



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

December 12, 2017

Peter Smith, Administrator  
Caldwell of Cascadia  
210 Cleveland Boulevard  
Caldwell, ID 83605-3622

Provider #: 135014

Dear Mr. Smith:

On **November 9, 2017**, a survey was conducted at Caldwell 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 a widespread deficiency that constitutes immediate jeopardy to resident health or safety, as documented on the enclosed CMS-2567, whereby significant corrections are required.** You were informed of the immediate jeopardy situation(s) in writing on **November 8, 2017**.

On **November 9, 2017**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the residents had been removed. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction.

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 **December 22, 2017**. Failure to submit an acceptable PoC by **December 22, 2017**, may result in the imposition of additional civil monetary penalties by **January 16, 2018**.

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.
- 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*.

Based on the immediate jeopardy cited during this survey:

- **F0225 -- S/S: L -- 483.12(a)(3)(4)(c)(1)-(4) -- Investigate/report Allegations/individuals**
- **F0226 -- S/S: L -- 483.12(b)(1)-(3), 483.95(c)(1)-(3) -- Develop/Implement Abuse/Neglect, Etc Policies**
- **F0323 -- S/S: L -- 483.25(d)(1)(2)(n)(1)-(3) -- Free of Accident Hazards/Supervision/Devices**
- **F0490 -- S/S: L -- 483.70 -- Effective Administration/resident Well-Being**
- **F0520 -- S/S: L -- 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) -- Qaa Committee-Members/meet Quarterly/plans**

Peter Smith, Administrator  
November 21, 2017  
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This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey. We are recommending to the CMS Regional Office that the following remedy(ies) be imposed:

- Civil money penalty
- Denial of Payment for New Admission effective **February 9, 2017**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 10, 2018**, 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

Your facility's noncompliance with the following:

- **F0225 -- S/S: L -- 483.12(a)(3)(4)(c)(1)-(4) -- Investigate/report Allegations/individuals;**
- **F0226 -- S/S: L -- 483.12(b)(1)-(3), 483.95(c)(1)-(3) -- Develop/implement Abuse/neglect, Etc Policies; F0323 -- S/S: L -- 483.25(d)(1)(2)(n)(1)-(3) -- Free Of Accident Hazards/supervision/devices**

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

- The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:
- Residents #1, 2, 3, 4, 5, 6, 7 and 8 as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

If you believe the 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.

Peter Smith, Administrator  
November 21, 2017  
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In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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 **December 22, 2017**. If your request for informal dispute resolution is received after **December 22, 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  
Enclosures

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

PRINTED: 01/08/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/09/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CALDWELL OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 CLEVELAND BOULEVARD</b> <b>CALDWELL, ID 83605</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>A Complaint survey was conducted at the facility on November 7, 2017 to November 9, 2017. Immediate Jeopardy was identified on November 8, 2017 at 42 CFR 483.12 [F225 and F226], 483.25(H) (1) and (2) [F323], 483.70 [F490], and 483.75(g) [F520].</p> <p>Immediate Jeopardy at F225, F226, F323, F490 and F520 was removed on November 9, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Teresa Kobza, RDN, LD, Team Coordinator Cecilia Stockdill, RN</p> <p>Definitions included:</p> <p>ADON = Acting Director of Nursing ALF = Assisted Living Facility CNA = Certified Nursing Assistant DC = discontinued DON = Director of Nursing ED = Executive Director GAD = Generalized Anxiety Disorder GDR = Gradual Dose Reduction LN = Licensed Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set mg = milligrams PRN = as needed RD = Registered Dietitian RN = Registered Nurse QAA = Quality Assessment and Assurance</p>	F 000			
F 166 SS=D	<p><b>RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</b></p> <p>CFR(s): 483.10(j)(2)-(4)</p>	F 166		1/4/18	

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

TITLE

(X6) DATE

Electronically Signed

12/22/2017

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 166	Continued From page 1  (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.  (j)(3) The facility must make information on how to file a grievance or complaint available to the resident.  (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:  (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;  (ii) Identifying a Grievance Official who is responsible for overseeing the grievance	F 166			

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F 166	<p>Continued From page 2</p> <p>process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;</p> <p>(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;</p> <p>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;</p> <p>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;</p> <p>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility</p>	F 166			

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F 166	<p>Continued From page 3</p> <p>or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and</p> <p>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident interview and review of the facility policies, it was determined the facility failed to ensure staff recognized and attempted to resolve resident grievances. This was true for 2 of 4 (#2 and #4) residents reviewed for grievances and had the potential for harm when the resident complaints entailed allegations of abuse that were not investigated. Findings include:</p> <p>The facility's Complaints/Grievances policy, dated 11/17/16, directed facility staff to:</p> <ul style="list-style-type: none"> <li>* Acknowledge and document complaints and grievances.</li> <li>* Notify the Executive Director (ED) of residents' grievances.</li> <li>* Investigate complaints and grievances.</li> <li>* Update residents and/or family/responsible parties on the status of grievances.</li> <li>* Discuss how to resolve complaints/grievances with family/responsible party.</li> </ul>	F 166	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>Resident Specific The Interdisciplinary (ID) team reviewed resident #2 and #4. The grievance log is updated with concerns and an incident report in completed related to intrusive wandering and verbal confrontations with resident #1. Reports were investigated and corrective action taken. Resident #2 and #4 have ongoing communication with Director of Nursing Services (DNS) and Executive Director (ED), and currently state these concerns have been resolved</p>		

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F 166	<p>Continued From page 4</p> <p>* Record the date and time complaints/grievances were resolved.</p> <p>* Ensure resolution of complaints/grievances was maintained.</p> <p>1. Resident #4 was admitted to the facility on 7/10/17 with diagnoses that included anxiety and difficulty walking.</p> <p>The 10/17/17 quarterly Minimum Data Set (MDS) assessment documented Resident #4 was cognitively intact.</p> <p>On 11/7/17 at 8:50 am, Resident #4 stated she had an altercation with Resident #1 on 11/3/17. Resident #4 reported the altercation to facility staff who, she said, had not followed up with her regarding the incident.</p> <p>2. Resident #2 was readmitted to the facility on 3/27/17 with diagnoses that included borderline personality disorder, dementia without behavioral disturbances, schizophrenia, and panic disorder.</p> <p>The quarterly MDS assessment, dated 10/6/17, documented Resident #2 was cognitively intact and exhibited no signs or symptoms of psychosis or delirium.</p> <p>An 11/4/17 Behavior Note documented Resident #2 was upset about another resident coming into her room. The Note documented Resident #2 informed social services and a nurse that she felt unsafe as a male resident (Resident #1) entered her room when she "was naked." The Note document Resident #2 looked at her and</p>	F 166	<p>by management and any new concerns have been addressed.</p> <p><b>Other Residents</b> The ID team interviewed other residents for unresolved grievances. Adjustments have been made as indicated.</p> <p>Residents have been re-educated on grievance process and how to make a grievance. Forms are displayed outside of each social services' office.</p> <p><b>Facility Systems</b> Staff are re-educated on the grievance process. Re-education was provided by the DNS and/or Staff Development Coordinator (SDC) to include but not limited to grievance process, investigation, allegation of abuse including verbal, communication and resident follow up. The system is amended to include review of residents' behavioral documentation to address potential verbal abuse in clinical meeting. Posting of grievance forms in a public location. Review of grievance log weekly in clinical meeting to validate current issues as included and addressed.</p> <p><b>Monitor</b> The ED and/or designee will conduct 4 resident interviews for potential grievances weekly for 4 weeks, then 4 residents twice monthly for 2 months starting the week of December 24th. Any grievances will have a grievance investigation completed and placed on</p>		

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F 166	<p>Continued From page 5</p> <p>repeated three times, "I'm not safe." The Note documented the nurse told Resident #2 that staff could not "stop" Resident #1 from walking the hallways, however, staff would be more diligent in attempting to keep him from entering other rooms.</p> <p>On 11/7/17 at 9:29 am, Resident #2 stated she did not feel safe in the facility because Resident #1 had entered her room where he saw her with her shirt off and threatened her. She stated she told a Registered Nurse (RN) about the incident, but no staff followed up with her about the incident. Resident #2 stated the RN told her that staff could not stop Resident #1 from walking the halls, however staff would try and prevent Resident #1 from entering other residents' rooms. Resident #2 stated staff did not believe her, were trying to discredit her, and that she did not believe staff would attempt to resolve the issue. Resident #2 stated she was "tired" of telling staff about her concerns when they did not believe her and the facility failed to take steps to resolve those concerns.</p> <p>The facility's grievance file did not contain any resident grievances from September and October 2017, or from 11/1/17 to 11/9/17.</p> <p>On 11/7/17 at 10:48 am, the facility's ED stated there were no grievances from September and October 2017, or from 11/1/17 to 11/9/17.</p> <p>On 11/8/17 at 9:40 AM, LSW #1 said a resident wandering into other residents' rooms should be investigated. LSW #1 stated the facility monitored verbal aggressive behaviors through behavior monitors, which should reflect escalation in</p>	F 166	<p>the grievance log. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 166	Continued From page 6 behaviors that would trigger an abuse investigation. LSW #1 said she was aware of Resident #1 calling other residents names, but did not know who the residents were. LSW #1 said she was aware of a "verbal altercation" involving Resident #1 and Resident #4 the previous week, and of another altercation between Resident #1 and Resident #2. LSW #1 could not explain the lack of investigation involving the "verbal altercation" between Resident #2 and Resident #1, or Resident #2's feelings of being "unsafe" as described in the resident's 11/4/17 Behavior Note. LSW #1 stated the ED told her which verbal incidents to investigate as abuse, LSW #1 said the facility needed to protect others, and that the facility was attempting various approaches, including adjusting Resident #1's medications, encouraging him to walk in a different direction, and stopping him before he entered other residents' room. LSW #1 said it was "hearsay" that Resident #1 wandered into other residents' rooms and that staff cannot stop a mobile resident from wandering. LSW #1 said she did not know how many resident rooms Resident #1 had entered or how many residents he had threatened. LSW #1 said residents who reside in the hall at the opposite end of the building from Resident #1 had been asked to "gently re-direct him" if he entered their room.	F 166			
F 174 SS=E	RIGHT TO TELEPHONE ACCESS WITH PRIVACY CFR(s): 483.10(g)(6)(7)(i)  (g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being	F 174		1/4/18	

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F 174	<p>Continued From page 7</p> <p>overheard. This includes the right to retain and use a cellular phone at the resident's own expense.</p> <p>(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to:</p> <p>(i) A telephone, including TTY and TDD services; This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review and interview, it was determined the facility failed to provide access to a telephone where residents could communicate in privacy. This was true for 1 of 4 residents (#2) reviewed for privacy who had to use the facility's telephone only while in the presence of a nurse. The deficient practice created the potential for harm when residents were unable to report ongoing abuse to someone outside the facility. Findings include:</p> <p>1. Resident #2 was readmitted to the facility on 3/27/17 with diagnoses that included borderline personality disorder, dementia, schizophrenia, and panic disorder.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 10/6/17, documented Resident #2 was cognitively intact and had no signs or symptoms of psychosis or delirium.</p> <p>A Behavior Monitor documented Resident #2 wanted to call police on 11/3/17 at 6:30 am about a male (Resident #1) being present on the hall where her room was located. Resident #2 was</p>	F 174	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>Resident Specific The ID team educated resident #2 on phone use policy. Guided resident #2 to address any discrepancies with social services. Facility phones are currently available and mobile to take to private locations. Application has been made for resident #2 to receive a personal free cell phone.</p> <p>Other Residents The ID team reviewed other residents for</p>		

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F 174	Continued From page 8 told she could make the phone call only in the presence of a nurse. Resident #2 then asked another resident to obtain the phone and a call was made to 9-1-1.  On 11/7/17 at 3:39 pm, Licensed Nurse (LN) #1 stated the facility phone could be used for 10 minutes at a time. LN #1 stated residents who used the facility phone could not use it again for 2 hours if other residents were waiting to also use the phone. LN #1 stated some residents were required to wait for 2 hours between calls when others were not waiting for the phone because of repeated calls to family and/or friends, who requested the facility limit their access to the facility phone.  On 11/8/17 at 11:00 am, the Acting Director of Nursing (ADON) stated residents had the right to take a phone to their room for privacy. The ADON stated police would notify the facility when a resident called police. The ADON stated residents' use of the facility phone was limited to 15 minutes per call because the facility had only two resident phones and more than 60 residents.	F 174	possible phone restriction, no widespread issues identified. All residents re-educated on rights to use phone. Adjustments have been made as indicated.  Facility Systems Staff are educated on phone use policy. Re-education was provided by SDC and/or designee to include but not limited to use of phone in private, how to manage when other residents are on the phone, other options for phone use. The system is amended to include assistance with an application for residents who choose to receive a personal phone at no cost. Utilization of alternate phones at the facility.  Monitor Social Services and/or designee will conduct 3 resident interviews regarding timely access to phone weekly for 4 weeks, then twice monthly for two months. Starting the week of December 24th, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 225 SS=L	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4)  483.12(a) The facility must-	F 225		1/4/18	

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F 225	<p>Continued From page 9</p> <p>(3) Not employ or otherwise engage individuals who-</p> <p>(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;</p> <p>(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</p> <p>(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.</p> <p>(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.</p> <p>(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>(1) Ensure that all alleged violations involving 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</p>	F 225			

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F 225	<p>Continued From page 10</p> <p>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.</p> <p>(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>(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 observation, resident and staff interview, and review of clinical records and Incident and Accident Reports, it was determined the facility failed to:</p> <ul style="list-style-type: none"> <li>* Ensure allegations of verbal abuse reported by residents and/or staff were thoroughly investigated.</li> <li>* Ensure staff recognized certain resident complaints as allegations of verbal, mental, or sexual abuse.</li> <li>* Ensure allegations of verbal abuse were reported to the facility's abuse coordinator and thoroughly investigated.</li> <li>* Ensure the facility's administrator/abuse coordinator was notified of potential verbal abuse</li> </ul>	F 225	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care of Cascadia and its Executive Director does not admit that the deficiencies listed on the CMS Form-2567 exist or that the staff quotations listed are accurate and/or in context. Nor does the Facility admit to any statements, findings, facts, or conclusions that for the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts, and conclusions that form the basis for the deficiency.</p>		

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F 225	<p>Continued From page 11 incidents in a timely manner.</p> <p>* Ensure all residents were protected from verbal abuse and/or threats of physical abuse.</p> <p>* Consistently provide abuse and neglect training to staff.</p> <p>This was true for 4 of 4 sample residents (#s 1-4), 4 of 4 random residents (#s 5-8), and had the potential to affect all 60 residents in the facility. Specifically:</p> <p>a) Resident #1 was exposed to the potential for harm by other residents whose rooms he intrusively wandered into on numerous occasions.</p> <p>b) Resident #4 sustained psychosocial harm when Resident #1 verbally assaulted her and raised his hand in a physical threat to strike her.</p> <p>c) Resident #2 sustained psychosocial harm from multiple instances in which Resident #1 verbally abused her and wandered into her room while Resident #2 was in a state of partial undress.</p> <p>d) Residents #3 and Resident #s 5 - 8 experienced occasions of verbal abuse from Resident #1 or witnessed Resident #1 verbally abusing other residents.</p> <p>This deficient practice placed Residents #'s 1 - 8 in immediate jeopardy of serious harm, injury, or death and had the potential to adversely affect the remaining 52 residents in the facility due to the facility's failure to recognize, prevent, protect, and report potential incidents of abuse and/or neglect. Findings include:</p>	F 225	<p>Resident Specific</p> <p>The ID team reviewed resident's #1-8:</p> <ul style="list-style-type: none"> <li>• Resident #1: Was given 1:1 supervision to assist in redirecting him before he infringes on other resident's privacy and/or safety. Care plan is updated as indicated.</li> <li>• Resident #2, #4: Filed allegation of abuse to State Agency and investigation completed. Resident #1 on 1:1 supervision.</li> <li>• Resident #3: Reported allegation of abuse to State Agency and investigation completed, no adverse psychosocial outcomes.</li> <li>• Resident #5-8: Upon interview state that they do not feel threatened and have no further concerns with wandering residents.</li> </ul> <p>Other Residents</p> <p>The ID team reviewed other interviewable residents to determine if there were any unidentified allegations of abuse. One additional allegation was reported to the State Agency, investigation completed.</p> <p>Facility Systems</p> <p>Staff are re-educated on facility's abuse/neglect policy. Re-education was provided by SDC and/or designee to include but not limited to identification of types of abuse to include verbal, identification of the abuse coordinator, process for notification of suspected or known abuse, investigation process and notification of state agency. Employee files were reviewed for documentation of</p>		

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F 225	<p>Continued From page 12</p> <p>The facility's abuse prevention policy and procedure, release date 10/31/17, documented the facility was responsible for identifying residents most at risk of neglect and abuse, including those with dementia; psychosocial/interactive disorders; verbally and/or physically aggressive behavior; and those who wander into other residents personal rooms/space. The policy and procedure required the facility to assess, care plan, and monitor these residents whose "needs and behaviors ... might lead to conflict or neglect."</p> <p>1. Resident #1 was admitted to the facility on 9/20/17 with diagnoses that included major depressive disorder with psychotic features and Alzheimer's disease.</p> <p>Resident #1's 9/27/17 admission MDS (Minimum Data Set) assessment documented severe cognitive impairment, delusions, and physical behaviors.</p> <p>The Behavior Care Plan, initiated 9/22/17, documented Resident #1 would "punch and hit unexpectedly" and was "verbally abusive to staff." The care plan directed staff to approach Resident #1 "carefully and from the side," contact a specific family member, provide "a 5 min[ute] time out" and re-approach when the resident was "agitated," explain themselves before attempting an interaction, and "remove other residents from area if [he] is out of control." Other areas of the care plan directed staff to remove Resident #1 from the room before getting his roommates out of bed, administer psychotropic medications as ordered, talk about his former employment, decrease stimulation, consider relocating the</p>	F 225	<p>training regarding prohibition and prevention of forms of abuse. Training was provided to any employee that did not have documentation of current training. Education provided to facility leadership team by Director of Clinical Operations to include abuse &amp; neglect prevention, identification and reporting. The system is amended to include review of behavioral documentation in clinical meeting, and interview of staff to validate understanding of abuse/neglect policy.</p> <p>Monitor The ED and/or designee will conduct 4 resident interviews weekly for potential abuse or witnessed abuse weekly for 4 weeks, then 4 residents twice monthly for 2 months. The SDC and/or designee will conduct 4 staff interviews to validate staff awareness and understanding for reporting potential abuse and neglect weekly for 4 weeks, then 4 staff twice monthly for 2 months. Starting the week of December 24th, 2017, the reviews will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 225	<p>Continued From page 13</p> <p>resident from a room with 3 roommates to a room with only 1 roommate, and remove the resident to a "calm safe environment" where he could "vent/share feelings" when a conflict arose.</p> <p>Physician Orders for 9/20/17 through 11/20/17 documented staff were to monitor the number of the following behaviors each shift: Delusions, resistance to cares, frequent mood changes, verbal aggression, and frequent wandering into other residents' rooms or areas.</p> <p>Resident #1's 9/20/17 Admission Note documented he arrived at the facility at 2:20 pm from a hospital after striking an employee and another resident at his previous assisted living facility (ALF) residence. The Note documented Resident #1 did not remember the incident.</p> <p>A 9/22/17 Post Fall Assessment documented at 6:20 am that Resident #1 was sitting on his bed as 2 CNAs were assisting his roommates from bed. Resident #1 suddenly stood up, grabbed the Hoyer lift, and punched one CNA in the face when she tried to get him to release his grip on the Hoyer lift. Resident #1 tried to "ram" the CNA with the Hoyer lift, lost his balance and fell onto the floor, striking his head. Resident #1, who was assessed with a large bump and abrasion to the forehead, denied falling or hitting the CNA and refused vital signs, treatment, or neurological checks. A 9/25/17 Investigation Interview regarding the 9/22/17 incident confirmed the Post Fall Assessment findings.</p> <p>A 9/25/17 Health Status Note documented Resident #1's order for physical therapy was discontinued due to the resident's violent</p>	F 225			

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F 225	<p>Continued From page 14 behavior.</p> <p>A 10/4/17 Behavior Note documented at 3:00 am that Resident #1 was "hitting and grabbing any item he can grab in his hands and swinging the item, slamming doors, disrupting other residents' sleep," and that he pushed a wheelchair into a staff member's knee. Resident #1's physician was contacted by phone and a medication order was requested to "help the resident calm down so he won't be a danger to himself or others."</p> <p>A 10/17/17, Behavior Note documented at 1:04 pm that Resident #1 became angry at breakfast, where he shouted at a tablemate, calling the tablemate a "fat f***," and threatened the tablemate by saying, "I'll come over there and kill you, you fat pig." The Behavior Note also documented Resident #1 was "peeking into [other residents'] bedrooms but rarely putting a foot inside the bedrooms."</p> <p>A 10/18/17 Behavior Note documented at 1:50 am that Resident #1 was restless, aggressive towards staff, pacing and walking in the hallway for nearly 4 hours, and attempted to enter other residents' rooms multiple times.</p> <p>An 11/2/17 Behavior Note documented at 2:47 pm that Resident #1 was walking "every waking moment" and opened a female resident's door multiple times without knocking. When a staff member attempted to re-direct Resident #1, he stated, "I own this building and I'll go anywhere I damn well please." At 3:56 pm, staff documented Resident #1 was "very verbally aggressive towards residents and staff," yelling and threatening to harm other residents and staff, and</p>	F 225			

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F 225	<p>Continued From page 15</p> <p>calling others in inappropriate names. At 9:20 pm, staff documented Resident #1 continued to wander and exhibit aggressive behavior.</p> <p>Behavior/Antidepressant Monitor Flowsheets for October and November 2017 documented the following:</p> <ul style="list-style-type: none"> <li>* Resident #1 exhibited delusions on multiple dates and times in October and November.</li> <li>* Resident #1 exhibited physical aggression at night on multiple dates and shifts in October.</li> <li>* Resident #1 exhibited verbal aggression towards others on multiple dates during night shift in November.</li> <li>* Resident #1 wandered into others' rooms on multiple dates and times during November.</li> </ul> <p>Behavior Monitoring Flowsheets documented the following:</p> <ul style="list-style-type: none"> <li>* 10/23/17 - Resident #1 attempted to enter other residents' rooms, went to the other side of the building, called other residents names, and became angry when staff attempted to redirect him.</li> <li>* 10/24/17 and 10/25/17 - Resident #1 attempted to enter other residents' rooms and became aggressive when redirected by staff.</li> <li>* 11/2/17 - Resident #1 was verbally aggressive towards other residents and staff, wandered into other residents' rooms, woke residents by telling them to leave their own rooms, and screamed</li> </ul>	F 225			

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F 225	<p>Continued From page 16</p> <p>when he was asked to leave. Resident #1 was described as "wanting to hit and threaten[ed] to kill residents on [the] other side!"</p> <p>*On 11/3/17, Resident #1 was "continuously" entering other residents' rooms and started yelling when CNAs redirected him.</p> <p>On 11/7/17 at 1:40 pm, Resident #1 was observed walking up and down the hall at the opposite end of the building from his room. Resident #1 entered another resident's room for approximately one and one-half minutes. No other residents were in the room at the time. A male staff member entered the room and redirected the resident back into the hall. Resident #1 briefly entered another resident's room approximately two minutes later and exited the room on his own accord.</p> <p>On 11/7/17 at 2:13 pm, Resident #1 was observed entering another resident's room, where a CNA directed him to exit the room.</p> <p>2. Resident #2 was readmitted to the facility on 3/27/17 with diagnoses that included borderline personality disorder, dementia without behavioral disturbances, schizophrenia, and panic disorder.</p> <p>The quarterly MDS assessment, dated 10/6/17, documented Resident #2 was cognitively intact and exhibited no signs or symptoms of psychosis or delirium.</p> <p>A 10/9/17 Social Services Progress Note documented Resident #2 exhibited increased behaviors and was recently verbally aggressive and argumentative.</p>	F 225			

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F 225	<p>Continued From page 17</p> <p>A 10/10/17 Incident Note documented Resident #2 had a "verbal altercation" with another resident and accused the other resident of stealing her food.</p> <p>An 11/3/17 Health Status Note documented Resident #2 was awake most of that night and upset about another resident.</p> <p>An 11/4/17 Behavior Note documented Resident #2 was upset about another resident (Resident #1) coming into her room. The Note documented Resident #2 informed social services and a nurse that she felt unsafe as Resident #1 entered her room when she "was naked." The Note document Resident #2 looked at her side and repeated three times, "I'm not safe;" the nurse told Resident #2 that staff could not "stop" Resident #1 from walking the hallways, but would be more diligent in attempting to keep him from entering others' rooms.</p> <p>The facility did not provide evidence of an investigation for the 11/4/17 incident.</p> <p>On 11/7/17 at 9:29 am, Resident #2 stated she did not feel safe in the facility because Resident #1 saw her with her shirt off and threatened her. Resident #2 stated she told Licensed Nurse (LN) #2 and Licensed Social Worker (LSW) #1 about the incident, but they did not believe her or follow up on her report. Resident #2 stated she had become increasingly frustrated in the previous few weeks and lashed out at others because staff did not take her concerns seriously. Resident #2 stated LN #2 told her staff could not stop Resident #1 from walking the halls, but would try</p>	F 225			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/09/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CALDWELL OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 CLEVELAND BOULEVARD CALDWELL, ID 83605</b>		
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F 225	<p>Continued From page 18</p> <p>and make sure he did not enter other residents' rooms.</p> <p>On 11/7/17 at 9:35 am, Resident #2 stated she began feeling unsafe at the facility a few weeks prior when Resident #1, while walking the halls, "clicked" his walker and knocked on walls, doors and hand rails. Resident #2 stated Resident #1 walked into her room one day, peered around her privacy curtain, and stared at her. Resident #2 stated she told a CNA about the incident and that she was fearful of Resident #1, but the facility failed to respond to her fear. On another occasion, Resident #2 stated she was changing her shirt with her back to the door when she reached for her night shirt and Resident #1 was standing next to her bed. Resident #2 stated she realized Resident #1 was in the room only when she reached for her shirt her hand brushed his walker. Resident #2 stated she was startled by his presence, and Resident #1 asked her if he could share a room with her. Resident #2 stated she asked him nicely to leave twice, but he would not leave. Resident #2 stated Resident #1 was staring at the "top-half" of her body in a manner that made her feel she was visually "raped." Resident #2 stated after asking nicely twice, she yelled, "You don't belong here! Get out! Get out," to which Resident #1 responded by yelling, "You f***ing bitch! I'll take you to hell!" Resident #2 stated she told a nurse about the incident, but no resolution had yet been reached. Resident #2 stated Resident #1 entered her room on another occasion since then, hit his walker against the end of her bed, and stared at her with a "menacing look." Resident #2 stated she did not want to leave her room because she feared possible negative interactions with Resident #1</p>	F 225			

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F 225	<p>Continued From page 19</p> <p>and that she did not feel safe in her room either because she was fearful of him walking in. Resident #2 stated she now kept her door closed to prevent Resident #1 from returning. Resident #2 stated she was aware that Resident #1 wandered into other residents' rooms on the hall and threatened them as well.</p> <p>On 11/7/17 at 9:12 am, Resident #3 stated she was in her room the previous week when she heard Resident #2 arguing with Resident #1, in Resident #2's room. Resident #3 stated she heard Resident #1 calling Resident #2 a "f***ing bitch." Resident #3 stated she left her room, went to Resident #2's room next door, and told Resident #1 to leave.</p> <p>3. Resident #4 was admitted to the facility on 7/10/17 with diagnoses that included generalized anxiety and difficulty walking.</p> <p>The 10/17/17 quarterly MDS assessment documented Resident #4 was cognitively intact.</p> <p>On 11/7/17 at 8:50 am, Resident #4 said that she was waiting for medications at the medication cart on or about the afternoon of 11/3/17 while Resident #1 walked up and down the hallway nearby. She stated Resident #1 suddenly lunged at the nurse. When Resident #4 yelled at Resident #1 to stop, she said, Resident #1 turned toward Resident #4 and said, "I will knock your block off, you f***ing b*tch" and raised his fist as if to hit her. The nurse placed herself between Resident #1 and Resident #4 to prevent a physical altercation. Resident #4 stated the nurse spoke to the Executive Director (ED) about the incident, however no staff member followed up</p>	F 225			

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F 225	<p>Continued From page 20 with her regarding the incident.</p> <p>On 11/7/17 at 2:20 pm, LN #1 stated she recalled the 11/3/17 incident. LN #1 stated Resident #1 yelled and raised his fist as if to strike Resident #4 and she intervened by getting between them to prevent a "physical altercation." LN #1 stated she would not call it an "actual altercation" because Resident #1 did not make physical contact with Resident #4. LN #1 stated if Resident #1 had struck Resident #4 she would have called "the event" an altercation and initiated an investigation into the matter. LN #1 stated the process to investigating a resident to resident altercation consisted of separating residents and explaining to residents that their actions were not appropriate and brainstorming a better way to handle the situation. LN #1 stated she would report the event to the nurse manager and the social worker. LN #1 stated the social worker would chart the incident in the residents' medical record.</p> <p>On 11/7/17 at 2:50 pm, CNA #1 said during the incident on 11/3/17, Resident #1 raised his arm to Resident #4, then the LN stepped in and got Resident #1 to move away from Resident #4. CNA #1 stated if an incident of resident to resident altercations occurred they were reported to the nurse manger and the social worker.</p> <p>4. Additional Resident Reports:</p> <p>a) Resident #3 was admitted to the facility on 7/22/14 with diagnoses which included alcohol dependence with alcohol induced persisting dementia.</p>	F 225			

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F 225	<p>Continued From page 21</p> <p>On 11/7/17 at 1:43 pm, Resident #3 stated Resident #1 wandered down the hall often and he would "click" his walker and knock loudly on the walls and doors. Resident #3 stated a few weeks ago Resident #1 "banged" his walker into her door and came into her room. Resident #3 stated Resident #1 raised his voice to her, pointed his finger at her, and told her to, "stay in her room," and, "do not come out." Resident #3 stated she did not stay in her room and as soon as he left she went and told a CNA. She could not remember the exact date this occurred or the name of the CNA she told.</p> <p>Resident #3's clinical record did not contain documentation of the incident.</p> <p>b) Resident #5 was admitted to the facility on 2/23/17 with diagnoses which included anxiety and bipolar disorder.</p> <p>On 11/7/17 at 2:05 pm, Resident #5 stated Resident #1 wandered down the hall often "clicking" his walker and knocking on doors and walls while he walks. Resident #5 stated Resident #1 recently entered his room. Resident #5 stated he "yelled at him to get out." He stated he did not give Resident #1 the option to talk back to him and Resident #5 stated he currently was not threatened by him, however, Resident #5 stated Resident #1 "could be dangerous." Resident #5 stated he had seen Resident #1 being "defiant" with staff and other residents, for example, when someone asked him to stop doing something Resident #1 told them "no, he would do what he wanted to do."</p>	F 225			

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F 225	<p>Continued From page 22</p> <p>c) Resident #6 was readmitted to the facility on 9/13/17 with diagnoses which included bipolar disorder.</p> <p>On 11/7/17 at 1:50 pm, Resident #6 stated there were two residents who wandered into his room. Resident #6 stated one of them was Resident #1. Resident #6 said Resident #1 would argue with him about Resident #6's room being Resident #1's room. In addition, Resident #6 stated he was watching television in his room the previous week with his door closed when he heard the loud voices of a man and woman yelling at each other. Resident #6 stated he did not remember what was said but stated he heard explicit language being used.</p> <p>d) Resident #7 was readmitted to the facility on 7/1/16 with diagnoses which included depression.</p> <p>On 11/7/17 at 1:59 pm, Resident #7 stated Resident #1 wandered down the hall "clicking" and knocking frequently. Resident #7 stated Resident #1 had wandered into his room twice while he was present in the room. Resident #7 stated on one of these occasions, Resident #1 threatened to "kick my ass, and kick me in the balls." Resident #7 stated LN #3 was present in the hall when Resident #1 threatened him and Resident #7 asked LN #3 if s/he heard what Resident #1 had said to him. Resident #7 stated LN #3 stated s/he had heard the remarks Resident #1 made towards Resident #7.</p> <p>Resident #7's clinical record did not contain documentation of the incident.</p>	F 225			

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F 225	<p>Continued From page 23</p> <p>e) Resident #8 was admitted to the facility on 8/4/11 with diagnoses which included depression, schizophrenia, and dementia.</p> <p>On 11/7/17 at 2:01 pm, Resident #8 stated Resident #1 entered his room and took his walker a few weeks ago. Resident #8 stated he was without his walker for a period of time before being given his walker back later that day. Resident #8 stated Resident #1 had wandered into his room on other occasions as well.</p> <p>Resident #8's clinical record did not contain documentation of the incident.</p> <p>The facility did not provide evidence of an investigation regarding the allegations of verbal abuse involving Resident #1 and other residents.</p> <p>5. Facility Leadership Interviews:</p> <p>On 11/8/17 at 9:13 am, LSW #2 stated calling someone a "f***ing b*tch" would be "verbal abuse," but she was not aware of any residents doing that. LSW #2 said she was not aware of any incidents of verbal abuse being investigated involving Resident #1 and any of the identified residents above. LSW #2 said she was aware that Resident #1 had wandered into a female resident's room, however, she was not aware that an incident of verbal abuse occurred between the two residents. LSW #2 was not aware that Resident #1 called two other residents "f***ing bitches." LSW #2 said she was not sure if the facility was aware of Resident #1's history of aggressive behavior prior to his admission. LSW #2 said she was aware of the altercation involving Resident #1, and the CNA using the</p>	F 225			

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F 225	<p>Continued From page 24</p> <p>mechanical lift after Resident #1's admission, but she was not aware the resident hit the CNA in the face. LSW #2 said if an altercation occurred between two residents, ideally it would be documented in each residents' chart. LSW #2 said in order to determine if abuse occurred it would be discussed with the ED, acting Director of Nursing (ADON), the nurse, and LSW #1. LSW #2 she did not know what happened in the incidents above and why she was not notified.</p> <p>On 11/8/17 at 9:40 am, LSW #1 stated:</p> <ul style="list-style-type: none"> <li>* If a resident exhibited "verbal aggression" such as name calling or swearing, it was not always thought of as "verbal abuse."</li> <li>* If a resident called another resident a "f***ing b*tch" it would be considered "verbal aggression" because, "with dementia they don't always know what they're saying."</li> <li>* The facility monitored "verbally aggressive" behaviors through resident behavior monitors, and if the monitor showed an escalation in behaviors that would trigger an investigation.</li> <li>* If a resident wandered into another resident's room, it should be investigated.</li> <li>* The ED told LSW #1 which "verbal incidents" needed to be investigated.</li> </ul> <p>During the same interview LSW #1 stated, regarding Resident #1 and #2 specifically:</p> <ul style="list-style-type: none"> <li>* She was aware of Resident #1 calling other residents names, but was not sure which residents.</li> <li>* She was aware of a "verbal altercation" involving Resident #1 and Resident #2 the previous week.</li> </ul>	F 225			

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F 225	<p>Continued From page 25</p> <ul style="list-style-type: none"> <li>* She was present when Resident #2 reported the "altercation," and that the "altercation" made her feel "unsafe."</li> <li>* The "altercation" had not been investigated.</li> <li>* Reports of Resident #1's wandering were "hearsay."</li> <li>* The facility needed to protect other residents from Resident #1, and had implemented measures including adjusting the resident's medications, attempting to get him to walk in another direction, and stopping him before he entered other resident's rooms.</li> <li>* The facility could not stop a mobile resident, such as Resident #1, from wandering.</li> <li>* Other residents in the facility had been educated to "gently redirect" Resident #1 if he wandered into their rooms.</li> <li>* She did not know how many resident rooms Resident #1 had entered, how long he had remained in the rooms, whether other residents were in the rooms when he entered, or how frequently this behavior occurred.</li> <li>* Without an investigation into the allegations of verbal abuse regarding Resident #1, it was not possible to rule out physical, mental, or sexual abuse, given the nature of the allegations.</li> </ul> <p>On 11/8/17 at 10:10 am, the ADON said they would consider a resident calling another resident a "f***ing b*tch" verbal abuse, but she was not aware of this happening in the facility. The ADON stated the facility did not investigate allegations of verbal abuse. The ADON stated if verbal abuse occurred it was facility practice to separate the residents and speak with them about the incident.</p> <p>On 11/8/17 at 10:19 am, the ED said he was</p>	F 225			

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F 225	<p>Continued From page 26</p> <p>aware of Resident #4 yelling at Resident #1 when she approached him "aggressively and unsolicited" on 11/3/17, and said Resident #4 did not like Resident #1. The ED stated he was not aware of the other incidents involving Resident #1, and would have to look to see if any investigations had been completed. The ED stated one resident calling another a "f***ing b*tch" would be verbal abuse, but the facility did not investigate all allegations of verbal abuse.</p> <p>On 11/9/17 at 12:40 pm, the Medical Director stated he doubted the facility called him on all verbal abuse incidents, but he hoped if the verbal abuse was "really bad" that the staff would notify him so medications could be adjusted or added, and closer observation could be ordered.</p> <p>6. Notification and Removal of Immediate Jeopardy</p> <p>The facility was notified verbally and in writing on 11/8/17 at 4:52 pm of the Immediate Jeopardy.</p> <p>On 11/9/17 at 12:00 pm, the facility provided an acceptable plan to remove the Immediate Jeopardy. The plan included:</p> <ul style="list-style-type: none"> <li>* Newly identified allegations of abuse, including verbal abuse, were reported to the State agency.</li> <li>* Providing 1:1 staff to Resident #1 to ensure the safety of other residents, and to protect him from residents who may respond to his intrusiveness or aggression.</li> <li>* Speaking with all interviewable residents to rule out further unrecognized allegations of abuse.</li> </ul>	F 225			

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F 226 SS=L	<p>* Providing education to the facility's leadership team and facility staff regarding abuse and neglect prevention, identification and reporting.</p> <p>Implementation of the above actions was verified on-site and the facility informed on 11/9/17 at 5:00 pm, that the immediate jeopardy was removed.</p> <p><b>DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</b> CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3)</p> <p><b>483.12</b> (b) The facility must develop and implement written policies and procedures that:</p> <p>(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>(2) Establish policies and procedures to investigate any such allegations, and</p> <p>(3) Include training as required at paragraph §483.95,</p> <p><b>483.95</b> (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-</p> <p>(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.</p>	F 226		1/4/18	

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F 226	<p>Continued From page 28</p> <p>(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property</p> <p>(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure:</p> <ul style="list-style-type: none"> <li>* Allegations of verbal abuse were investigated by the facility's leadership team and reported to the State Agency.</li> <li>* Facility Abuse policies and procedures on abuse training, prevention, recognition, protection, reporting, and investigation were operationalized.</li> </ul> <p>This deficient practice placed 4 of 4 sample residents (#s 1-4) and 4 of 4 random residents (#s 5-8) in Immediate Jeopardy of serious harm, injury, or death and had the potential to impact the remaining 52 residents in the facility due to the facility's failure to ensure all staff were trained on abuse and neglect; recognize a resident's history of past abuse as an indicator of future abusive behavior; identify the resident was abusing others and was at risk of being abused himself; recognize resident reports of abuse; protect residents from further abuse, report allegations of abuse; and investigate all allegations of abuse. Findings include:</p> <p>1. The facility's Detecting Abuse, Neglect, Misappropriation, and Injuries of Unknown Origin Policy and Procedure, revised 10/31/17, directed facility staff to do the following: 1) Identify events</p>	F 226	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>Resident Specific See F225 for Residents #1-8.</p> <p>Other Residents See F225 for Residents #1-8.</p> <p>Facility Systems Staff were re-educated on facility's operationalizing of abuse/neglect policy. Re-education was provided by SDC and/or designee to include but not limited to abuse policies and procedures for training of staff, types of abuse to include verbal, prevention and recognition of abuse to include intrusive wandering, protection of residents, and reporting of</p>		

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F 226	<p>Continued From page 29</p> <p>and occurrences that may involve abuse and neglect 2) Investigate allegations of abuse including physical, sexual, verbal, neglect, involuntary seclusion, corporal punishment, unusual occurrences, misappropriation, exploitation, and injuries of unknown origin 3) Report mistreatment, neglect, or abuse 4) Respond to allegations of abuse, and 5) Document the allegations. Specifically:</p> <p>* Identification - The policy documented grievances; complaints; allegations of abuse, neglect, injuries of unknown origin, and misappropriation of resident property; or any other evidence of physical, verbal, sexual, or psychological abuse should be reviewed and immediately reported to the Executive Director (ED), Director of Nursing (DON) and/or Social Services. Any affected resident should be assessed for signs of "negative psychosocial impact" from the event.</p> <p>*Protection: The facility should immediately increase supervision for the victim and other residents as indicated, with staffing and room changes as necessary. The victim should be provided emotional support and counseling during and after the investigation.</p> <p>* Investigation - An investigation into any allegation of abuse included observations and interviews with the person/s involved to determine the specifics of the allegation. Interviews should include residents, staff, and any other potential witnesses.</p> <p>* Reporting - Staff should immediately report any alleged mistreatment, neglect, or abuse to a</p>	F 226	<p>an allegation.</p> <p>Education provided to facility leadership team by Director of Clinical Operations to include how to operationalize policy for abuse &amp; neglect prevention, identification and reporting. The system is amended to include review of behavioral documentation in clinical meeting, as well as to interview staff to validate understanding of abuse/neglect policy. Additionally, SDC will validate new hires receive training and are able to verbalize understand of the abuse/neglect policy.</p> <p>Monitor SDC and/or designee will review staff training records to validate new hires and current staff have abuse/neglect current training and at least annually. Reviews will occur monthly for 3 months starting December 2017 and documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 226	<p>Continued From page 30</p> <p>senior clinician or leader, and other officials are notified in accordance with state regulations and within designated timeframes. If the reportable event did not involve serious bodily injury, it was reported to the State Agency no later than 24 hours after the allegation. The affected resident's family should be contacted and given a report regarding care of the resident's distress or injury.</p> <p>* Responding - The facility should analyze the results of the investigation to determine why the abuse occurred and if changes are needed to prevent recurrence. Staff members should be trained and demonstrate competency regarding response to abuse allegations. All allegations of abuse should be reported immediately to the ED and to other officials, including the State agency and adult protective services, no later than 2 hours after the allegation has been made if serious bodily injury is involved, and no more than 24 hours if no abuse and no serious bodily injury is involved.</p> <p>* Documentation - Staff were to document the affected resident's physical and psychosocial status, action taken by clinical staff, notification of the physician and new orders received, and notification of the family in the resident's clinical record.</p> <p>2. Resident #1 was admitted to the facility on 9/20/17 with diagnoses which included major depression with psychotic features and Alzheimer's disease, with a known history of physical and verbal aggression. Resident #1's Health Status Notes, Behavior Notes, and Post Fall Assessment Notes between 9/20/17 and 11/7/17 documented Resident #1 displayed</p>	F 226			

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F 226	<p>Continued From page 31</p> <p>physical and verbal aggression in the facility towards staff and other residents, as well as intrusive wandering. Between 11/7/17 and 11/9/17, Resident #s 2-8 stated they had experienced and/or witnessed Resident #1's physical and verbal aggression, and had reported those events to staff. Resident #s 2-8 all stated the facility had not responded to their reports.</p> <p>The facility had no documentation of grievances or of abuse allegations for September or October 2017, or between 11/1/17 and 11/9/17. The facility had no documentation the State agency or other entities were notified of allegations of verbal abuse.</p> <p>On 11/7/17 at 10:48 am, the Administrator confirmed the facility had not documented any allegations of abuse since 6/28/17, grievances in September or October 2017, or between 11/1/17 and 11/9/17.</p> <p>On 11/7/17 at 2:20 pm, LN #1 stated if a resident struck another resident she would call "the event" an altercation and initiated an investigation into the matter. LN #1 stated if she intervened before physical contact she would not consider it an incident to investigate. LN #1 stated the process to investigating a resident to resident altercation consisted of separating residents and explaining to residents that their actions were not appropriate and brainstorming a better way to handle the situation. LN #1 stated she would report the event to the nurse manager and the social worker. LN #1 stated the social worker would chart the incident in the residents' medical record.</p>	F 226			

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F 226	<p>Continued From page 32</p> <p>On 11/7/17 at 2:50 pm, CNA #1 stated if an incident of resident to resident altercations occurred they were reported to the nurse manger and the social worker.</p> <p>On 11/8/17 at 9:13 am, LSW #2 stated calling someone a "f***ing b*tch" would be "verbal abuse," but she was not aware of any residents doing that. LSW #2 said she was not aware of any incidents of verbal abuse being investigated involving Resident #1 and any of the identified residents above. LSW #2 said she was aware that Resident #1 had wandered into a female resident's room, however, she was not aware that an incident of verbal abuse occurred between the two residents. LSW #2 was not aware that Resident #1 called two other residents "f***ing bitches." LSW #2 said she was not sure if the facility was aware of Resident #1's history of aggressive behavior prior to his admission. LSW #2 said she was aware of the altercation involving Resident #1, and the CNA using the mechanical lift after Resident #1's admission, but she was not aware the resident hit the CNA in the face. LSW #2 said if an altercation occurred between two residents, ideally it would be documented in each residents' chart. LSW #2 said in order to determine if abuse occurred it would be discussed with the ED, acting Director of Nursing (ADON), the nurse, and LSW #1. LSW #2 she did not know what happened in the incidents above and why she was not notified. LSW #2 stated if she witnessed an abuse incident she would intervene right then and there and would not always document it. She stated if an abusive incident was reported to her she would investigate the incident and document it on an abuse investigation form.</p>	F 226			

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F 226	<p>Continued From page 33</p> <p>On 11/8/17 at 9:40 am, LSW #1 stated:</p> <ul style="list-style-type: none"> <li>* If a resident exhibited "verbal aggression" such as name calling or swearing, it was not always thought of as "verbal abuse."</li> <li>* If a resident called another resident a "f***ing b*tch" it would be considered "verbal aggression" because, "with dementia they don't always know what they're saying."</li> <li>* The facility monitored "verbally aggressive" behaviors through resident behavior monitors, and if the monitor showed an escalation in behaviors that would trigger an investigation.</li> <li>* If a resident wandered into another resident's room, it should be investigated.</li> <li>* The ED told LSW #1 which "verbal incidents" needed to be investigated.</li> </ul> <p>During the same interview LSW #1 stated, regarding Resident #1 and #2 specifically:</p> <ul style="list-style-type: none"> <li>* She was aware of Resident #1 calling other residents names, but was not sure which residents.</li> <li>* She was aware of a "verbal altercation" involving Resident #1 and Resident #2 the previous week.</li> <li>* She was present when Resident #2 reported the "altercation," and that the "altercation" made her feel "unsafe."</li> <li>* The "altercation" had not been investigated.</li> <li>* Reports of Resident #1's wandering were "hearsay."</li> <li>* The facility needed to protect other residents from Resident #1, and had implemented measures including adjusting the resident's medications, attempting to get him to walk in</li> </ul>	F 226			

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F 226	<p>Continued From page 34</p> <p>another direction, and stopping him before he entered other resident's rooms.</p> <p>* The facility could not stop a mobile resident, such as Resident #1, from wandering.</p> <p>* Other residents in the facility had been educated to "gently redirect" Resident #1 if he wandered into their rooms.</p> <p>* She did not know how many resident rooms Resident #1 had entered, how long he had remained in the rooms, whether other residents were in the rooms when he entered, or how frequently this behavior occurred.</p> <p>* Without an investigation into the allegations of verbal abuse regarding Resident #1, it was not possible to rule out physical, mental, or sexual abuse, given the nature of the allegations.</p> <p>On 11/8/17 at 12:23 pm, the ADON (Acting Director Of Nursing) said "perhaps" incidents of verbal abuse were not reported because the "policy does not say we need to." The ADON said it sounded like verbal abuse, "Has been happening but it was not documented."</p> <p>On 11/8/17 at 12:39 pm, the Administrator said it was clear "we need to be a little deeper" in recognizing and reporting verbal abuse. The Administrator stated it was not facility protocol to investigate verbal abuse allegations.</p> <p>3. Abuse Training</p> <p>The facility's abuse prevention policy, release date 10/31/17, documented in-service training would be provided to new and existing staff regarding prohibition and preventing all forms of abuse.</p>	F 226			

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F 226	<p>Continued From page 35</p> <p>CNA A's employee file documented she was hired on 8/8/17. There was no documentation she received any training regarding prohibition and preventing all forms of abuse.</p> <p>On 11/9/17 at 12:23 pm, the ADON said that staff members should know the categories of abuse and they just had training in October. When asked to provide evidence that CNA A received training regarding prohibition of abuse, the ADON said the facility was bought by another company and the previous company kept some documentation regarding previous training that employees received, and the facility has not been able to access this information. The ADON stated the presumption was CNA A's training records were among that information.</p> <p>The facility did not provide documentation that CNA A received training regarding prohibition of abuse.</p> <p>4. Refer to F 225 as related to the facility's failure to ensure all staff recognized and reported abuse, including verbal abuse; preventive measures were implemented for residents at risk of abuse or of abusing others; allegations of abuse were identified and investigated; residents were protected from further abuse once an allegation was made; and allegations of abuse, including verbal abuse, were reported to the State Agency.</p> <p>5. The facility was notified in writing on 11/8/17 at 4:52 pm of the Immediate Jeopardy and the need to formulate and implement and plan of removal.</p> <p>On 11/9/17 at 12:00 pm, the facility provided an</p>	F 226			

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F 226	Continued From page 36 acceptable plan to remove the Immediate Jeopardy. The plan included:  * Reporting newly identified allegations of abuse to the State agency.  * Providing 1:1 staff to a resident who was implicated in abuse allegations.  * Interviewing residents regarding abuse.  * Operationalization of policies and procedures regarding abuse allegations.  * Providing education to the leadership team and facility staff.  Implementation of the above actions was verified on-site and the facility informed on 11/9/17 at 5:00 pm, that the immediate jeopardy was removed.	F 226			
F 250 SS=G	PROVISION OF MEDICALLY RELATED SOCIAL SERVICE CFR(s): 483.40(d)  (d) The facility must provide medically-related social services 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, interview, and record review, it was determined the facility failed to ensure medically related social services were provided for residents. This was true for 3 of 4 sample residents (#s 1, 2 and 4) when the residents did not receive social services interventions after Resident #1 repeatedly	F 250	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or	1/4/18	

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F 250	<p>Continued From page 37</p> <p>demonstrated verbally and physically aggressive behavior. Residents #2 and #4 experienced psychosocial harm due to Resident #1's behavior. Resident #1 was at risk for harm from other residents. Findings include:</p> <p>1. Resident #1 was admitted on 9/20/17 with diagnoses including major depressive disorder with psychotic features and Alzheimer's.</p> <p>Resident #1's 9/27/17 Admission MDS (Minimum Data Set) assessment documented severe cognitive impairment, delusions, and physical behaviors.</p> <p>Resident #1's care plan to address his psychosocial and behavior problems documented to remove him to a calm, safe environment when a conflict occurs; approach him from the side carefully, facilitate the resident talking to his son-in-law on the phone; give a 5 minute "time out" when agitation is expressed and then re-approach; identify yourself and what you want the resident to do; re-direct him by talking about his work history when he becomes agitated; remove him from other residents in the area if his behavior is "out of control"; consider moving him to a room with two beds (instead of four beds) to decrease stimulation; and get him dressed and out of his room prior to his roommates getting up.</p> <p>Resident #1's 9/20/17-11/20/17 Order Summary Report documented behavior monitoring regarding the number of episodes per shift of the following behaviors: delusions, resistive to cares, frequent changes in mood, verbal aggression, and frequent wandering into others' rooms or</p>	F 250	<p>conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>Resident Specific The ID team reviewed resident's #1, 2, and 4:</p> <ul style="list-style-type: none"> <li>• Resident #1: Was reassessed for intrusive wandering and aggressive behaviors. Behavior monitor in place. Care plan was updated as indicated.</li> <li>• Resident #2: Has had medication evaluation by physician and counselling from her external therapist. Increased behavioral review and interventions by Social Workers regarding escalation of behaviors. Physician orders and care plan is updated as indicated.</li> <li>• Resident #4: Social Worker followed-up on allegations of abuse and personal safety concerns. Care plan was updated as indicated.</li> </ul> <p>Other Residents See F225.</p> <p>Facility Systems Social Workers were re-educated on medically related social services. Re-education was provided by the DNS and/or designee to include but not limited to documentation post allegation of abuse to address psychosocial harm and/or concerns, addressing trending and single event documentation in behavioral</p>		

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F 250	<p>Continued From page 38 areas.</p> <p>On 9/20/17 at 2:20 pm, Resident #1's Admission Note documented he arrived at the facility from the hospital after he struck an employee at his previous residence in an ALF (Assisted Living Facility).</p> <p>On 10/4/17 at 3:00 am, Resident #1's Behavior Note documented he was being physically aggressive, "hitting and grabbing any item he can grab in his hands and swinging the item..." The resident slammed doors, disrupted other residents' sleep, and pushed a wheelchair into a staff member's knee without any injury to the staff member. Resident #1's physician was contacted by phone and a medication order was requested to "help the resident calm down so he won't be a danger to himself or others."</p> <p>On 10/17/17 at 1:04 pm, Resident #1's Behavior Note documented he became angry during breakfast, shouting at a tablemate, calling his tablemate a "fat f****" and threatened, "I'll come over there and kill you, you fat pig." Resident #1 was also walking in the hallway, "peeking into bedrooms but rarely putting a foot inside the bedrooms."</p> <p>On 10/18/17 at 1:50 am, Resident #1's Behavior Note documented he was restless, aggressive towards staff, pacing and walking in the hallway for nearly 4 hours, and attempted to enter other residents' rooms multiple times.</p> <p>On 11/2/17 at 2:47 pm, Resident #1's Behavior Note documented he was walking "every waking moment" and he opened an unidentified female</p>	F 250	<p>monitoring, prevention of intrusive wandering, and record documentation to address issues. The system is amended to include review of progress notes and care plans in behavioral review meetings.</p> <p>Monitor The DNS and/or designee will review 4 resident interviews and behavioral/progress notes trending to validate timely documentation and resident follow up weekly for 4 weeks, then 4 residents twice monthly for two months. Starting the week of December 24th, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/09/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CALDWELL OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 CLEVELAND BOULEVARD</b> <b>CALDWELL, ID 83605</b>		
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F 250	<p>Continued From page 39</p> <p>resident's door multiple times without knocking. When a staff member attempted to re-direct Resident #1, he said, "I own this building and I'll go anywhere I damn well please."</p> <p>On 11/2/17 at 3:56 pm, Resident #1's Behavior Note documented he was "very verbally aggressive towards residents and staff," yelling and threatening to harm residents and staff members, calling others inappropriate names.</p> <p>On 11/2/17 at 9:20 pm, Resident #1's Health Status Note documented he continued to wander and exhibit aggressive behavior.</p> <p>Resident #1's 11/2/17 Behavior Monitor Additional Behavior Details documented he was wandering into other residents' rooms, waking residents up, telling them to leave, yelling and screaming when he was asked to leave. The note documented Resident #1 was, "wanting to hit and threaten[ed] to kill residents on [the] other side!"</p> <p>Resident #1's 11/3/17 Behavior Monitor Additional Behavior Details documented he was "continuously" entering other residents' rooms and started yelling when CNAs (Certified Nursing Assistants) redirected him.</p> <p>On 11/7/17 at 1:40 pm, Resident #1 was observed walking up and down the hall at the opposite end of the building from his room. Resident #1 entered another resident's room for approximately one and one-half minutes. No other residents were in the room at the time. A male staff member entered and redirected the resident back out into the hall. Resident #1</p>	F 250			

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F 250	<p>Continued From page 40</p> <p>entered another resident's room approximately two minutes later and exited the room on his own accord.</p> <p>On 11/7/17 at 2:13 pm, Resident #1 entered another resident's room and staff directed him to exit the room.</p> <p>The facility did not have evidence of a social service evaluation of Resident #1's wandering and other behavioral symptoms and the potential risk to residents safety.</p> <p>2. Resident #2 was readmitted to the facility on 3/27/17 with diagnoses which included borderline personality disorder, dementia without behavioral disturbances, schizophrenia, and panic disorder.</p> <p>Resident #2's Quarterly MDS assessment, dated 10/6/17, documented she was cognitively intact and had no signs and symptoms of psychosis or delirium.</p> <p>Resident #2's Progress Notes, dated 10/1/17 through 11/7/17, documented 3 episodes of verbal aggression, "increased behaviors," and "verbally aggressive and argumentative" on 10/9/17; "verbal altercation" on 10/10/17; and calling a staff member a 'horrible word' on 11/4/17. The 11/4/17 note documented Resident #2 had no memory of the incident and was "waiting to be punished."</p> <p>Resident #2's Behavior Monitor Flowsheets contained an Additional Behavior Details section which documented "upset with other res[ident]" on 10/2/17; "yelling" on 10/8/17; "ganging up on other residents" on 10/10/17; "manic most of the</p>	F 250			

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F 250	<p>Continued From page 41</p> <p>day" on 10/11/17; "upset because a Resident is walking in the hallway" on 10/30/17; "bullying" on 11/1/17; "[Resident #2] wanted to call the police because [Resident #1] was on this side of the building" on 11/3/17; "Very paranoid about [Resident #1] coming to her room" on 11/4/17; and, "Paranoid about res[ident] from another hall hiding in her bathroom" in an undated entry.</p> <p>Resident #2's Progress Notes documented multiple episodes of the resident being upset, including:</p> <p>* An 11/3/17 Health Status Note documented Resident #2 was awake most of the night and was upset about another resident.</p> <p>* An 11/4/17 Behavior Note documented Resident #2 was upset about another resident coming into her room. The note documented Resident #2 started to tell Licensed Nurse (LN) #2 and Licensed Social Worker (LSW) #1 about a concern and Resident #2 asked LSW #1 to leave the room. The note documented LSW #1 did not leave the room as the staff members felt that Resident #2's agitation level was high. The note documented Resident #2 informed social services and the nurse that she felt unsafe as a male resident (Resident #1) entered her room when she "was naked." The note document Resident #2 looked at her side and repeated three times, "I'm not safe." The note documented the nurse told Resident #2 that staff could not stop the resident (Resident #1) from walking the hallways, however, staff would be more diligent in attempting to keep him from entering other rooms.</p>	F 250			

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F 250	<p>Continued From page 42</p> <p>On 11/6/17, Resident #2's Psychiatric Progress Note documented Resident #2's delusions and hallucinations had "worsened the past couple weeks." The note documented Resident #2 was, "seeing people in her room and frequently is yelling out and accusing staff and other patients of various things that are not occurring."</p> <p>On 11/7/17 at 9:29 am, Resident #2 stated she did not feel safe in the facility due to Resident #1 coming into her room, seeing her with her shirt off and threatening her. She stated she told LN #2 and LSW #1 about the situation and "no one" had followed up with her about it or believed her. Resident #2 stated when LN #2 and LSW #1 talked to her on 11/4/17, she twice asked the LSW #1 leave the room due to LSW #1 not believing her, but the LSW did not leave. Resident #1 stated she no longer felt safe in the presence of LSW #1 because LSW #1 "never" believed her and she felt LSW #1 tried to discredit her. Resident #2 stated she was "not stupid" and knew when she got upset it was hard for her to calm down. Resident #2 stated she was tired of telling staff about Resident #1 and them not believing her. She stated that both LSW #1 and LSW #2 told her that they did not believe that Resident #1 was ever in her room.</p> <p>Resident #2 stated when she got frustrated she "lashed out" at people, which had been happening more frequently in the past few weeks since Resident #1 started wandering into her room. Resident #2 stated sometimes all she needed was someone taking the time to sit and listen to her concerns.</p> <p>On 11/7/17 at 9:35 am, Resident #2 described</p>	F 250		

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F 250	Continued From page 43 the events over the "last few weeks" and that she did not feel safe. Resident #2 stated a few weeks ago Resident #1 was walking the halls and "clicked" his walker and knocked on walls, doors and hand rails. Resident #2 stated around that time, Resident #1 walked into her room and, "peered around my curtain and just stared at me." She stated it scared her that he walked into her room unnoticed. Resident #2 stated she told a CNA and nothing was done about it. Another instance happened one night the previous week when she was changing her shirt with her back to the door. When she reached for her night shirt Resident #1 was standing next to her bed, which she discovered when she reached for her shirt her hand brushed his walker. Resident #2 stated Resident #1 asked her if he could share a room with her. Resident #2 stated she asked him nicely to leave twice and he wouldn't leave. Resident #2 stated Resident #1 was staring at her top-half and if she could be "raped" with eyes she felt she was being "raped." Resident #2 stated after asking nicely twice, she, "Yelled at him saying 'You don't belong here! Get out! Get out!'" Resident #2 stated she continued to, "Yell 'Get out!'" Resident #2 stated Resident #1 responded by yelling back, "You f***ing b*tch!! I'll take you to hell!" Resident #2 stated she told an RN about the incident but the facility did not follow up with her. Resident #2 stated Resident #1 had entered her room one more time since the shirt incident and she stated he had banged his walker against the end of her bed and stared at her again with a "menacing look." Resident #2 stated she did not want to leave her room because she feared possible negative interactions with Resident #1 and she stated she did not feel safe in her	F 250			

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F 250	<p>Continued From page 44</p> <p>room either because she was fearful of Resident #1 entering. Resident #2 stated she had started keeping her door closed to try and prevent him from returning. Resident #2 stated Resident #1 had wandered into other residents' rooms on this hall and threatened them as well.</p> <p>On 11/7/17 at 9:12 am, Resident #3 stated she was in her room last week and she heard Resident #2 arguing with Resident #1. Resident #3 stated she heard Resident #1 calling Resident #2 a "f***ing b*tch." Resident #3 stated she left her room and went next door to Resident #2's room and told Resident #1 to leave.</p> <p>On 11/8/17 at 9:13 am, LSW #2 said she was aware that Resident #1 had wandered into a female resident's room, however, she was not aware that the female resident had considered this event "abusive." LSW #2 was not aware that Resident #1 called other residents "f***ing bitches." LSW #2 said she was not sure if the facility was aware of Resident #1's history of aggressive behavior prior to his admission. LSW #2 said if an altercation occurred between two residents, ideally social services would have followed up, and it would be documented in each residents' chart. LSW #2 stated she had not followed up on any such incidents recently. LSW #2 stated if she witnessed an abuse incident she would intervene right then and there and would not always document it. She stated if an abusive incident was reported to her she would investigate the incident and document it on an abuse investigation form.</p> <p>On 11/8/17 at 9:40 am, LSW #1 stated:</p>	F 250			

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F 250	<p>Continued From page 45</p> <ul style="list-style-type: none"> <li>* If a resident exhibited "verbal aggression" such as name calling or swearing, it was not always thought of as "verbal abuse."</li> <li>* If a resident called another resident a "f***ing b*tch" it would be considered "verbal aggression" because, "with dementia they don't always know what they're saying."</li> <li>* The facility monitored "verbally aggressive" behaviors through resident behavior monitors, and if the monitor showed an escalation in behaviors that would trigger an investigation.</li> <li>* If a resident wandered into another resident's room, it should be investigated.</li> <li>* The ED told LSW #1 which "verbal incidents" needed to be investigated.</li> </ul> <p>During the same interview LSW #1 stated, regarding Resident #1 and #2 specifically:</p> <ul style="list-style-type: none"> <li>* She was aware of Resident #1 calling other residents names, but was not sure which residents.</li> <li>* She was aware of a "verbal altercation" involving Resident #1 and Resident #2 the previous week.</li> <li>* She was present when Resident #2 reported an allegation of "verbal abuse" and she felt "unsafe." LSW #1 could not explain the lack of investigation for this allegation. This altercation was previously described in the 11/4/17 behavior note above.</li> <li>* The "altercation" had not been investigated.</li> <li>* Reports of Resident #1's wandering were "hearsay."</li> <li>* The facility needed to protect other residents from Resident #1, and had implemented measures including adjusting the resident's medications, attempting to get him to walk in</li> </ul>	F 250			

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F 250	<p>Continued From page 46</p> <p>another direction, and stopping him before he entered other resident's rooms.</p> <p>* The facility could not stop a mobile resident, such as Resident #1, from wandering.</p> <p>* Other residents in the facility had been educated to "gently redirect" Resident #1 if he wandered into their rooms. The facility was unable to provide evidence this education with other residents had occurred.</p> <p>* She did not know how many resident rooms Resident #1 had entered, how long he had remained in the rooms, whether other residents were in the rooms when he entered, or how frequently this behavior occurred.</p> <p>* Without an investigation into the allegations of verbal abuse regarding Resident #1, it was not possible to rule out physical, mental, or sexual abuse, given the nature of the allegations.</p> <p>3. Resident #4 was admitted on 7/10/17 with diagnoses including generalized anxiety and difficulty walking.</p> <p>Resident #4's 10/17/17 quarterly MDS assessment documented she was cognitively intact.</p> <p>On 11/7/17 at 8:50 am, Resident #4 said that on approximately November 3, 2017 in the afternoon, she was waiting to receive medication at the nurse's cart and Resident #1 had been walking up and down the hall. Resident #1 lunged at the nurse, Resident #4 said she was afraid Resident #1 was going to hurt the nurse, and yelled at Resident #1 to stop. Resident #1 then "turned" on Resident #4 and said, "I will knock your block off you f***ing bitch," while raising his fist as if to hit her. The nurse placed</p>	F 250			

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F 250	<p>Continued From page 47</p> <p>herself between Resident #1 and Resident #4 to prevent a physical altercation. Resident #4 stated the RN (Registered Nurse) spoke with the Administrator about the incident. Resident #4 stated no staff member followed up with her. Resident #4 stated she was aware of other incidents where Resident #1 had either intrusively wandered into resident rooms, or was physically or verbally abusive with other residents. Resident #4 stated the facility was not taking resident complaints of abuse seriously and not investigating them. Resident #4 stated she was concerned not only for her personal safety, but the safety of others.</p> <p>On On 11/8/17 at 9:13 am, LSW #2 said she had not followed up with either Resident #1 or Resident #4 following the incident.</p> <p>On On 11/8/17 at 9:40 am, LSW #1 said she had not followed up with either Resident #1 or Resident #4 following the incident.</p> <p>The facility failed to provide social services interventions to reduce risk of altercations or abuse. when Resident #1 engaged in intrusive wandering and aggression towards others. Resident #s 2 and 4 reported incidents which they identified as allegations of verbal, mental, and/or sexual abuse. The facility failed to provide social services to follow up to ensure Resident #s 2 and 4 had not experienced further instances of abusive behavior, and did not experience latent effects of past abuse allegations. Resident #2 was harmed when she began to feel unsafe, "lash out at others," and self isolate after Resident #1 began wandering into her room, threatening and frightening her. Resident #4 was</p>	F 250			

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F 250	Continued From page 48 harmd when the facility's failure to respond to Resident #1's aggressiveness and intrusiveness led her to act out in defense towards Resident #1.	F 250			
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1)  483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.  483.21 (b) Comprehensive Care Plans  (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -  (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and  (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 279		1/4/18	

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F 279	<p>Continued From page 49 treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative (s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure resident-specific care plans were appropriately developed and implemented for 2 of 4 sample residents (#1 and #2). This deficient practice created the potential for residents to receive inappropriate or inadequate care with a subsequent decline in health. Findings include:</p> <p>1. Resident #1 was admitted on 9/20/17 with</p>	F 279	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal</p>		

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F 279	<p>Continued From page 50</p> <p>diagnoses including major depressive disorder with psychotic features &amp; Alzheimer's.</p> <p>Resident #1's 9/27/17 Admission MDS (Minimum Data Set) assessment documented severe cognitive impairment, delusions, and physical behaviors.</p> <p>Resident #1's care plan did not document wandering or depression as potential problem areas. There were no interventions for wandering.</p> <p>Resident #1's 9/20/17-11/20/17 Order Summary Report documented behavior monitoring regarding the number of episodes per shift of the following behaviors: delusions, resistive to cares, frequent changes in mood, verbal aggression, and frequent wandering into others' rooms or areas.</p> <p>Resident #1's Behavior Notes, Health Status Notes, and Behavior Monitors documented Resident #1 was wandering near or into other resident rooms and/or threatening other residents, and required redirection on 10/17/17, 10/18/17, 11/2/17, and 11/3/17.</p> <p>On 11/7/17 at 1:40 pm, Resident #1 was observed walking up and down the hall at the opposite end of the building from his room. Resident #1 entered another resident's room for approximately one and one-half minutes. No residents were in the room at the time. A male staff member entered and redirected the resident back out into the hall. Resident #1 entered another resident's room approximately two minutes later and exited the room on his own</p>	F 279	<p>proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>Resident Specific</p> <p>Residents #1 and 2 were reviewed by the clinical management team:</p> <ul style="list-style-type: none"> <li>•Resident #1: Care plan has been updated to include wandering, depression, agitation and 1:1 Supervision.</li> <li>•Resident #2: Care plan has been updated to include resident specific behaviors for nonpharmacological interventions and medication use.</li> </ul> <p>Other Residents</p> <p>The Clinical Management Team reviewed other residents for person centered care plans that reflect measurable objectives and clear interventions for medication use and psychosocial behaviors.</p> <p>Adjustments have been made as indicated.</p> <p>Facility Systems</p> <p>The Clinical Management Team, licensed nurses, and social workers were re-educated and re-trained to person centered care planning by the SDC and/or designee. The education includes but is not limited to behavioral monitoring, interventions for behaviors, and medication use. The system is amended</p>		

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F 279	<p>Continued From page 51 accord.</p> <p>On 11/7/17 at 2:13 pm, Resident #1 entered another resident's room and the CNA directed him to exit the room.</p> <p>On 11/7/17 at 2:45 pm, CNA #1 stated she observed #1 walking the halls; however, she never saw him enter other residents' rooms. CNA #1 stated Resident #1 was "usually" easily redirected but sometimes he got agitated. CNA #1 stated a female resident told her Resident #1 attempted to enter the female resident's room.</p> <p>On 11/8/17 at 10:10 am, the acting Director of Nursing (ADON) said they try to keep Resident #1 in his own hall. The ADON confirmed Resident #1 did not have a wandering care plan. The ADON stated she thought Resident #1 was on 1:1 supervision and care when he first entered the facility, but she could not be certain, and did not know when or why that intervention would have been discontinued.</p> <p>On 11/8/17 at 12:05 pm, the ED (Executive Director) said Resident #1's care plan did not address wandering.</p> <p>On 11/9/17 at 5:45 pm, the ADON said she did not see anything in the care plan regarding Resident #1's depression and the care plan would be updated. The ADON said the social worker should address the resident's behaviors on the care plan.</p> <p>2. Resident #2 was readmitted to the facility on 3/27/17 with diagnoses which included borderline</p>	F 279	<p>to include person centered care plan review with behavioral changes in clinical meeting, behavioral meeting, and at least quarterly.</p> <p>Monitor</p> <p>The DNS and/or designee will audit 4 care plans for person centered approach to behaviors weekly for 4 weeks and 4 care plans twice monthly for 2 months. Starting the week of December 24th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 279	Continued From page 52 personality disorder, dementia without behavioral disturbances, schizophrenia, and panic disorder.  Resident #2's Quarterly MDS assessment, dated 10/6/17, documented she was cognitively intact and had no signs and symptoms of psychosis or delirium.  Resident #2's Schizophrenia, Borderline Personality Disorder and Bipolar Care Plan, revised 10/18/17, documented she had these diagnoses and staff were to look at the Medication Administration Record for specific behaviors. Resident #2's care plans did not identify resident-specific behaviors  On 11/8/17 at 10:10 am, the ADON acknowledged that no specific behaviors were identified on Resident #2's care plan. The ADON acknowledged that the behaviors should be clearly defined and specific for Resident #2's delusions so that the monitoring would assist with determining if the current medication/s were effective in treating her schizophrenia and psychosis. The ADON said the social worker should address the resident's behaviors on the care plan.	F 279			
F 323 SS=L	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3)  (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	F 323		1/4/18	

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F 323	<p>Continued From page 53 and assistance devices to prevent accidents.</p> <p>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure residents were provided with the level of supervision necessary for safety. This was true for 4 of 4 sample residents (#s 1-4) and 4 random residents (#s 5-8), and had the potential to impact the remaining 52 residents in the facility. Specifically:</p> <p>a) Resident #1 had the potential for being seriously injured from retaliation by other residents when he wandered unsupervised into other residents' rooms and negative outcomes occurred.</p> <p>b) Resident #2 reported she was abused when Resident #1 intrusively wandered into her room unsupervised while she was partially dressed</p>	F 323	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>Resident Specific The ID team reviewed:</p> <ul style="list-style-type: none"> <li>• Residents #1: 1:1 supervision implemented as noted in the CMS-2567.</li> </ul>		

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F 323	<p>Continued From page 54 and threatened her.</p> <p>c) Residents #s 3-8 were impacted by Resident #1's intrusive wandering.</p> <p>This deficient practice placed Residents #'s 1-8 in immediate jeopardy of serious harm, injury, or death and had the potential to impact the remaining 52 residents in the facility due to the facility's failure to provide supervision to a resident with known physical and verbal aggression, who was not easily redirected and who was allowed wander unsupervised. Findings include:</p> <p>The facility's 10/31/17 Accidents and Supervision to Prevent Accidents policy and procedures documented facility staff were directed to identify resident behaviors with potential risk to resident safety, resident to resident altercations, and unsafe wandering. Facility staff were directed to implement interventions on the care plan, supervise staff and residents, document the interventions, implement "individualized, resident-based interventions" such as adequate supervision to reduce risks of injury, and monitor the effectiveness of the interventions and modify the interventions as necessary. Facility staff were directed to provide adequate supervision to prevent accidents and to identify residents with a history of "disruptive or intrusive interactions" or other behaviors that would increase the likelihood of an altercation. When facility staff identified a resident with these risks, the policy and procedure directed staff to provide staffing levels that would ensure adequate supervision, ensure staff assignments were consistent for the resident, provide areas for the resident to remain</p>	F 323	<p>Assessment and care plan are updated to reflect 1:1 supervision related to wandering and aggressive behaviors. Sitters are educated on how to manage intrusive and/or aggressive behaviors.</p> <ul style="list-style-type: none"> <li>Resident #2: Resident interview reveals that she currently feels safe and that she at times will close her door for privacy. Noted she does not feel threatened by resident #1 as he has 1:1 supervision as noted above.</li> <li>Residents #3-8: State that they do not feel threatened as resident #1 has 1:1 supervision and is not entering their rooms.</li> </ul> <p>Other Residents The ID team reviewed other residents for intrusive wandering or increased supervision. Currently 3 residents on 1:1 supervision.</p> <p>Facility Systems Staff are re-educated on supervision to prevent accidents. Re-education was provided by SDC and/or designee to include but not limited to supervision to prevent intrusive wandering and/or aggressive behaviors, how to manage intrusive and/or aggressive residents. In addition, clinical management team is educated by the Director of Clinical Operations on supervision to prevent accidents, to include but not limited to management of newly admitted residents with history of altercations, resident to resident verbal altercations, resident bullying, intrusive wandering, supervision</p>		

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F 323	<p>Continued From page 55</p> <p>safe and have unrestricted movement, eliminate or reduce the sources of distressing behavior, monitor the environment for sources such as temperature, lighting, and noise levels, and provide ongoing training, competency, and supervision of facility staff in regards to managing resident behaviors.</p> <p>1. Resident #1 was admitted on 9/20/17 with diagnoses including major depressive disorder with psychotic features and Alzheimer's.</p> <p>Resident #1's 9/27/17 Admission MDS (Minimum Data Set) assessment documented severe cognitive impairment, delusions, and physical behaviors. The MDS documented Resident #1 did not wander.</p> <p>Resident #1's care plan directed staff to intervene in the following ways to address his psychosocial and behavior problems: remove him to a calm, safe environment when a conflict occurs, approach him from the side carefully, facilitate the resident talking to his son-in-law on the phone, give a 5 minute "time out" when agitation is expressed and then re-approach, identify yourself and what you want the resident to do, re-direct him by talking about the saw mill when he becomes agitated, remove him from other residents in the area if his behavior is out of control, consider moving him to a room with two beds (instead of four beds) to decrease stimulation, and get him dressed and out of his room prior to his roommates getting up.</p> <p>Resident #1's care plan did not include the need for supervision to address wandering.</p>	F 323	<p>to prevent altercations, and review of trending through QAPI. The system is amended to include review of potential admissions, new admissions, and current resident progress notes and behavior monitors in clinical meeting for allocation of increased supervision.</p> <p>Monitor The DNS and/or designee will review 4 residents that are newly admitted, with aggressive behaviors, and/or intrusive wandering for person centered care plan which may include requirement for increased supervision weekly for 4 weeks, then 4 residents twice monthly for 2 months. Starting the week of December 24th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 323	<p>Continued From page 56</p> <p>Resident #1's 9/20/17-11/20/17 Order Summary Report documented behavior monitoring regarding the number of episodes per shift of the following behaviors: delusions, resistive to cares, frequent changes in mood as exhibited by physical aggression, verbal aggression, and frequent wandering into others' rooms or areas.</p> <p>On 10/17/17 at 1:04 pm, Resident #1's Behavior Note documented Resident #1 was walking in the hallway, "peeking into bedrooms but rarely putting a foot inside the bedrooms." The facility did not provide increased supervision or otherwise update his care plan to reflect the resident's wandering.</p> <p>On 10/18/17 at 1:50 am, Resident #1's Behavior Note documented he was restless, aggressive towards staff, pacing and walking in the hallway for nearly 4 hours, and attempted to enter other residents' rooms multiple times. The facility did not update his care plan or provide increased supervision in response to the resident attempting to enter other rooms.</p> <p>On 11/2/17 at 2:47 pm, Resident #1's Behavior Note documented he was walking "every waking moment" and he opened a female resident's door multiple times without knocking. When a staff member attempted to re-direct Resident #1, he said "I own this building and I'll go anywhere I damn well please." The facility did not update his care plan or provide increased supervision in response to the resident entering other resident rooms.</p> <p>On 11/2/17 at 9:20 pm, Resident #1's Health Status Note documented he continued to wander</p>	F 323			

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F 323	<p>Continued From page 57</p> <p>and exhibit aggressive behavior. The facility did not increase supervision for Resident #1.</p> <p>Resident #1's 11/2/17 Behavior Monitor Additional Behavior Details documented he was wandering into other residents' rooms, waking residents up, telling them to leave, yelling and screaming when he was asked to leave. The note documented Resident #1 was, "Wanting to hit and threaten[ed] to kill residents on [the] other side!"</p> <p>Resident #1's 11/3/17 Behavior Monitor Additional Behavior Details documented he was "continuously" entering other residents' rooms and started yelling when Certified Nursing Assistants (CNAs) redirected him.</p> <p>Resident #1's clinical record did not document or show evidence of increased supervision following any of the above events.</p> <p>On 11/7/17 at 1:40 pm, Resident #1 was observed walking up and down the hall at the opposite end of the building from his room, unsupervised. Resident #1 entered another resident's room for. No other residents were in the room at the time. After approximately one and one half minutes, a male staff member entered and redirected the resident back out into the hall. Resident #1 entered another resident's room approximately two minutes later and exited the room on his own accord.</p> <p>On 11/7/17 at 2:13 pm, Resident #1 entered another resident's room and the CNA directed him to exit the room.</p>	F 323			

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F 323	<p>Continued From page 58</p> <p>On 11/8/17 at 12:05 pm, the Executive Director (E.D.) said Resident #1 should be on every 15 minute checks to make sure he was not being intrusive to other residents. The E.D. said he was not sure if the resident was previously on 1:1 supervision but he was on 1:1 supervision as of this date.</p> <p>2. Resident #2 was readmitted to the facility on 3/27/17 with diagnoses which included borderline personality disorder, dementia without behavioral disturbances, schizophrenia, and panic disorder.</p> <p>Resident #2's Quarterly MDS assessment, dated 10/6/17, documented she was cognitively intact and had no signs and symptoms of psychosis or delirium.</p> <p>An 11/3/17 Health Status Note documented Resident #2 was awake most of the night and was upset about another resident.</p> <p>An 11/4/17 Behavior Note documented Resident #2 was upset about another resident coming into her room. The note documented Resident #2 informed social services and a nurse that she felt unsafe as a male resident (Resident #1) entered her room when she "was naked." The note document Resident #2 looked at her side and repeated three times, "I'm not safe." The note documented the nurse told Resident #2 that staff could not stop Resident #1 from walking the hallways; however, staff would be more diligent in attempting to keep him from entering other rooms. The note did not document a specific plan to increase supervision for Resident #1.</p> <p>On 11/7/17 at 9:29 am, Resident #2 stated she</p>	F 323			

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F 323	Continued From page 59 did not feel safe in the facility due to Resident #1 coming into her room and seeing her with her shirt off and threatening her. She stated she told a Registered Nurse (RN) about the situation but there had been no follow up. Resident #2 stated the RN told her staff could not stop Resident #1 from walking the halls; however they would try and make sure he did not enter other residents' rooms. Resident #2 stated the situation started a few weeks ago she noticed Resident #1 walking the halls, "clicking" his walker and knocking on walls, doors and hand rails. Resident #2 stated Resident #1 walked into her room and, "Peered around my curtain and just stared at me." She stated it scared her that he just walked into her room. Resident #2 stated she told a CNA and nothing was done about it. Resident #2 stated on a second occasion, which was just the previous week, she was in her room and had removed her shirt to get ready for bed when she reached behind her to get her nightshirt and touched Resident #1's walker. Resident #2 stated she turned to find Resident #1 standing right next to her bed. Resident #2 stated she was startled by his presence and Resident #1 asked her if he could share a room with her. Resident #2 stated she asked him nicely to leave twice and he wouldn't leave, so she yelled at Resident #1 and told him to get out of her room. Resident #2 stated Resident #1 responded by yelling back, "You f***ing bitch I'll take you to hell!" Resident #2 stated she told a RN about the incident and no resolution was found yet. Resident #2 stated Resident #1 had entered her room one more time since the shirt incident and banged his walker against the end of her bed and stared at her again with a "menacing look." Resident #2 stated she did not want to leave her room	F 323			

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F 323	<p>Continued From page 60</p> <p>because she feared possible negative interactions with Resident #1 and she stated she did not feel safe in her room either because she was fearful of Resident #1 walking in. Resident #2 stated she had started keeping her door closed to try and prevent him from returning. Resident #2 stated Resident #1 had wandered into other residents' rooms on this hall and threatened them as well.</p> <p>Resident #1's clinical record did not document, and the facility had no evidence of, increased supervision following Resident #2's reports.</p> <p>3. Resident #4 was admitted on 7/10/17 with diagnoses including generalized anxiety and difficulty walking.</p> <p>Resident #4's 10/17/17 quarterly MDS assessment documented she was cognitively intact.</p> <p>Resident #4 stated one day the previous week, Resident #1 had been walking in the hall when she saw him "lunge" at a nurse. Resident #4 stated she was afraid for the nurse's safety, so she yelled at Resident #1 to stop. Resident #4 stated Resident #1 then turned his attention to her and yelled, "I will knock your block off you f***ing bitch." Resident #4 stated the nurse had to physically intervene to keep her (Resident #4) safe, but placed her own safety at risk in doing so.</p> <p>On 11/7/17 at 8:50 am, Resident #4 stated that Resident #1 had wandered into her room on occasion, she was aware Resident #1 wandered into other residents' rooms as well.</p>	F 323			

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F 323	Continued From page 61  4. Resident #3 was admitted to the facility on 7/22/14 with diagnoses which included alcohol dependence with alcohol induced persisting dementia.  Resident #3's Quarterly MDS assessment, dated 10/11/17, documented she was cognitively intact and had no signs and symptoms of psychosis, delirium or behaviors.  On 11/7/17 at 1:43 pm, Resident #3 stated Resident #1 wandered down the hall often and he would "click" his walker and knock loudly on the walls and doors. Resident #3 stated a few weeks ago Resident #1 "banged" his walker into her door and came into her room. Resident #3 stated Resident #1 raised his voice to her, pointed his finger at her, and told her to stay in her room and, "Do not come out."  5. Resident #5 was admitted to the facility on 2/23/17 with diagnoses which included anxiety and bipolar.  Resident #5's Quarterly MDS assessment, dated 8/17/17, documented he was cognitively intact and had no signs and symptoms of psychosis, delirium or behaviors.  On 11/7/17 at 2:05 pm, Resident #5 stated Resident #1 wandered down the hall often "clicking" his walker and knocking on doors and walls while he walks. Resident #5 stated Resident #1 recently entered his room. Resident #5 stated he "yelled" at him to "get out." He stated he did not give Resident #1 the option to talk back to him and Resident #5 stated he	F 323			

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F 323	<p>Continued From page 62</p> <p>currently was not threatened by him, however, Resident #5 stated Resident #1 "could be dangerous." Resident #5 stated he had seen Resident #1 being "defiant" with staff and other residents, for example, when someone asked him to stop doing something Resident #1 told them "no, he would do what he wanted to do."</p> <p>6. Resident #6 was readmitted to the facility on 9/13/17 with diagnoses which included bipolar disorder.</p> <p>Resident #6's Quarterly MDS assessment, dated 8/18/17, documented he was cognitively intact and had no signs and symptoms of psychosis, delirium or behaviors.</p> <p>On 11/7/17 at 1:50 pm, Resident #6 stated Resident #1 wandered into his room on more than one occasion, and when Resident #6 told him to leave, Resident #1 would argue that the room was not Resident #6's room.</p> <p>7. Resident #7 was readmitted to the facility on 7/1/16 with diagnoses which included depression.</p> <p>Resident #7's Quarterly MDS assessment, dated 10/6/17, documented he was cognitively intact and had no signs and symptoms of psychosis, delirium or behaviors.</p> <p>On 11/7/17 at 1:59 pm, Resident #7 stated Resident #1 wandered down the hall "clicking" and knocking frequently. Resident #7 stated Resident #1 had wandering into his room twice while he was present in the room. Resident #7 stated on one of these occasions not too long</p>	F 323			

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F 323	<p>Continued From page 63 ago, Resident #1 threatened to "Kick my ass, and kick me in the balls."</p> <p>8. Resident #8 was admitted to the facility on 8/4/11 with diagnoses which included depression, schizophrenia, and dementia.</p> <p>Resident #8's Quarterly MDS assessment, dated 10/20/17, documented he was cognitively intact and had no signs and symptoms of psychosis, delirium or behaviors.</p> <p>On 11/7/17 at 2:01 pm, Resident #8 stated Resident #1 had wandered into his room as well.</p> <p>Residents' #s 3-8 clinical records did not contain documentation of the incidences involving Resident #1's wandering.</p> <p>9. Staff Interviews</p> <p>On 11/7/17 at 2:45 pm, CNA #1 stated she observed #1 walking the halls; however, she never saw him enter other residents' rooms. CNA #1 stated Resident #1 was "usually" easily redirected but sometimes he got agitated. CNA #1 stated a female resident told her Resident #1 attempted to enter the female resident's room.</p> <p>On 11/8/17 at 9:13 am, Licensed Social Worker (LSW) #2 said she was aware that Resident #1 had wandered into a female resident's room; however, she was not aware that a verbal altercation occurred between the two residents.</p> <p>On 11/8/17 at 9:40 AM, LSW #1 said the facility needs to protect others from Resident #1, and they were trying measures such as adjusting</p>	F 323			

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F 323	<p>Continued From page 64</p> <p>Resident #1's medications, attempting to get him to walk in a different direction, and stopping him before he entered another resident's room. LSW #1 said it was "hearsay" that Resident #1 wandered into others' rooms, and the facility could not stop a mobile person from wandering. LSW #1 said the residents who resided in the hall at the opposite end of the building from Resident #1 had been asked to "gently re-direct him" if he entered their room. The facility did not increase supervision for Resident #1 to protect other residents from Resident #1's unwanted entrance into their rooms, name calling and/or verbal threats. The facility failed to ensure Resident #1 was supervised to ensure his safety.</p> <p>On 11/8/17 at 10:10 am, the acting Director of Nursing (ADON) said they try to keep Resident #1 in his own hall. The ADON confirmed Resident #1 did not have a wandering care plan. The ADON stated she thought Resident #1 was on 1:1 supervision and care when he first entered the facility, but she could not remember when or why that intervention had been discontinued. The ADON stated the facility had no formal plan to increase supervision for Resident #1.</p> <p>On 11/8/17 at 12:05 pm, the Executive Director stated Resident #1's wandering had not been identified as an issue, and the facility had not increased supervision for Resident #1.</p> <p>Refer to F225 and F226 as it relates to the faculties failure to identify Resident #1's behaviors as verbal abuse, threatening and/or intimidating to other residents.</p> <p>The facility was notified in writing on 11/8/17 at</p>	F 323			

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F 323	Continued From page 65 4:52 pm of the Immediate Jeopardy and the need to formulate and implement and plan of removal.  6. On 11/9/17 at 12:00 pm, the facility provided an acceptable plan to remove the Immediate Jeopardy. The plan included:  * Reporting newly identified allegations of abuse to the State agency.  * Providing 1:1 staff to a resident who was implicated in abuse allegations.  * Interviewing all interviewable residents regarding abuse.  * Operationalization of policies and procedures regarding abuse allegations.  * Providing education to the leadership team and facility staff regarding abuse and neglect prevention, identification and reporting.  Implementation of the above actions was verified on-site and the facility informed on 11/9/17 at 5:00 pm, that the immediate jeopardy was removed.	F 323			
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2)  483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--  (1) In excessive dose (including duplicate drug therapy); or	F 329		1/4/18	

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F 329	Continued From page 66  (2) For excessive duration; or  (3) Without adequate monitoring; or  (4) Without adequate indications for its use; or  (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or  (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.  483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--  (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;  (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure psychotropic medications were administered to treat specific diagnoses and behaviors and that staff monitored the efficacy of those medications. This was true for 2	F 329	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility		

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F 329	<p>Continued From page 67</p> <p>of 4 residents (#1 and #2) reviewed for use of psychoactive medications and had the potential for harm from inappropriate use, inadequate monitoring, and/or dosage adjustments. Findings include:</p> <p>1. Resident #2 was readmitted to the facility on 3/27/17 with diagnoses that included borderline personality disorder, dementia without behavioral disturbances, schizophrenia, and panic disorder.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 10/6/17, documented Resident #2 was cognitively intact and exhibited no signs and/or symptoms of psychosis or delirium.</p> <p>Recapitulated Physician's Orders for November 2017 documented staff was to administer several psychotropic medications to Resident #2 that exceeded manufacturer recommended dosages. Resident #2's physician ordered the following medications/dosages:</p> <ul style="list-style-type: none"> <li>* Abilify 20 milligrams (mg) daily for schizophrenia, ordered 3/27/17</li> <li>* Abilify increased to 30 mg daily on 11/6/17</li> <li>* Clonazepam 1 mg daily and 2 mg three times a day for schizophrenia, ordered 5/29/17</li> <li>* Cymbalta 30 mg daily for panic disorder, ordered 7/10/17</li> <li>* Cymbalta increased to 60 mg daily on 10/2/17</li> <li>* Loxapine 50 mg daily for schizoaffective disorder, ordered 3/27/17</li> <li>* Loxapine 25 mg daily for psychosis, ordered 3/29/17</li> <li>* Rozerem 8 mg daily for insomnia, ordered 3/27/17</li> </ul>	F 329	<p>admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p><b>Resident Specific</b> The clinical management team completed comprehensive review of resident #1 and 2's medication regimen. Adjustments have been made as indicated with documentation to address indications for use, dosing over manufacturer thresholds, multi-drug therapy, monitoring, efficacy, potential dosage adjustments, and care planning.</p> <p><b>Other Residents</b> The clinical management team reviewed all residents for unnecessary medications. Adjustments have been made as indicated.</p> <p><b>Facility Systems</b> Licensed nurses and social workers educated on residents' rights to a drug regimen that is free from unnecessary drugs by DNS and/or designee. Education included but is not limited to, definition of unnecessary drug, indications for use, drugs not to exceed manufacturer thresholds, multi-drug therapy, consent, environmental impact on behaviors, nonpharmacological interventions, documentation, adequate monitoring, efficacy, and GDR. The system is</p>		

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F 329	<p>Continued From page 68</p> <p>The 2018 Nursing Drug Handbook documented Clonazepam was to be used to treat seizures and panic disorder, with a maximum dose of no more than 4 mg a day. Indications for use did not include schizophrenia. The Medication Administration Record (MAR) documented Resident #2 received 7 mg of Clonazepam daily as physician ordered from 10/1/17 to 11/7/17.</p> <p>The 2018 Nursing Drug Handbook documented Cymbalta was indicated for the treatment of major depressive disorder and generalized anxiety disorder. Indications for use did not include panic disorder.</p> <p>The Nursing Drug Handbook 2018 documented the following potential adverse side effects for these medications:</p> <ul style="list-style-type: none"> <li>* Clonazepam - anxiety, hostility, irritability, insomnia, sleep disorder</li> <li>* Cymbalta - anxiety, irritability, insomnia, sleep disorder</li> <li>* Abilify - anxiety, hostility, insomnia</li> </ul> <p>On 10/2/17, the physician ordered an increase in Resident #2's Cymbalta from 30 mg daily to 60 mg daily, and on 11/6/17 the physician increased Resident #2's Abilify from 20 mg daily to 30 mg daily; neither physician order documented a clinical rationale for the dosage increase.</p> <p>On 11/9/17 at 12:40 pm, Resident #2's psychiatrist stated a clinical rationale for medication increases should be documented in progress notes within the resident's clinical record.</p>	F 329	<p>amended to include representative of nursing to attend all behavioral meetings.</p> <p>Monitor The DNS and/or designee will audit 4 residents for unnecessary medications weekly for 4 weeks, then 4 residents twice monthly for 2 months. Starting the week of December 24th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 329	<p>Continued From page 69</p> <p>b. Resident #2's Schizophrenia, Borderline Personality Disorder and Bipolar Care Plan, revised 10/18/17, documented staff were to review MARs for specific behaviors, however neither the care plan nor MARs described which specific behaviors staff were to monitor.</p> <p>c. Resident #2's October and November 2017 MARs included space for staff to monitor the resident's behaviors related to "antipsychotic (delusions, verbal aggression), anxiolytic (yelling out instead of using call light, rapid mood change), [and] hypnotic (sluggishness, sleep disturbance)."</p> <p>The October 2017 MAR documented Resident #2 did not exhibit any episodes of delusions or verbal aggression.</p> <p>The November 2017 MAR documented Resident #2 exhibited delusions from 11/2/17 through 11/4/17 and was verbally aggressive on 11/3/17 and 11/4/17.</p> <p>The October 2017 Behavior Monitor Flowsheets documented Resident #2 experienced continuous delusions during morning shift from 10/10/17 through 10/17/17, and three times daily on 10/19/17, 10/23/17, 10/25/17, and 10/28/17.</p> <p>November 2017 Behavior Monitors documented Resident #2 exhibited continuous delusions during morning shift from 11/3/17 through 11/7/17, and delusions during the 11/3/17 evening shift.</p> <p>October 2017 Behavior Monitors documented</p>	F 329			

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F 329	<p>Continued From page 70</p> <p>Resident #2 was verbally aggressive during morning shift on 10/1/17 through 10/9/17; 10/11/17 through 10/17/17; 10/19/17; 10/21/17; 10/23/17; 10/28/17; and 10/30/17.</p> <p>November 2017 Behavior Monitors documented Resident #2 was verbally aggressive during morning shift from 11/1/17 through 11/7/17, and during evening shift from 11/1/17 through 11/3/17.</p> <p>The October and November 2017 Behavior Monitors included an additional section in which staff documented Resident #2 was "yelling" on 10/8/17; "ganging up on other residents" on 10/10/17; "manic most of the day" on 10/11/17; "bullying" on 11/1/17; "very paranoid about [Resident #1] coming to her room" on 11/4/17; and "paranoid" about an unidentified resident "from another hall hiding in her bathroom" in an undated entry.</p> <p>Progress Notes, dated 10/1/17 through 11/7/17, did not document Resident #2 experienced delusions, but noted the resident was verbally aggressive, displayed "increased behaviors," and was "argumentative" on 10/9/17. A 10/10/17 progress note documented Resident #2 was involved in a "verbal altercation," and called a staff member a "horrible word" on 11/4/17.</p> <p>A Psychiatric Progress Note, dated 11/6/17, documented Resident #2's delusions and hallucinations had worsened the previous "couple weeks," and that she was "seeing people in her room and frequently ... yelling out and accusing staff and other patients of various things that are not occurring."</p>	F 329			

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F 329	Continued From page 71  d. A Gradual Dose Reduction (GDR) Review for Abilify, Clonazepam, Loxapine, and Rozerem, dated 9/22/17, documented Resident #2's behavior was "stable" with 32 instances of verbal aggression, 32 hallucinations, and 19 delusions, all on morning shift. Resident #2's clinical record did not include documentation that staff monitored for hallucinations.  The Psychoactive Medication Review addressed the following medications, but did not address Cymbalta, which was ordered 7/10/17 to treat Resident #2 for panic disorder:  * Abilify 20 mg each night for hallucinations, paranoia, and delusions.  * Clonazepam 1 mg three times daily and 0.5 mg each night for hallucinations, paranoia, delusions and verbal aggression. Resident #2's physician had ordered a daily Clonazepam dosage of 7 mg.  * Loxapine 50 mg each night and 25 mg twice daily for hallucinations, paranoia, delusions and verbal aggression. Resident #2's physician had ordered a daily Loxapine dosage of 75 mg.  * 8 mg Rozerem each night for insomnia.  The GDR Review did not consider whether these psychotropic medications, as well as the physician-ordered Cymbalta, potentially contributed to Resident #2's documented behaviors and/or insomnia.  A Pharmacy Note to Resident #2's physician, dated 10/6/17, documented Resident #2 received	F 329		

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F 329	<p>Continued From page 72</p> <p>Abilify 20 mg and Loxapine 25 mg each morning and 50 mg each night for "schizoaffective disorder," for which the facility was required to provide a clinical rationale for the dual therapy.</p> <p>On 10/30/17, Resident #2's physician responded to the Pharmacy Note by stating Resident #2's Abilify and Loxapine were ordered to treat schizophrenia. Neither the pharmacist nor physician addressed Resident #2's use of Clonazepam for schizophrenia.</p> <p>On 11/8/17 at 9:13 am, LSW #2 stated Resident #2's Abilify dosage was increased due to address an increase in delusions, which included seeing different people and hearing voices, which tended to increase during holidays. LSW #2 stated she could not determine whether an incident involving Resident #1 entering her room uninvited may have contributed an increase in behaviors and medication increases, but that the incident "might not have helped."</p> <p>On 11/8/17 at 10:10 am, the Acting Director of Nursing (ADON) said specific behaviors were not, but should have been, identified on Resident #2's care plan. Including specific behaviors, the ADON stated, would have assisted staff monitoring and evaluating the efficacy of the resident's medications in treating her schizophrenia. The ADON stated she did not know whether Resident #2's increased behaviors were related to the incident involving Resident #1 wandering into her room uninvited and swore at Resident #2, who was in a state of undress.</p> <p>On 11/9/17 at 12:40 pm, Resident #2's physician stated the Abilify was increased to address staff</p>	F 329			

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F 329	<p>Continued From page 73</p> <p>reports of increased accusatory behaviors and delusions. The physician stated Resident #2 believed "things were happening to her" that were not and that she accused others of "things" they had not done. The physician stated facility nurses should also document the clinical rationale for dosage increases in progress notes, and that he was not aware of the incident involving Resident #1 and Resident #2.</p> <p>2. Resident #1 was admitted on 9/20/17 with diagnoses including major depressive disorder with psychotic features and Alzheimer's.</p> <p>Resident #1's 9/27/17 Admission MDS assessment documented severe cognitive impairment, delusions, and physical behaviors.</p> <p>Resident #1's 9/20/17-11/20/17 Order Summary Report documented medications including:</p> <ul style="list-style-type: none"> <li>* Benadryl tablet 25 mg three times a day for pruritis (itching), ordered on 10/21/17.</li> <li>* Geodon 20 mg intramuscularly (an injection into the muscle) every 12 hours as needed for agitation, ordered on 10/4/17</li> <li>* Risperdal tablet 0.5 mg one time a day for dementia-related psychosis, ordered on 11/2/17.</li> <li>* Risperdal tablet 1 mg in the afternoon for dementia-related psychosis, ordered on 11/2/17.</li> <li>* Rozerem tablet 8 mg one time a day for insomnia, ordered on 10/24/17.</li> <li>* Tegretol tablet 200 mg by mouth two times a day for intermittent explosive disorder, ordered on 9/25/17.</li> <li>* Trazodone tablet 100 mg one time a day for depression, ordered on 11/2/17.</li> </ul>	F 329			

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F 329	<p>Continued From page 74</p> <p>* Xanax tablet 0.25 mg one time a day for generalized anxiety disorder, ordered on 11/6/17. * Zyprexa tablet 5 mg every 6 hours as needed for psychosis, ordered on 10/24/17.</p> <p>Resident #1's 10/1/17-10/9/17 pharmacy Consultation Report documented the pharmacist recommendation to the physician that the orders for Risperdal, Zyprexa, and Geodon should be reviewed regarding why the combined therapy was needed. The physician responded on 10/30/17, "Zyprexa DCd (discontinued). Due to the high levels of psychotic behaviors he is in need of both a scheduled and prn (as needed) antipsychotic to keep him and others safe from harm. PRN will be discontinued once he stabilizes on the scheduled meds."</p> <p>Resident #1's 9/20-17-11/20/17 Order Summary Report documented Zyprexa Zydis tablet 5 mg 1 every 6 hours as needed for psychosis was ordered on 10/24/17.</p> <p>Resident #1's 10/31/17 Physician's Order Note documented the physician discontinued the Zyprexa Zydis on the previous day.</p> <p>Resident #1's 11/1/17-11/30/17 MAR documented the Zyprexa Zydis tablet was administered on 11/5/17, 11/6/17, and 11/7/17. There was no documentation that a new order for Zyprexa was received, no documentation regarding the indications for use of Zyprexa and no documentation regarding non-pharmacological interventions tried before PRN administration.</p> <p>Resident #1's 9/20-17-11/20/17 Order Summary</p>	F 329			

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F 329	<p>Continued From page 75</p> <p>Report documented Xanax tablet 0.25 mg one time a day for Generalized Anxiety Disorder, ordered on 11/6/17.</p> <p>Resident #1's 11/6/17 Physician's Order Note documented the physician ordered Xanax 0.25 mg twice a day. The rationale for the medication order was not documented.</p> <p>Resident #1's 11/1/17-11/30/17 MAR documented the Xanax was administered on 11/7/17, 11/8/17, and 11/9/17.</p> <p>Resident #1's Behavior Monitor Flowsheets-Antidepressant, documented the following:</p> <ul style="list-style-type: none"> <li>* Resident #1 exhibited delusions continuously on multiple dates and times in October and November.</li> <li>* Resident #1 exhibited physical aggression at night on multiple dates in October and multiple dates on the am shift and pm shift.</li> <li>* Resident #1 exhibited verbal aggression towards others on multiple dates in November on the pm shift.</li> <li>* Resident #1 exhibited wandering into others' rooms on multiple dates and times during November.</li> </ul> <p>Resident #1's Behavior Monitor Additional Behavior Details documented the following:</p> <ul style="list-style-type: none"> <li>* On 10/23/17, Resident #1 attempted to enter other residents' rooms, went to the other side of</li> </ul>	F 329			

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F 329	<p>Continued From page 76</p> <p>the building, called other residents names, and became "mad" when staff attempted to redirect him.</p> <p>* On 10/24/17 and 10/25/17, Resident #1 tried to enter other residents' rooms and became aggressive when staff redirected him.</p> <p>*On 11/2/17, Resident #1 was verbally aggressive towards other residents and staff. Resident #1 was wandering into other residents' rooms, waking residents up, telling them to leave, yelling and screaming when he was asked to leave. Resident #1 "wanting to hit and threaten[ed] to kill residents on [the] other side!"</p> <p>*On 11/3/17, Resident #1's 11/3/17 was "continuously" entering other residents' rooms and started yelling when CNAs redirected him.</p> <p>On 11/7/17 from 2:18 pm - 3:39 pm, Resident #1 was asleep in the television room facing a fish tank.</p> <p>On 11/8/17 at 9:10 am, Resident #1 was asleep in a chair while sitting in the hallway near the Executive Director's office.</p> <p>On 11/8/17 at 4:45 pm, Resident #1 was sitting in the same chair in the hallway near the Executive Director's office. Resident #1 appeared somnolent, and was observed sitting in this chair and frequently sleeping throughout most of the day.</p> <p>On 11/9/17 at 5:20 pm, the ADON said Resident #1 was given PRN medication to keep him from "hurting staff." The ADON said Resident #1 was</p>	F 329			

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F 329	Continued From page 77 more calm the past couple of days and she thought it was due to his medication regimen. The ADON said a GDR had been attempted for Resident #1 but it didn't work. The ADON said they tried the GDR on a Monday and Resident #1 "blew up in the hall" on Thursday, so they called the physician and obtained an order to administer an injection of Zyprexa (an antipsychotic medication) and then resumed the previous Zyprexa because it did not work to take him off the medication. The ADON said they called to obtain an order for the Zyprexa injection because they could not get Resident #1 distracted enough after 15 minutes. The ADON said the medications for Resident #1 would be discussed at the next GDR meeting and she did not know when the physician would see the resident again. The ADON said sometimes it is appropriate to give medications because there is nothing else to calm the resident and keep them from hurting themselves. The ADON said first the staff should try to distract and re-direct the resident. The ADON said the reason for administering a PRN medication and non-pharmacological interventions should be documented in the resident's Progress Notes or Behavior Monitor.  On 11/9/17 at 12:40 pm, the physician said the RN (Registered Nurse) should put a note in the resident's chart regarding the reason that a medication was administered.	F 329			
F 363 SS=E	MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED CFR(s): 483.60(c)(1)-(7)  (c) Menus and nutritional adequacy.  Menus must-	F 363		1/4/18	

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F 363	Continued From page 78  (c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;  (c)(2) Be prepared in advance;  (c)(3) Be followed;  (c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;  (c)(5) Be updated periodically;  (c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and  (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, review of menus, and resident and staff interviews, the facility failed to ensure menus were followed for 1 of 4 sampled residents (#4). This failed practice had the potential for harm if residents were dissatisfied with their meals or weight loss. Findings include:  The Diet Guide Sheet, for the 11/7/17 breakfast service, included scrambled eggs, pumpkin chocolate chip muffin, choice of cereal, milk, and 100% juice of choice.  On 11/7/17 beginning at 7:36 am, breakfast was served to residents in the East and West dining	F 363	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.		

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F 363	<p>Continued From page 79</p> <p>rooms. The kitchen staff served residents on regular diets a small pumpkin chocolate chip muffin, scrambled eggs, cereal, and milk. At 7:40 am, Cook #1 told her staff "we are out of muffins and will have to use Texas Toast." Breakfast trays were served with one slice of white bread cut in half toasted with cinnamon and sugar.</p> <p>On 11/7/17 at 8:32 am, Cook #1 stated she had to use Texas Toast in the middle of breakfast services because there were no more muffins. Cook #1 stated she was unsure why there were not enough muffins prepared for breakfast services. Cook #1 stated she would guess the cook who prepared the muffins did not make enough or there were not enough ingredients to make the muffins. Cook #1 stated the facility did not currently have a Dietary Manager and two of the other cooks were responsible for the ordering in her absence. Cook #1 stated a new Dietary Manager was hired, however, she would not start until later in the month.</p> <p>On 11/7/17 at 1:31 pm, Registered Dietitian (RD) #1 stated she was unsure why the muffins ran out at breakfast. RD #1 stated the facility was responsible for ensuring the foods listed on the menu were available to residents.</p>	F 363	<p><b>Resident Specific</b> The ID team reviewed resident #4 for weight loss and other adverse effects based on the findings of the CMS-2567. No adverse effects were identified, resident satisfied with menu and what is being served.</p> <p><b>Other Residents</b> The new Culinary Manager hosted a culinary specific meeting with residents to address culinary concerns, a review of the menu and available menu alternatives. Additionally the facility followed-up on resident specific culinary grievances.</p> <p><b>Facility Systems</b> Culinary team is educated by the new culinary director to serve the food as identified on the menu, to include but not limited to preparing enough for the facility census. The new culinary director is educated by the Resource Culinary Director to place food orders based on current and anticipated census. The system is amended to include filling the culinary director vacant position.</p> <p><b>Monitor</b> The Social Worker and/or designee will conduct 4 resident interviews weekly to determine menu items served as indicated for 4 weeks, then 4 residents twice monthly for 2 months. In addition, the new culinary director will host resident meetings twice monthly for 3 months to review the facilities menu options, quality</p>		

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F 363	Continued From page 80	F 363	and other culinary issues as identified by the residents. Starting the week of Dec 24th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 490 SS=L	<p><b>EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</b> CFR(s): 483.70</p> <p>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, review of facility policies and procedures, resident grievances, and resident and staff interviews, it was determined the facility failed to follow their policies and standards of practice regarding identification, reporting, and investigation of abuse and neglect; train and verify staff competency in the provision of care and services; and ensure adequate supervision was provided to protect residents from harm. This failed practice placed the health and safety of 4 of 4 (#'s 1-4) residents and all other residents in the facility in immediate jeopardy of serious harm, impairment or death from abuse or neglect. Findings include:</p> <p>1. Immediate Jeopardy was identified in the following areas:</p>	F 490	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care of Cascadia and its Executive Director does not admit that the deficiencies listed on the CMS Form-2567 exist or that the staff quotations listed are accurate and/or in context. Nor does the Facility admit to any statements, findings, facts, or conclusions that for the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts, and conclusions that form the basis for the deficiency.</p> <p>Resident Specific</p>	1/4/18	

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F 490	<p>Continued From page 81</p> <p>* Refer to F 225 as it relates to the facility's failure to ensure allegations of abuse were recognized, investigated, and reported to the facility's Abuse Coordinator as abuse or neglect.</p> <p>* Refer to F 226 as it relates to the facility's failure to operationalize policies and procedures to prevent, identify, investigate, protect against, and report potential incidents of resident abuse, neglect, and/or misappropriation of property.</p> <p>* Refer to F 323 as it relates to the facility's failure to ensure adequate supervision was provided to wandering residents whom then engaged in verbally abusive altercations with other residents.</p> <p>* Refer to F 520 as it relates to the facility's failure to ensure the Quality Assessment and Assurance program effectively monitored facility care processes to protect residents from potential harm.</p> <p>On 11/7/17 at 2:50 pm, CNA #1 stated she never witnessed Resident #1 going into another residents room.</p> <p>On 11/8/17 at 9:13 am, LSW #2 said she was aware that a male resident #1 had wandered into a female resident's room, however, she was not aware that the female resident had considered this event "abusive." LSW #2 said if an altercation occurred between two residents, ideally social services would have followed up, and it would be documented in each residents' chart. LSW #2 stated she had not followed up on any such incidents recently. LSW #2 stated if she</p>	F 490	<p>See F 225 and F323</p> <p>Other Residents See F225 and F323</p> <p>Facility Systems Administrative staff received education from the Director of Clinical Operations related to following policies and standards of practice regarding abuse and neglect, accidents and incidents to include supervision of residents, QAPI, and responsibilities of Administration. The system is amended to include review of new admissions, behavioral trending, and residents with intrusive wandering and/or aggressive behaviors in behavioral meeting. Adjustments to be made as indicated.</p> <p>Monitor The Director of Operations and/or designee will review grievance logs, incident reporting, behavior trending, survey interviews, and QAPI agendas monthly for 3 months starting January 2018. The review will be documented and added to QAPI agenda for team review. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>CALDWELL OF CASCADIA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 CLEVELAND BOULEVARD CALDWELL, ID 83605</b>		
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F 490	<p>Continued From page 82</p> <p>witnessed an abuse incident she would intervene right then and there and would not always document it. She stated if an abusive incident was reported to her she would investigate the incident and document it on an abuse investigation form.</p> <p>On 11/8/17 at 9:40 am, LSW #1 stated:</p> <ul style="list-style-type: none"> <li>* If a resident wandered into another resident's room, it should be investigated.</li> <li>* The ED told LSW #1 which "verbal incidents" needed to be investigated.</li> </ul> <p>During the same interview LSW #1 stated, regarding Resident #1 and #2 specifically:</p> <ul style="list-style-type: none"> <li>* She was aware of Resident #1 calling other residents names, but was not sure which residents.</li> <li>* She was aware of a "verbal altercation" involving Resident #1 and Resident #2 the previous week.</li> <li>* She was present when Resident #2 reported an allegation of "verbal abuse" and she felt "unsafe." LSW #1 could not explain the lack of investigation for this allegation.</li> <li>* The "altercation" had not been investigated.</li> <li>* Reports of Resident #1's wandering were "hearsay."</li> <li>* The facility needed to protect other residents from Resident #1, and had implemented measures including adjusting the resident's medications, attempting to get him to walk in another direction, and stopping him before he entered other resident's rooms.</li> <li>* The facility could not stop a mobile resident, such as Resident #1, from wandering.</li> </ul>	F 490		

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F 490	<p>Continued From page 83</p> <p>* Other residents in the facility had been educated to "gently redirect" Resident #1 if he wandered into their rooms. The facility was unable to provide evidence this education with other residents had occurred.</p> <p>* She did not know how many resident rooms Resident #1 had entered, how long he had remained in the rooms, whether other residents were in the rooms when he entered, or how frequently this behavior occurred.</p> <p>* Without an investigation into the allegations of verbal abuse regarding Resident #1, it was not possible to rule out physical, mental, or sexual abuse, given the nature of the allegations.</p> <p>On 11/8/17 at 10:10 am, the Executive Director (ED) stated it was not facility protocol to complete a full investigation for "all" incidents of verbal abuse. The ED stated the facility was a behavior unit and the staff would be doing investigations "all the time" if they completed an investigation for each incident. The ED stated he was not aware of the verbally abusive incidents that occurred as identified in F225. He stated the QAA had not recently reviewed abuse and neglect in their QAA committee meeting. The ED stated the facility cannot always keep residents on their designated sides, however, the facility tried to segregate them. The ED stated he was aware of a person who wandered and staff were instructed to try and keep that resident from going beyond the kitchen.</p> <p>The facility's failure to have knowledge of the impact of Resident #1's unsupervised wandering, recognize and investigate all allegations of abuse, and protect residents from further abuse, placed all residents in the facility at immediate</p>	F 490			

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F 490	<p>Continued From page 84 risk of serious harm or injury.</p> <p>The facility was notified in writing of the Immediate Jeopardy and the need to develop and implement a plan of removal on 11/8/17 at 4:52 pm.</p> <p>On 11/9/17 at 12:00 pm, the facility provided an acceptable plan to remove the immediacy. The plan included:</p> <ul style="list-style-type: none"> <li>* Administrative staff received education from the Director of Clinical Operations related to abuse and neglect, accidents and incidents to include supervision of residents, the QAA and responsibility of the Administration. The Director of Clinical Operations would also educate all staff prior to their next shift.</li> <li>* The ED would ensure the facility investigated verbal abuse incidents and implement the facility's abuse policy.</li> <li>* The leadership team would provide oversight to staff regarding the management of wandering residents and increased supervision to prevent resident to resident altercations and verbal abuse.</li> </ul> <p>Implementation of the above actions was verified on-site and the facility informed on 11/9/17 at 5:00 pm, that the immediate jeopardy was removed.</p> <p>2. Non-Immediate Jeopardy deficiencies were identified in the following areas:</p> <ul style="list-style-type: none"> <li>* Refer to F 166 as it relates to residents'</li> </ul>	F 490			

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F 490	Continued From page 85 complaints not being recognized or investigated as allegations of abuse.  * Refer to F 174 as it relates to inadequate private phone access for residents.  * Refer to F 250 as it relates to the facility's failure to provide medically related social services to residents whose behaviors placed them at risk of being abused by other residents, or to residents who had been abused by other residents.  * Refer to F 279 as it relates to the development of comprehensive care plans.  * Refer to F 329 as it relates to the failure of identification of targeted behaviors, indications for the use of psychotropic medications, and monitoring of psychotropic medication usage.  * Refer to F 497 as it relates to the failure of completion of staff in-service trainings and competency-based trainings.  * Refer to F 501 as it relates to the facility's policies and procedures were not reviewed and signed off by the Medical Director.	F 490			
F 497 SS=E	NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE CFR(s): 483.35(d)(7)  (d)(7) Regular In-Service Education  The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these	F 497		1/4/18	

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F 497	<p>Continued From page 86 reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to develop and implement a nurse aide training program that documented at least 12 hours per year of in-service education to maintain competency of 46 of 59 CNAs. This failure had the potential to harm all residents in the facility due to lack of documentation that nurse aides were able to competently provide care to residents. Findings include:</p> <p>On 11/9/17 at 3:35 pm, the ADON (Acting Director of Nursing) stated the facility was transitioning to a new system due to new ownership. The ADON stated the previous company took the documentation when the facility was sold. The ADON stated the present staff in-service and competency-based training documentation did not include education provided in 2016. The ADON stated the facility could not provide documentation CNAs received at least 12 hours of training in the last 12 months. The ADON stated she was in the process of completing CNA performance reviews.</p>	F 497	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>Resident Specific CNAs with hire dates in November and December have 12 hours of inservice education documented in their files.</p> <p>Other Residents Other CNA records are reviewed and monitoring implemented to validate 12 hours of education prior to their annual review.</p> <p>Facility Systems CNA's were educated by SDC regarding requirements for 12 hours of education documented annually. Staff will be removed from the schedule if the education is not completed prior to their annual hire date. The system is amended to include a listing by staff as to the education that they have completed and</p>		

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F 497	Continued From page 87	F 497	monitoring by the SDC. Offering of 1 or more CEUs each month to staff. Additionally, software programs for education and competency testing is added to the curriculum.  Monitor The SDC and/or designee will review staff with upcoming annual reviews for required 12 hours of education monthly. The review will be documented on the employee listing of hire dates. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 520 SS=L	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i)  (g) Quality assessment and assurance.  (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:  (i) The director of nursing services;  (ii) The Medical Director or his/her designee;  (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and  (g)(2) The quality assessment and assurance committee must :	F 520		1/4/18	

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F 520	Continued From page 88  (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and  (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;  (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.  (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and review of the facility's policies and procedures, it was determined the facility failed to ensure the Quality Assessment and Assurance Program (QAA) identified deficient practices, and developed and implemented effective plans of action to protect residents related to potential abuse and neglect, accidents, incidents, and quality of care issues that placed the health and safety of all 62 residents in the facility in Immediate Jeopardy of serious harm, impairment or death. The QAA program additionally failed to ensure prior deficient practice did not recur. The lack of a effective ongoing QAA processes placed all	F 520	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care of Cascadia and its Executive Director does not admit that the deficiencies listed on the CMS Form-2567 exist or that the staff quotations listed are accurate and/or in context. Nor does the Facility admit to any statements, findings, facts, or conclusions that for the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts, and conclusions that form the basis for the deficiency.		

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F 520	<p>Continued From page 89</p> <p>residents in the facility in immediate jeopardy of impairment, or death. Findings include:</p> <p>1. The following deficiencies were identified as an Immediate Jeopardy during the survey:</p> <p>* Refer to F 225 as it related to the facility's failure to ensure verbal abuse was recognized, investigated, and reported to the facility's Abuse Coordinator as potential indicators of abuse or neglect.</p> <p>* Refer to F 226 as it related to the facility's failure to operationalize policies and procedures to prevent, identify, investigate, protect against, and report potential incidents of resident abuse, neglect, and/or misappropriation of property.</p> <p>* Refer to F 323 as it related to the facility's failure supervise residents who engaged in verbally abuse, entering other resident rooms uninvited and intimidation of other residents. The facility was previously cited at F 323 during the prior recertification surveys on 12/2/16.</p> <p>* Refer to F 490 as it related to the oversight of daily operations related to resident care.</p> <p>On 11/8/17 at 10:10 am, the Executive Director (ED) stated it was not facility protocol to complete a full investigation for "all" incidents of verbal abuse. The ED stated the facility was a behavior unit and the staff would be doing investigations "all the time" if they completed an investigation for each incident. The ED stated he was not aware of the verbally abusive incidents that occurred as identified in F 225.</p>	F 520	<p>Resident Specific</p> <p>The Quality Assurance Performance Improvement (QAPI) committee met on November 9th, 2017 to address the concerns noted in F225, F226, F323 and F490. The safety plan was approved as noted in the CMS-2567.</p> <p>Other Residents</p> <p>All facility residents are impacted by the QAPI committee. Additional ad hoc committee's and monthly committee meeting are completed with minutes.</p> <p>Facility Systems</p> <p>Staff received education from the Director of Clinical Operations related to abuse and neglect, increased supervision to prevent resident to resident abuse, QAPI, and responsibility of the administrative staff. The QAPI committee meets monthly or as needed to address all cases of abuse, neglect, accidents, resident grievances, administrative oversight, and other items requiring monitoring or action plans for operations and clinical issues. The committee consists of the ED, DNS, Medical Director, Pharmacist, Social Workers, and other leadership roles as indicated. The system is amended to include documentation of action taken to meet operational compliance.</p> <p>Monitor</p> <p>The Director of Operations and/or designee will monitor the QAPI meeting agenda and minutes for 3 months to</p>		

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F 520	<p>Continued From page 90</p> <p>He stated the QAA had not recently reviewed abuse and neglect in their QAA committee meeting. The ED stated the facility cannot always keep residents on their designated sides, however, the facility tried to segregate them. The ED stated he was aware of a person who wandered and staff were instructed to try and keep that resident from going beyond the kitchen.</p> <p>The facility was notified in writing of the Immediate Jeopardy and the need to develop and implement a plan of removal on 11/8/17 at 4:52 pm.</p> <p>On 11/9/17 at 12:00 pm, the facility provided an acceptable plan to remove the immediacy. The plan included:</p> <ul style="list-style-type: none"> <li>* Administrative staff received education from the Director of Clinical Operations related to abuse and neglect, accidents and incidents to include supervision of residents, the QAA and responsibility of the Administration. The Director of Clinical Operations would also educate all staff prior to their next shift.</li> <li>* The ED and leadership team would provide oversight to staff regarding the management of wandering residents and increased supervision to prevent resident to resident altercations. Concerns regarding potential verbal abuse would be presented in the QAA committee meetings as needed.</li> <li>* The facility would review their abuse policy and procedure in the QAA committee. The QAA committee would ensure the facility investigated incidents of verbal abuse appropriately and</li> </ul>	F 520	<p>ensure the facility is appropriately identifying deficient practices. The CMS-2567 Plan of Correction audits will be reviewed at the QAPI meeting to validate compliance beginning January 2018.</p>		

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F 520	<p>Continued From page 91 ensure the facility's abuse policy was implemented.</p> <p>Implementation of the above actions was verified on-site and the facility informed on 11/9/17 at 5:00 pm, that the immediate jeopardy was removed.</p> <p>2. The facility's QAA program did not provide sufficient monitoring to maintain ongoing compliance and had the potential for harm to all residents in the facility due to care and services not being provided in a safe and effective manner as follows:</p> <p>* Refer to F 329 as it related to the administration of medications with specific target behaviors identified for monitoring, specific indications for use and clinical rational and justification for the continued use of a medication.</p> <p>On 11/8/17 at 12:05 pm, the ED stated the QAA recently reviewed staffing issues, infection control, weight loss, workers compensation, and phase 2 regulation changes in their meeting. The ED stated the QAA committee had not previously identified the issues above or other concerns brought forth during the survey.</p>	F 520			



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
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E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

January 4, 2019

Bryan McNeil, Administrator  
Caldwell of Cascadia  
210 Cleveland Boulevard  
Caldwell, ID 83605-3622

Provider #: 135014

Dear Mr. McNeil:

On **November 9, 2017**, an unannounced on-site complaint survey was conducted at Caldwell of Cascadia. The Complaint was investigated during a Complaint Survey conducted November 7, 2017 to November 9, 2017. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007666**

**ALLEGATION #1:**

The facility failed to investigate allegations of verbal abuse, resident complaints and grievances.

**FINDINGS #1:**

The Complaint was investigated during a Complaint Survey conducted November 7, 2017 to November 9, 2017.

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

Bryan McNeil, Administrator  
January 4, 2019  
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The clinical records of the identified resident and three other residents were reviewed for quality of life and quality of care concerns. Specifically reviewed were abuse and neglect concerns, grievances, and resident to resident interactions. The facility's grievance files, Incident and Accident reports, and reportables were also reviewed. A full abuse and neglect task was completed.

Interviews were conducted with multiple individual residents. Direct care staff, including nurses, and nursing aides; and the facility's Acting Director of Nursing Services, Social Workers, Executive Director, and Medical Director were also interviewed. Interview questions included resident phone access, abuse and neglect, quality of life and quality of care.

Based on interviews with residents and facility staff, there were concerns with resident complaints and grievances and verbal abuse incidents not being investigated.

Based on interviews and record reviews the allegation was substantiated and cited at F174, F225, F226, F250, F490, and F520.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #2:

The facility failed to allow residents private access to use the phone.

#### FINDINGS #2:

Interviews were conducted with multiple individual residents, nurses, nursing aides, and the Acting Director of Nursing Services. The interviews included questions about private phone access.

The identified resident's clinical record was reviewed and notes were found documenting the nurse told the resident she had to make a phone call in front of the nurse.

Based on interviews with residents and facility staff and record review there were concerns lack of private phone use and the allegation was substantiated and cited at F174.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Bryan McNeil, Administrator  
January 4, 2019  
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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 any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in cursive script that reads "Belinda Day".

Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj