees. The Administrator stated the company has placed	F 353		

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F 353	Continued From page 104 advertisements outside of the state, had met with colleges, and recruited from area medical facilities. He stated the facility retention rate was good. Resident #1 was admitted to the facility on 5/7/16 with diagnosis of a cerebral vascular accident (stroke) which resulted in hemiparesis (unable to move one side of the body.) Resident #1's annual Minimum Data Set [MDS] assessment, dated 4/17/17, documented resident required total staff assist for bathing and had severe cognitive impairment. The Care Plan directed staff to provide Resident #1 with 2 showers each week. Resident #1's clinical record, reviewed for showers/bathing between 5/8/17-6/5/17, documented Resident #1 received a shower on 5/29/17. The clinical record documented resident refusal for 5/25/17, and 6/5/17. No other documentation of showers for these dates were provided. On 6/8/17 at 3:30 PM, the ADCS #3 stated the facility had a twice weekly routine for resident bathing. She stated the resident was allowed to refuse a bath/shower, but that should be documented and offered at another time. The ADCS #3 was asked how it would be documented if there was no time or opportunity for the staff to bathe a resident, and she stated "I don't know."	F 353		
F 490 SS=F	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	F 490		8/8/17

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F 490	Continued From page 105 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff; resident; and resident's interested party interviews, review of facility policies and procedures, staffing records, and resident records, it was determined the facility was not administered in a manner to effectively use its resources to attain or maintain the highest practicable well-being of each resident. The administration failed to ensure the facility was in compliance with the following regulatory requirements, which affected or potentially affected all residents in the facility. This failed practice had the potential to adversely affect the health and safety of 20 of 20 sampled residents (#1 - #20) residing in the facility, as well as all other residents receiving services and treatment at the facility. Findings include: 1. Deficiencies related to ineffective administration: Refer to F151 as it related to the facility infringing upon residents civil rights. Refer to F156 as it pertains to the facility's failure to provide Resident #20 and her interested party with whom her primary care physician was or how to contact them. Refer to F157 as it related to the facility's lack of physician / interested party notification in regards	F 490	F 490 For all sampled residents and for all residents in the facility, the facility shall ensure operations that promote the use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Please refer to POC at: " F151 " F156 " F157 " F201 " F203 " F208 " F225 " F226 (was not specifically cited in the 2567L but the issues was addressed in the POC for F225.) " F281 " F309 " F323, and " F353 Support and oversight visits conducted by the Director of Operations and the Director of Compliance and Clinical Resource are reported to the Cascadia	

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F 490	Continued From page 106 to multiple suspicious bruises, multiple accidents resulting in major injury, and changes of condition. Refer to F201 as it related to the facility's failure to hold a bed for residents if the resident was admitted to an acute care setting. Refer to F203 as related to the facility's failure to issue a 30 day notice before discharging a resident. Refer to F208 as it related to the facility requiring a resident to waive their rights as a condition of admission. Refer to F225 as it related to the facility's failure to provide a thorough investigation of an abuse allegation, and of the failure of the faciltiy's abuse policy to require all investigations of injuries of unknown origin to be investigated. Refer to F226 as it related to the facility's abuse policy which permitted the Administrator to determine whether to investigate an injury of unknown origin as a possible instance of abuse or neglect. Refer to F281 as it related to the facility's failure to assess a resident's bruises, perform neurological checks after a fall, administer medications, and label IV antibiotics. Refer to F309 as it related to the facility's failure to timely assess and treat residents' injuries, administer medications as ordered, treat and manage low blood glucose levels and develop a hyperglycemic protocol.	F 490	CEO for review and additional comment. These reports are made weekly during a Cascadia conference call. These support and oversight visits shall continue until the survey is cleared. Once the survey is cleared ongoing support and oversight visits shall be conducted at least monthly. All support and oversight visits are reported to Cascadia via the weekly conference call. Responsible party: Administrator, Cascadia Director of Operations, and Cascadia Director of Compliance and Clinical Resource.	

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F 490	Continued From page 107 Refer to F 323 as it related to the facility failure to provide adequate staff supervision which resulted in residents experiencing major injuries following falls. Refer to 353 as it related to the facility failure to provide adequate staffing to provide the basic resident needs of toileting, hygiene, bathing, repositioning, answering call lights, providing fluids, and providing care planned needs of female only staff. On 6/15/17 at 4:00 pm, the Administrator stated he was aware the facility had some challenges with staffing levels, but otherwise did not feel the facility had failed to administer resources according to resident needs, and the facility was effective in the care provided to its residents.	F 490		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain-	F 514		8/8/17

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F 514	Continued From page 108 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure the clinical records for 1 of 20 sample residents (#20) were accurate and complete. This deficient practice placed residents at risk of medical complications due to inaccurate and/or incomplete medical records. Findings include: Resident #20 was admitted to the facility on 6/7/16 with diagnoses which included dementia and congestive heart failure. a. On 6/9/17 at 9:39 pm, Resident #20's Nurse's Notes [NN] documented the resident had been discovered bruises were noted to the resident's right upper arm, left upper arm, and right hip area. The NN documented, "LN on the floor [LPN #2] witnessed skin impairments with this LN and	F 514	F 514 Resident #20 is no longer at the facility. For all residents at the facility, the facility shall ensure that all documentation shall be thorough, accurate, and completed timely. The facility policy and procedure related to documentation will be reviewed and revised if necessary. Revisions to the policy and procedure shall be approved by the medical director. This reviewed policy and procedure shall be presented to the QA committee for review and further comment as indicated. All clinical staff shall be re-educated in	

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F 514	Continued From page 109 will complete a report." The NN was signed by ADCS #3. On 6/9/17 at 9:44 pm, Resident #20's NN documented, "...Measurements to follow..." The NN was signed by LPN #2. A "Skin Event" form in Resident #20's record documented bruises were discovered on her right wrist (5.3 x 4 cm), right upper arm (6.5 x 17 cm), left upper arm (5.4 x 3.3 cm), right hip (5.2 x 10.8 cm); and a scab (0.6 x .05 cm) was discovered on her left elbow, all on 6/9/17 at 9:20 pm. The form was signed and dated on 6/14/17 by ADCS #3. On 6/16/17 at 8:55 am, LPN #1 stated she had been Resident #20's nurse on 6/10/17, the day after the bruises were discovered. LPN #1 stated Resident #20's daughter approached her mid-morning on 6/10/17 and asked about the results of the facility's assessment of the bruises. LPN #1 stated she looked in Resident #20's record and saw that a "Skin Event" had been initiated, but no specific documentation as exact locations, sizes, or appearance of the bruises was documented. LPN #1 stated she "eyeballed" the bruises, then documented the "approximate" measurements in the record. LPN #1 stated later that day (6/10/17), she received the measurements taken by ADCS #3 from the date and time the Skin Event sheet was started, so those measurements were entered into Resident #20's record accordingly. b. On 6/10/17 at 10:09 am, 10:55 am, and 11:30 am, Resident #20's NN documented entries labeled as "Late Entry." The late entries did not	F 514	documentation standards. Specific to focused assessments, such as a skin assessment of new bruises, the assessment is to be initiated immediately after staff has knowledge of a new skin issue. The formal assessment in PointClick Care (PCC) the UDA (user defined assessment), shall be completed within no more than 8 hours after the initial assessment is initiated. All skin event assessments (UDA) shall be audited by ADCS's and RN supervisor. Audits will be completed weekly for 2 months. Those not completed within 8 hours shall be immediately remediated and the clinical staff shall be re-educated on a 1:1. The results of this audit and all remediation/re-education shall be reported to the QA Committee for review and further comment as appropriate. Following the initial weekly audits, the audit will be done monthly for 4 months. The results of this audit and all remediation/re-education shall be reported to the QA Committee for review and further comment as appropriate. Responsible party: Administrator, DCS, ADCS, Social Services, and clinical staff	

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F 514	Continued From page 110 document the date and time they were made. On 6/16/17 at 11:05 am, the Health Information Director stated she should be able to get a printout of when the entries were made in Resident #20's record. On 6/16/17 at 3:41 pm, the facility provided a typed statement that stated they had no further timestamp's to provide beyond what had already been provided.	F 514		

Bureau of Facility Standards

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	MDS001790		C **06/16/2017**

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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during a complaint investigation survey completed at the facility from 6/6/17 to 6/9/17. The surveyors conducting the survey were: Edith Cecil, RN, Team Coordinator Susan Costa, RN Linda Kelly, RN Abbreviations include: CNA = Certified Nursing Assistant LN = Licensed Nurse RN = Registered Nurse	C 000		
C 762	02.200,02,c,ii When Average Census 60-89 Residents ii. In SNFs with an average occupancy rate of sixty (60) to eighty-nine (89) patients/residents a registered professional nurse shall be on duty for each a.m. shift (approximately 7:00 a.m. - 3:00 p.m.) and p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) and no less than a licensed practical nurse on the night shift. This Rule is not met as evidenced by: Based on review of a three-week nursing schedule and copies of timecards provided by the facility, it was determined the facility did not meet the State requirement for RN coverage when the resident occupancy rate was between 60 and 89 residents for each of the days	C 762	C762 For all residents in the facility, the facility shall ensure that all care staff are sufficient in number deployed in such a fashion as to meet the assessed needs of	8/5/17

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 07/20/17

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C 762	Continued From page 1 reviewed. Inadequate RN coverage had the potential to negatively affect all residents living in the facility. Findings include: The three-week nursing schedule and timecards for 5/14/17 through 6/3/17, for RN coverage, documented there was no RN coverage on the Evening Shift on the following days: * 5/21/17- The resident census was 75. * 6/1/17- The resident census was 77. On 6/8/17 at 8:30 am, the Administrator reviewed the worksheets and nursing schedule, and stated 1 RN that worked each day from 6:00 am to 6:00 pm. He stated the computer staffing program was new to them in the last 30 days and he would review the work to verify or change the numbers. He stated the facility was currently not admitting residents, as the census of 75 with the current staffing was at max capacity. He stated the goal for staffing was to always include an LN and 2-3 CNAs on the secure unit. He stated the facility used a lot of agency staff, and described their efforts to recruit new employees. The Administrator stated the company had placed advertisements outside of the state, had met with colleges, and recruited from area medical facilities. He stated the facility retention rate was good.	C 762	the all residents. Additionally, to the extent when census is above 60 and below 89 patients/residents a registered professional nurse shall be on duty for each a.m. shift and p.m. shift and no less than a licensed practical nurse on the night shift. The Administrator and DCS shall review the daily staffing assignments to ensure there is sufficient resource available to meet the assessed needs of all residents, and to meet the requirements of having a registered professional nurse on duty each a.m. and p.m. shift when census is between 60 and 89 patients/residents. To ensure that staff were appropriately deployed and responsive to assessed and/or immediate resident need, the Administrator and DCS shall randomly interview a 10% sample of residents. To ensure the needs of residents with impaired cognition and/or communication are audited, the Administrator and/or DCS shall contact responsible parties and/or surrogates with the same interview. If the results of these interviews indicate 2 or more residents/surrogates with negative responses the sample size shall be doubled. This sample interviewing shall be done two times every month for 6 months. The results of these interviews shall be reported to the QA Committee for further review and/or comment as appropriate. The Administrator shall report monthly to the QA Committee about recruiting activity and present the log related to	

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C 762	Continued From page 2	C 762	applications, interviews, and offers. Additionally, the Administrator shall present to the QA Committee the number of agency staff used during the month and the percentage of consistency. The administrator will also report on state staffing requirements and actual performance specifically regarding when census is between 60 and 89 patients/residents we will have an RN on duty during the a.m. and p.m. shift. This reporting shall be done consistently for a period of 6 months. At that time, the QA Committee shall determine whether further reporting is required. Responsible party: Administrator, DCS, Clinical leadership, and appropriate designees	

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON– 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

September 14, 2017

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

Provider #: 135090

Dear Mr. Roedel:

On **June 16, 2017**, an unannounced on-site complaint survey was conducted at Shaw Mountain of Cascadia. The complaint was investigated during a survey event extending from June 6, 2017 through June 16, 2017.

The records of 20 residents, including the identified resident, were reviewed for Quality of Care, Quality of Life, Resident Rights, and Abuse and Neglect concerns. Resident and Resident Family interviews were conducted. Obervations of the provision of care in the facility were made between June 6 and June 8, 2017. Seventeen staff members were interviewed. Facility incident reports and investigations from mid-May 2017 through mid-June 2017 were reviewed. Facility staffing ratios were reviewed. The facility's policy for Abuse and Neglect prevention, recognition, reporting, investigating, and protecting residents was reviewed; as was the facility's policy for Admission and Discharge of residents.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007549

ALLEGATION #1:

The Reporting Party stated an identified resident was discovered with significant bruising, which was brought to the facility's attention. The Reporting Party stated the facility did not assess the bruises or have the resident evaluated for internal injuries or fractures for several hours.

FINDINGS:

The identified resident's family noticed several large bruises on the resident between approximately 4:45 pm and 6:60 pm. The family member who discovered the bruises reported the first bruise to the nurse on duty at approximately 5:00 pm. The identified resident's bruises were not assessed by the facility until approximately 9:20 pm. The facility nurses did not remove the identified resident's Attends to fully assess a large bruise to the right hip area. The facility did not notify the physician of the discovery of the bruises. The morning following the discovery of the bruises, the identified resident was taken via ambulance, per family request, to be evaluated at the emergency department, after the nurse on duty that morning stated she had not been made aware of the resident's bruising, so had not assessed the resident for injury.

The allegation is substantiated and cited at F 157, F 281, F 309, and F 514.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The Reporting Party stated the facility did not conduct a thorough investigation of an identified resident's bruising to ensure that the resident had not experienced abuse or neglect.

FINDINGS:

The facility's policy for the investigation of injuries of unknown origin allowed for the facility Administrator to determine which of these injuries needed to be investigated, while the regulatory requirement is that all injuries of unkown origin need to be throroughly investigated to rule out that abuse or neglect may have occurred. The facility's investigation of the above identified event lacked several components of a thorough investigation.

The allegation is substantiated and cited at F 225.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility declined to have an identified resident's bruising evaluated by a physician.

FINDINGS:

There were two nurses on duty at the time the resident's bruising was discovered. After the discovery, it is not clear when, how, or if the physician was notified of the bruising. When the family asked the nurse on duty the next day if the resident's physician should see the resident based on the severity of the bruising, the nurse declined on the presumption that the physician was aware of the extent of the bruising and did not feel the resident needed further evaluation.

The allegation is substantiated, and cited at F 157.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

The Reporting Party stated an identified resident was not allowed to return to the facility after evaluation in the emergency room.

FINDINGS:

The identified resident's records from the hospital emergency room confirmed the facility would not allow the resident to return, although did not identify a clinical reason prohibiting the resident's return. The facility confirmed through interview that the resident was not allowed to return from the emergency room that day. The allegation was substantiated and cited at F 201 and F 203.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

The Reporting Party stated the facility retaliated against an identified resident's family for making an allegation of abuse by involuntarily discharging a resident from the facility.

FINDINGS:

The identified resident's family summoned emergency services to the facility after they discovered the resident to have several large bruises. The facility did decline to accept the identified resident back from the emergency room until after a care conference was held two days later. Several attendees at the care conference described that the facility had determined the resident could not return to the facility on the day in question as the resident's family had inquired as to whether the resident's bruising may have been the result of abuse, and had called police to investigate.

The allegation is substantiated and cited at F 151.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #6:

The Reporting Party stated an identified resident was required to waive their right to visitation with persons of their choosing as a condition of readmission.

FINDINGS:

The facility did not allow the identified resident to return directly from an evaluation at the emergency room for several large bruises, and informed both the resident's family and the emergency room staff that they would need to meet with family before the resident could return. When the facility met with the identified resident and her family two days later, the facility informed them they would only allow the resident to return if one of her family members had supervised visits only.

The allegation is substantiated and cited at F 208.

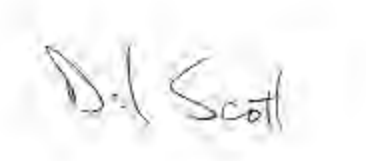
CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



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

DS/lj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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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

May 17, 2018

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

Provider #: 135090

Dear Mr. Roedel:

On **June 16, 2017**, an unannounced on-site complaint survey was conducted at Shaw Mountain Of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007533

ALLEGATION #1:

The Reporting Party said the facility had an inadequate number of staff to meet the residents' needs.

FINDINGS #1:

Refer to the survey reports for informaton relating to citations at federal deficiency at F353 and state deficiency at C762 as relates to a lack of suffienct staffing to meet residents' needs.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The Reporting Party said the facility lacks supplies to meet the resident needs.

FINDINGS #2:

This complaint was invesigated during an on-site survey conducted June 6, 2017 through June 9, 2017. During the complaint survey, licensed nursing staff and CNAs were interviewed regarding the availability of supplies necessary for safe resident care. The pharmacy supplies provided for individual resident use was adequate to meet resident needs for IVs, tubing, dressings, and emergency medications. The inventory report listed each item removed for the resident need. The treatment carts exhibited individual resident care products as well as supplies for general use. Individual residents reported their needs were met.

No deficiencies were cited for this allegation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The Reporting Party said an identified resident had a PICC line and a dialysis port that had dirty old dressings because the facility was out of dressings. At one point the PICC line had no luer lock and was just clamped.

FINDINGS #3:

This complaint was invesigated during an on-site survey conducted June 6, 2017 through June 9, 2017. During the complaint survey, the identified resident's treatment record was reviewed, the supplies provided for dressing change, and the available supply of luer locks for the PICC line were reviewed. The pharmacy provided dressings and luer locks specific to the identified resident. The identified resident receives dialysis 3 times a week. The dialysis center staff provide the dressing changes on the dialysis port. The facility provided documentation of dressing changes on the PICC line site which was completed per direction. No deficiencies were cited for this allegation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The Reporting Party said an identified resident complained of throat pain, trouble swallowing, received a steroid medication for weight loss. The reporting party said the identified resident was started on a different medication to increase appetite and began losing weight. The reporting parting said the identified resident received an antifungal medication for a mouth infection.

FINDINGS #4:

This complaint was invesigated during an on-site survey conducted June 6, 2017 through June 9, 2017. The identified resident did not verbalized concerns regarding the medication management provided by the physician. The Medication Administration Record, Nurse's notes, Physician Orders, and Physician Progress notes were reviewed. Allegations were substantiated regarding the treatment, however, deficiciences were not found.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #5:

The Reporting Party said an identified resident had wounds that were not documented or treated despite months of toe pain. The identified resident was refered to a specialist where it was determine the identified resident required surgical intervention.

FINDINGS #5:

This complaint was invesigated during an on-site survey conducted June 6, 2017 through June 9, 2017. The identified resident's medical record was reviewed. Nurses' notes, Medication Administration Records, Treatment Records, Physician Progress notes, and the wound clinic notes were reviewed. The identified resident verbalized medical complications requiring surgical intervention. The allegations are substantiated, however, no deficiencies were found.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #6:

The Reporting Party stated an identified resident was ordered to remain in bed except for 1 hours at meal d/t a stage 4 pressure ulcer on the coccyx.

FINDINGS # 6:

This complaint was invesigated during an on-site survey conducted June 6, 2017 through June 9, 2017. The identified resident and nursing staff were interviewed, The identified residents medical record was reviewed. The treatment record and wound care documentation was reviewed. The care plan for the identified resident was reviewed. The allegation was substantiated with no deficiencies cited.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #7:

The Reporting Party said an identified resident was on isolation precautions and there was no documentation as to why.

FINDINGS #7:

This complaint was invesigated during an on-site survey conducted June 6, 2017 through June 9, 2017. The identified resident's medical record was reviewed. The identified resident was on isolation precautions of which was identified and documented in the medical record. The allegation is substantiated, however, no deficiencies were found.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #8:

The Reporting Party said an identified resident was on isolation precautions for C-Diff and there was feces on the carpet and isolation clothing and trash had not been put in isolation bags but was put in with regular trash and clothing.

FINDINGS #8:

This complaint was invesigated during an on-site survey conducted June 6, 2017 through June 9, 2017. Facility nursing staff and housekeeping staff were interviewed and were able to identify the proper procedures for handling body fluids, clothing, and trash in an isolation setting. The staff were monitored during the complaint survey and no infection control issues were identified. No deficiencies were cited for this allegation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #9:

The Reporting Party said there were several undocumented wounds, the Reporting Party said an identified resident had undocumented wound to the right shin.

FINDINGS #9:

This complaint was invesigated during an on-site survey conducted June 6, 2017 through June 9, 2017. The identified resident in the allegation communicated a "self inflicted scratch" to the shin caused by scratching. Documentation in the nurses' notes identified an area of impairment with appropriate treatment put in place for the identified resident. During the complaint survey, 12 residents were reviewed, including the identified resident. No deficiencies were cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #10:

The Reporting Party said skin checks were not being performed.

FINDINGS #10:

This complaint was invesigated during an on-site survey conducted June 6, 2017 through June 9, 2017. During the complaint survey, 12 residents were reviewed for skin assessments. Weekly skin assessments were found to be documented in the resident's medical records appropriately. No deficiencies were cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #11:

The Reporting Party said showers were not provided, being marked as refused, because there was not enough staff.

FINDINGS #11:

Refer to survey report for information relating to federal regulations F312 and F353 as relates to the provision of care for activies of daily living and lack of sufficient staff to meet residents' needs.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #12:

The Reporting Party said water was not being distributed to residents.

FINDINGS #12:

Refer to survey report for information relating to federal regulation F353 as relates to providing to meet residents' activities of daily living needs.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #13:

The Reporting Party said the Alzheimer's unit had no screens on windows, as well as most other window in the facility.

FINDINGS # 13:

This complaint was invesigated during an on-site survey conducted June 6, 2017 through June 9, 2017. During the complaint survey, multiple windows were observed to have screens missing. There were no observations of pests entering the facility when windows were open. No deficiencies were cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #14:

The Reporting Party said the LPNs are supervisors and don't seem educated.

FINDINGS #14:

This complaint was invesigated during an on-site survey conducted June 6, 2017 through June 9, 2017. No deficiencies were cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #15:

The Reporting Party said an identified LPN seems to write her own orders:
1. Order for oxygen at 10 LPM via nasal cannula for a headache for an identified resident
2. Heparin order for identified resident, believed to be in error
3. Valium ordered for the day of surgery for identified resident scheduled daily

FINDINGS # 15:

This complaint was investigated June 6, 2017 through June 9, 2017. During the complaint survey, the Reporting Party said a Licensed Practical Nurse " seems to write her own orders. "

Identified resident #1's clinical record was reviewed and an order for oxygen at 10 liters per minute as needed for headache was found. The order was signed by a Nurse Practitioner. The facility provided an article citing the benefits of high flow oxygenation for relief of headaches. The physician and the identified resident's family were aware of and in agreement of the therapy.

No deficiency was cited for this allegation.

Identified resident #2's clinical record was reviewed for heparin therapy. The admission orders included the heparin therapy order with no stop date provided. The admission orders were signed by the discharging acute care physician and the identified resident's facility physician.

No deficiencies were cited for this allegation. F157 was cited for the management of heparin following admission.

Identified resident #3's clinical record was reviewed for the dosing of Valium. The physician order and medication administration record was reviewed. The order for a one time dose of Valium 10 mg was reviewed. The medication administration record documented the nursing staff provided one dose of Valium 10 mg. An order for Valium 10 mg daily was not found.

No deficiencies were cited for this allegation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #16:

The Reporting Party said all allegations were brought to the attention of the Director of Nursing and the Administrator and nothing was done.

FINDINGS #16:

This complaint was investigated June 6, 2017 through June 9, 2017. The Administrator and Director of Nursing realize the facility struggles with staffing. The facility is addressing the issue with multiple campaign outlets for recruiting staff.

CONCLUSIONS:
Substantiated. Refer to the June 16, 2017 survey report, federal citation F353 as it relates to lack of sufficent staffing to meet residents' needs.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Debby Ransom, RN, RHIT at (208) 334-6626, option 5. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Debby Ransom, R.N., R.H.I.T., Chief
Bureau of Facility Standards

DR/lj

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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

May 17, 2018

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

Provider #: 135090

Dear Mr. Roedel:

On **June 16, 2017**, an unannounced on-site complaint survey was conducted at Shaw Mountain of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007535

ALLEGATION #1:

The Reporting Party said an identified resident was upset with cares not being provided in time due to lack of staff.

FINDINGS #1:

This complaint was investigated June 6, 2017 through June 9, 2017. During the complaint survey, 12 residents were reviewed, including the identified resident, who no longer resided at the facility.

The identified resident ' s clinical record, and those of 11 other residents, were reviewed and included physician orders, medication administration records, the provision of treatments, care plans, Social Services, physician progress notes, and nursing notes. Issues identified in the resident's clinical record during his stay at the facility were addressed by facility staff.

No deficiencies were cited for this allegation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The Reporting Party said an identified resident was concerned about getting transferred to bed and having to wait a long time because there was not enough staff.

FINDINGS #2:

This complaint was investigated June 6, 2017 through June 9, 2017. During the complaint survey, 12 residents were reviewed, including the identified resident. The identified resident was interviewed and had no concerns regarding the care provided by the staff.

No deficiencies were cited for this allegation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence

ALLEGATION #3:

The Reporting Party said there were several falls, all the time. The Reporting Party said an identified resident fell out of bed and broke her mandible.

FINDINGS #3:

This complaint was investigated June 6, 2017 through June 9, 2017. During the complaint survey, 12 residents were reviewed, including the identified resident. The facility was cited with deficient practice at F323. Please refer to F323 of the 2567 federal report for specific findings.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Debby Ransom, RN, RHIT at (208) 334-6626, option 5. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Debby Ransom, R.N., R.H.I.T., Chief
Bureau of Facility Standards

DR/lj