



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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3232 Elder Street
P.O. Box 83720
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February 1, 2018

David Welker, Administrator
Clearwater of Cascadia
1204 Shriver Road
Orofino, ID 83544-9033

Provider #: 135048

Dear Mr. Welker:

On **January 23, 2018**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of December 7, 2017. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- **F0323 -- S/S: G -- 483.25(d)(1)(2)(n)(1)-(3) -- Free Of Accident Hazards/supervision/devices**
- **F0329 -- S/S: D -- 483.45(d)(e)(1)-(2) -- Drug Regimen Is Free From Unnecessary Drugs**

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 **February 12, 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*.

As noted in the Bureau of Facility Standards' letters of **September 18, 2017** and **November 29, 2017**, following the surveys of **August 23, 2017** and **November 14, 2017**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for imposition of civil monetary penalties, Denial of Payment for New Admissions effective **November 28, 2017** and termination of the provider agreement on **February 25, 2018**, if substantial compliance is not achieved by that time. The findings of non-compliance on **January 23, 2018**, has resulted in a continuance of the recommended remedy(ies) previously mentioned to you on September 18, 2017 and November 29, 2017.

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

David Welker, Administrator
February 1, 2018
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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, 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.

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 **February 12, 2018**. If your request for informal dispute resolution is received after **February 12, 2018**, 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,



Debby Ransom, RN, RHIT, Supervisor
Long Term Care

David Welker, Administrator
February 1, 2018
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DR/lj

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

PRINTED: 02/26/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/23/2018
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS On January 22, 2018 through January 23, 2018, an on-site follow-up survey of your facility was conducted The surveyors conducting the survey were: David Scott, RN - Team Leader Nina Sanderson, LSW cm = centimeter CNA = Certified Nursing Assistant DON = Director of Nursing IDT = Interdisciplinary Team LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set mg = milligrams NN = Nurse's Notes PRN = as needed UTI = Urinary Tract Infection w/c = Wheelchair	{F 000}			
{F 323} SS=G	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 and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility	{F 323}		2/8/18	

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

TITLE

(X6) DATE

Electronically Signed

02/06/2018

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 323}	<p>Continued From page 1</p> <p>must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents were provided with adequate supervision and assistive devices to prevent accidents and injuries. This was true for 3 of 5 residents (#s 22, 24, and 26) reviewed for supervision and accidents. Resident #26 was harmed when she fell from a wheelchair and sustained 2 fractured ribs with acute onset of pain, and Resident #24 was harmed when she fell and sustained a head laceration requiring sutures. Findings include:</p> <p>1. Resident #26 was admitted to the facility on 4/24/17 with diagnoses that included dementia with behaviors, osteoarthritis, left hip pain, muscle weakness, and difficulty walking. The resident was also noted be be unsteady on her feet.</p> <p>A quarterly MDS assessment, dated 11/9/17, documented Resident #26 had experienced 1 fall with injury since admission to the facility.</p>	{F 323}	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Clearwater 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>F323 Accident Hazards/Supervision/Devices Resident Specific The Interdisciplinary (ID) team reviewed resident #22, 24, and 26 fall plans. The fall risk assessment was update, fall trending reviewed for patterns, and plan of care updated to address root-cause of</p>		

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{F 323}	<p>Continued From page 2</p> <p>An 11/2/17 Fall Risk Evaluation documented Resident #26:</p> <ul style="list-style-type: none"> * Experienced intermittent confusion * Experienced 1 - 2 falls within the preceding 3 months * Exhibited decreased muscular coordination * Experienced cognitive impairment * Was independently mobile in a wheelchair * Scored "12" on a scale placing residents at risk for falls when scoring "10 or higher <p>Resident #26's Physician Orders, dated 12/31/17, directed staff to assess Resident #26 for pain each shift and provide Tylenol, 500 mg, PRN twice daily for pain.</p> <p>The December 2017 Medication Administration Record (MAR) documented Resident #26 received 1 Tylenol tablet on 12/7/17.</p> <p>A Fall Scene Investigation Report documented Resident #26 fell on 1/1/18 at 11:00 am when she slid out of her wheelchair seat while visiting a male resident in the facility (Resident #28). The report documented Resident #26 and Resident #28 "frequently" visited one another in the male resident's room. The report documented Resident #26's w/c "rolled back and she slid out. Request to have anti-roll back [mechanism] placed on w/c."</p> <p>A 1/1/18 IDT Note documented Resident #26 "scouted to edge of wheelchair ... sitting next to male friend ... observed resident lean forward reaching for chest area on male friend. Slid off w/c seat onto floor." IDT Progress Notes</p>	{F 323}	<p>falls.</p> <p>" In addition, resident #26 has a monitor to validated function and placement of anti-roll back bars.</p> <p>" In addition, resident #24 has monitor to document 1:1 supervision when utilized.</p> <p>" In addition, resident #22 has a monitor to validate alarm function and placement.</p> <p>Other Residents The clinical management team completed new fall risk assessments. The care plans are reviewed to address fall prevention interventions based on the risk factors identified on the fall risk assessment. Plans are monitored for successful implementation. Monitor tools are established to document function and placement of anti-roll back bars, validate alarm function and placement, and document 1:1 supervision.</p> <p>Facility Systems Staff are re-educated to fall prevention by the Director of Nursing (DON) and/or the Staff Development Coordinator (SDC) to include but not limited to, accident prevention, reviewing falls and trending for root-cause, staff education to implement care plan updates, documentation of interventions to include those for increased supervision or equipment function, and ongoing monitoring to validate implementation of the plan of care. The system is amended to document function and placement of</p>		

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{F 323}	<p>Continued From page 3</p> <p>documented the resident did not experience pain following the 1/1/18 incident.</p> <p>A Maintenance Request Form documented an "anti-roll back" mechanism was requested for Resident #26's wheelchair on 1/3/18 and a Fall Prevention Care Plan documented an anti-roll back mechanism was installed on the resident's wheelchair on 1/4/17.</p> <p>A Fall Scene Investigation Report documented Resident #26 fell on 1/17/18 at 2:45 pm when she slid out of her wheelchair seat while visiting Resident #28. The report documented, "Resident in visiting male friend in room ... saw resident slip out of wheelchair to floor. Complaint [of] back [pain] noted on 1/18/18 ... Pain worsening by pm ... to hospital for x-ray. Emergency room and x-ray reports ... indicate rib fractures ... 5th and 7th rib." The report documented Resident #26 had "new" pain in the "right rib area;" the report did not contain any documentation related to an anti-roll back mechanism on the resident's wheelchair.</p> <p>A hospital Emergency Room report documented, "This is a 91-year-old female ... who fell 1 to 2 days ago and now complains of rib pain.[X-ray] shows ... fractures of the ... 5th and 7th ribs on the right."</p> <p>An IDT Note, dated 1/18/18 at 8:45 pm, documented Resident #26 returned from the hospital with "some [right] rib pain on movement."</p> <p>On 1/19/18, Resident #26's physician directed staff to administer Norco, 5/325 mg, every 4 to 6 hours PRN for pain.</p>	{F 323}	<p>fall prevention equipment i.e. anti-roll back bars and alarms, review in clinical meeting to validate fall prevention plans and documentation are effective, and improved communication with staff on fall prevention plan updates.</p> <p>Monitor The DON and/or designee will audit new residents, residents with falls or other change of condition for fall plan based on risk factors weekly for 12 weeks. Starting the week of February 4, 2018 the review will be documented on the Quality Assurance Performance Improvement (QAPI) audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance February 8, 2018</p>		

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{F 323}	Continued From page 4 The January 2018 MAR documented Resident #26 received one Tylenol tablet for PRN pain on 1/17/18, 1/19/18, and 1/20/18, and Norco twice on 1/19/18, once on 1/21/18, and twice on 1/22/18. Resident #26 received one administration of the analgesic medication for pain at the time of survey on 1/23/18. The January 2018 MAR documented each Norco administration was related to pain associated with the resident's fractured ribs. IDT Notes documented: * 1/17/18 - 2:45 pm: "Resident slipped from chair while in friend's room. Resident stated, 'I was sitting here [and] fell on the floor. I'm fine, I didn't hurt myself.' * 1/17/18 - 7:00 pm: "Resident complained of back pain. Given Tylenol ... PRN ..." * 1/18/18 - 9:45 am: "Called [physician] about back pain and waiting for orders regarding care. Gave [Tylenol] as ordered." * 1/18/18 - 12:45 pm: "[Physician] called and said no x-ray at this time." * 1/18/18 - 5:05 pm: "Increased pain right rib area. [Physician] here. Order for x-ray received." * 1/19/18 - 1:30 pm: "Resident complains of frequent pain to right side." * 1/22/18 - 12:50 pm: "Resident was grimacing and grabbing at her right side, she had complained of pain."	{F 323}			

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{F 323}	Continued From page 5 On 1/23/18 at 8:08 am, Resident #26 was observed eating breakfast in the dining room. The resident's wheelchair was equipped with an auto-locking "anti-roll back" mechanism, with left side properly positioned, however the right side of the mechanism was out of position and pointing toward the floor. On 1/23/18 at 8:53 am, Resident #26 was observed in her wheelchair next to Resident #28, who was sitting in a recliner in his room. Resident #26's auto-locking anti-roll back mechanism was observed in the same position as noted at 8:08 am. On 1/23/18 at 9:00 am, a CNA was observed transporting Resident #26 to her room for cares. At 9:07 am, Resident #26 and the CNA emerged from the resident's room. When approached by a surveyor, the resident grimaced, grabbed her right abdominal area with her left hand, and said, "Ow." Resident #26 stated she experienced "back pain" because "I fell somewhere." The auto-locking anti-roll back mechanism was in the same position noted at 8:08 am and 8:53 am and the resident was able to propel the wheelchair backward without difficulty. On 1/23/18 at 9:15 am, Resident #26 was observed in Resident #28's hallway with the auto-locking anti-rollback device in the same position previously observed. The resident entered Resident #28's room and the two residents watched television holding hands. On 1/23/18 at 10:08 am, Resident #26 was observed sitting in her wheelchair next to	{F 323}			

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{F 323}	<p>Continued From page 6</p> <p>Resident #28 in the recliner in his room. The auto-locking anti-roll back mechanism was in the same position noted at 8:08 am, 8:53 am, 9:00 am, 9:07 am, and 9:15 am.</p> <p>On 1/23/18, at 10:10 am, the DON was observed repairing the right arm of the auto-locking anti-roll back mechanism on Resident #26's wheelchair. Upon request, the DON returned the right side of the mechanism to its earlier observed position, placed the resident in a standing position, and rolled the wheelchair backward for approximately 18 inches without the auto-locking anti-rollback mechanism impeding the wheelchair's progress.</p> <p>On 1/23/18 at 11:15 am, the DON stated the 1/17/18 accident investigation report was not yet completed and that he was repairing Resident #26's auto-locking mechanism during the 10:10 am observation as part of his resident "rounds." When asked to address that day's earlier observations of the auto-locking mechanism, the DON stated he had "no comment."</p> <p>2. Resident #24 was admitted to the facility on 11/9/17 with diagnoses which included dementia and alteration in her activities of daily living.</p> <p>Resident #24's quarterly MDS, dated 1/8/18, documented she had severely impaired cognition; did not wander or reject cares; required extensive assist of one staff for transfers and locomotion in her wheelchair; and was not steady and required physical assistance to stabilize with surface to surface transfers, moving from a seated to standing position, and turning.</p> <p>Resident #24's fall prevention care plan, dated</p>	{F 323}			

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{F 323}	<p>Continued From page 7</p> <p>11/22/17, documented she was at risk for falls due to dementia, impaired mobility, history of falls, and weakness. The care plan directed staff to observe for changes in her cognitive or functional status and reorient her as needed. The care plan was updated to include an alarm to the resident's wheelchair on 11/27/17.</p> <p>Resident #24's behavior care plan, dated 11/22/17, documented a behavioral concern of repeatedly trying to self-transfer and stand up from her chair, with a goal that Resident #24 would have fewer attempts to "stand for no purpose."</p> <p>On 12/7/17 at 3:30 am, Resident #24's NN documented she had been awake most of the shift with "multiple attempts to stand." There were no further entries in the resident's NN until 6:00 that evening. A facility incident report documented Resident #24 was assisted to the floor while trying to self-transfer out of her wheelchair to a couch in the activities room on 12/7/17 at 9:15 am. The root cause of the fall was documented as "mood or mental status."</p> <p>On 12/7/17 at 6:00 pm, Resident #24's NN documented the resident was in her wheelchair in the hall, and "must be reminded continuously to stay in chair."</p> <p>On 12/12/17, Resident #24's Behavior progress note documented, "IDT met to discuss [Resident #24's] recent behavior change. She has become increasingly agitated and irritable. She has also been trying to stand and self-transfer not being able to verbalize why (has no purpose)..."</p>	{F 323}			

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{F 323}	<p>Continued From page 8</p> <p>Resident #24's NNs documented the resident had either continuous or multiple attempts to stand independently on 12/8, 12/10, and 12/11 through 12/15/17.</p> <p>On 12/15/17, Resident #24's care plan was updated to "keep the resident in line of sight with close staff monitoring when up in her wheelchair." Resident #24's NNs continued to document continuous or multiple attempts to stand between 12/16/17 and 1/19/18.</p> <p>On 1/11/18 at 1:30 pm, Resident #24's Behavior Meeting note documented, "...Since 1/2/18, [Resident #24] has been irritable 44 times, tried to self-transfer and stand up 89 times (continuous)...resident is unable to tell us why she cannot stay still or keep from trying to self-transfer..."</p> <p>On 1/20/18 at 6:00 am, Resident #24's NN documented the resident had multiple attempts to self-transfer and required "constant redirection." There were no further NN entries until 9:30 that evening.</p> <p>A 1/20/18 facility incident report documented Resident #24 fell from her wheelchair at 3:30 pm. The report documented the resident was in the hallway outside another resident's room, striking her head on the doorjamb and sustaining a 3 cm laceration to her head. The attached staff statements documented:</p> <p>* "Heard Resident #24's alarm coming from behind me as I was sitting down charting. She was starting to stand near the doorway of Room 25. I started jogging down C hall to get to her, but</p>	{F 323}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/23/2018
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
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{F 323}	<p>Continued From page 9 she stepped...away from her chair..."</p> <p>* "On 1/20/18 at approximately 3:30 pm I heard a chair alarm sound. I looked up from charting at the nurse's station to see Resident #24 laying on the floor down the C hall...Resident #24 was bleeding from the occipital area, so I grabbed gauze and applied pressure...an ambulance was called to get medical attention for the wound. Prior to incident I noted Resident #24 slowly propelling self past nurses station down C hall."</p> <p>The 1/20/18 incident report documented the resident had been toileted and was dry at 2:30 pm. The area of the form to account for the resident's activities and whereabouts in the three hours prior to the fall documented, "Occasionally attempt independent transfer. Staff monitoring."</p> <p>There was no documentation in Resident #24's clinical record regarding frequency of supervision between 1/20/18 at 6:00 am when the resident required "constant redirection," and the time of her fall more than 9 hours later. Neither staff statement documented the resident was in line of sight or receiving increased monitoring as was directed in the resident's care plan. The incident report did not make clear when or where the resident was last observed prior to the fall. Per the facility's floor plan, Room 25, where Resident #24 fell, was 62 feet from the nurse's station, on an opposite hall from the location of Resident #24's room.</p> <p>A 1/20/18 Emergency Room report documented Resident #24 received treatment at the hospital due to a fall at the facility, striking her head and causing a 2.5 to 3 cm laceration, which required</p>	{F 323}			

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{F 323}	<p>Continued From page 10 sutures.</p> <p>On 1/20/18 at 9:30 pm, Resident #24's NN documented she had returned from the hospital after receiving sutures to her wound, and the sutures could be removed in 10 days.</p> <p>On 1/23/18 at 7:40 am, CNA #1 stated Resident #24 "gets agitated a lot and tries to stand up out of her chair." CNA #1 stated the resident typically attempted to stand when she was hungry, had to use the toilet, or heard a loud noise. CNA #1 stated, "We try to keep her in sight, but she has an alarm to let us know when she's trying to get up."</p> <p>On 1/23/18 at 8:30 am, Resident #24 was observed sitting at breakfast in her wheelchair with a lap blanket across her legs. The blanket draped down on either side of her legs to the floor. Resident #24 responded to rote social questions, but did not respond to more specific inquiries. The resident placed her feet on the floor, and began to move her wheelchair backwards. The blanket became entangled in the wheels of her wheelchair. Resident #24 did not seem to be aware of the entanglement, and continued with her efforts to move her wheelchair backwards. The blanket wrapped around the wheels and prevented the chair from moving. The resident continued with her efforts, and her feet became entangled in the blanket as well. The resident did not seem to be aware the movement of her feet was restricted. At 8:40 am, CNA #1 approached the resident and removed the blanket.</p> <p>On 1/23/18 at 10:35 am, LN #1 stated she was</p>	{F 323}			

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{F 323}	<p>Continued From page 11</p> <p>Resident #24's nurse for the current shift. LN #1 stated she had last seen Resident #24 in the activity room, where someone was reading to her. LN #1 went to the activity room, but the resident was not there. LN #1 stated, "Hm. I'm not sure where she is," and walked away. When asked if Resident #24 required staff to be aware of her whereabouts if not in bed, LN #1 stated, "I suppose so," and used her headset to contact other staff to find out where the resident was. At 10:45 am, Resident #24 was located in a ball toss activity. LN #1 stated, "We trade her off, nursing and activities."</p> <p>On 1/23/18 at 10:45 am, Resident #24 was sitting in the ball toss activity, holding her head in her hands. A laceration with sutures was visible on her left occipital area, with her hair combed over the wound.</p> <p>On 1/23/18 at 12:30 pm, the DON stated Resident #24 was admitted to the facility with a known history of falls, noting "in fact, she had staples to the back of her head from a fall when she got here." The DON stated Resident #24 was noted with frequent attempts to self-transfer or stand from her wheelchair, which he attributed to anxiety. The DON stated the facility tried to refrain from using alarms for residents, but given Resident #24's history he thought the alarm was an appropriate fall prevention measure. The DON stated it was not clear from the facility's documentation when Resident #24 was seen prior to her 1/20/18 fall, or if the resident had the level of needed supervision documented in her care plan.</p> <p>On 1/23/18 at 12:45 pm, the Administrator stated</p>	{F 323}			

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{F 323}	<p>Continued From page 12</p> <p>the facility was providing increased supervision for Resident #24 to prevent falls. The Administrator stated, "We had one on one staffing for her both the day before her fall, and the day after." The Administrator stated he did not have documentation of the 1:1 staffing for Resident #24 the day before or after her fall, and did not recall if that level of supervision was in place on the day of the fall.</p> <p>Resident #24, who had a known history of falls and frequent attempts to stand and self-transfer, was harmed when the facility failed to provide adequate supervision to prevent a fall on 1/20/18. Resident #24 sustained a 3 cm laceration to her head, which required sutures.</p> <p>3. Resident #22 was admitted to the facility on 10/3/17 with diagnoses which included dementia and edema.</p> <p>Resident #22's Quarterly MDS assessment, dated 1/10/18, documented he had severely impaired cognition, required extensive assistance of 2 staff for transfers, was dependent on staff for locomotion in his wheelchair, and had 2 or more falls since his previous assessment.</p> <p>Resident #22's Fall Prevention care plan, dated 10/9/17, directed staff to keep his environment free from clutter, observe for adverse reactions to medications, observe for changes in cognition or functional status, and keep the resident in line of sight when up in his wheelchair. On 10/17/17, alarms were added to his bed and wheelchair. On 10/18/17, a new directive was added to make sure the resident was fully awake before transfers, and a perimeter mattress was added</p>	{F 323}			

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{F 323}	<p>Continued From page 13 on 11/29/17.</p> <p>Resident #22's physician's orders included: * Depakote 250 mg each morning and 500 mg at bedtime for dementia with behaviors, 10/19/17. * Lasix 80 mg every morning, 12/5/17. * Spironolactone 25 mg every morning, 12/5/17.</p> <p>Resident #22's Behavior Symptom Monitoring Flow Record for December 2017 and January 2018 documented the presence of "Repeatedly trying to stand up for no reason," and "self-transfers." Non-pharmacological interventions did not include providing increasing supervision for the resident when the behaviors were present. Pharmacological interventions were listed as Depakote and pain medications.</p> <p>A facility incident report documented Resident #22 fell from his wheelchair near the nurse's station on 12/10/17 at 6:35 am. The report documented the resident had received a diuretic medication within the 8 hours prior to the fall, but the space to document when the resident was last toileted was blank. The area of the form to recreate what the resident had been doing for the three hours prior to the fall documented at 6:00 am the resident had been left in his wheelchair at the nurse's station awake. The root cause of the fall was documented as, "Mood or mental status." Three witness statements were attached to the report documented all three responded to the sound of the alarm, then noticed the resident was on the floor. One statement documented staff did not respond to the alarm for 30 seconds after it first sounded. The initial interventions to prevent further falls were documented as, "keep in line of sight when in wheelchair" (which had already</p>	{F 323}			

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{F 323}	<p>Continued From page 14</p> <p>been added to Resident #22's care plan in October 2017), and the placement of auto lock brakes.</p> <p>A 12/15/17 Behavior progress note documented, "...[Resident #22] does tend to try and stand up repeatedly and self transfer. It happens almost daily..."</p> <p>A facility incident report documented Resident #22 fell from bed at 4:05 am on 12/31/17. The report documented the resident was unable to state what he was trying to do, but concluded the resident had, "climbed out of bed." The recreation of the last three hours of the fall documented the resident had been sitting at the edge of his bed a short time before the fall, and staff had "changed the resident and he laid back down." The report surmised the resident may have been trying to reach for something, as he had his oxygen tubing in his hand. The root cause of the fall was documented as, "Mood or mental status," and the plan to prevent further occurrence was to offer to get the resident out of bed, "and to where staff can monitor easily when awake."</p> <p>A facility incident report documented Resident 22 fell from his wheelchair near the nurse's station on 1/8/17 at 6:50 pm. The report documented the resident was unable to state what he had been trying to do before the fall. The recreation of the three hours before the fall documented Resident #22, "Had just returned from meal prior to fall. Toileted just prior to meal." The report documented the fall was an, "intentional change of plane. Resident lowered himself to the floor/foot pedals unable to determine reason."</p>	{F 323}			

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{F 323}	<p>Continued From page 15</p> <p>The plan to prevent further occurrences was, "Continue current instructions."</p> <p>On 1/17/18, a Resident Care Conference Report documented, "...He has had several recent falls and discussed all the interventions that have been put in place. Staff currently checks alarms on his chair and his bed..."</p> <p>On 1/23/18 at 7:25 am, Resident #22's room was observed. The bed had a pressure alarm which was in the "off" position and a perimeter mattress. There was no nightstand or over bed table. There was a small hutch to the left of the head of his bed, even with the pillow. The hutch would have been neither in reach nor in view if the resident was in bed. The resident's water mug and a package of candy was on the hutch. The water mug was empty. CNA #2 entered the room and stated the bed alarm was not always left on as the resident had a preference to sit at the edge of his bed. CNA #2 stated when Resident #22's alarm was going off, it usually meant that he needed the bathroom, or was hungry or thirsty. CNA #2 stated if the resident continued to set his alarms off after those needs had been addressed, she had been instructed to get the resident up and dressed and bring him out of his room. CNA #2 stated she thought what Resident #22 really wanted to do when he was setting his alarm off repeatedly was to get up and walk, but she had been told staff couldn't do that.</p> <p>On 1/23/18 at 8:30 am, Resident #22 was sitting at breakfast. He responded when addressed by name, but did not respond to simple questions or statements beyond that.</p>	{F 323}			

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{F 323}	<p>Continued From page 16</p> <p>On 1/23/18 at 12:30 pm, the DON stated Resident #22 was "a recent admission" and "really needs an alarm" for his own safety. The DON stated the reason Resident #22's bed alarm was in the "off" position was to save on the number of batteries the facility was required to supply.</p> <p>Regarding the resident's fall on 12/10/17, the DON stated the resident had end stage dementia, no safety awareness, and often tried to transfer independently for no apparent reason, so fall prevention was very difficult. The DON stated, "That's why the alarms are important for this resident." The DON did not know if supervision was being provided per the resident's care plan prior to his fall, but stated, "We added the auto-lock brakes."</p> <p>Regarding the 12/31/17 fall from bed, the DON stated the facility determined the resident had intentionally climbed out of bed, rather than fallen, because no one heard the fall. The DON stated, "If he had fallen, there would have been a noise, so we concluded he did it on purpose." The DON stated Resident #22 had anxiety and agitation, and often became "wild with his hands." The DON stated he presumed the resident was either trying to grab something or stand up when he "climbed out of bed." The DON stated the resident had an over bed table in his room where his personal items were placed for easy access to the resident, and when informed of the observation that morning when no over bed table was present stated, "Well it's usually there."</p> <p>Regarding the 1/8/18 fall from the wheelchair, the DON offered no explanation as to how the facility</p>	{F 323}			

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{F 323}	Continued From page 17 determined it was an intentional act for the resident to slide forward out of his wheelchair and sit on his foot pedals.	{F 323}		
{F 329} SS=D	<p>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2)</p> <p>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--</p> <p>(1) In excessive dose (including duplicate drug therapy); or</p> <p>(2) For excessive duration; or</p> <p>(3) Without adequate monitoring; or</p> <p>(4) Without adequate indications for its use; or</p> <p>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--</p> <p>(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;</p>	{F 329}		2/8/18

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{F 329}	Continued From page 18 (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 observation, interview, and record review, it was determined the facility failed to monitor the efficacy of medications used for resident behaviors. This was true for 2 of 6 residents (#22 and 24) sampled for psychotropic medication use. The deficient practice created the potential for harm if the physician made treatment decisions based on misinformation about resident behaviors. Findings include: 1. Resident # 24 was admitted to the facility on 11/9/17 with diagnoses which included depression and dementia. Resident #24's physician's recapitulation orders for January 2018 documented: * Depakote 250 mg twice daily for dementia with behaviors, starting 12/12/17 * Zoloft 50 mg daily beginning 12/12/17 Resident #24's quarterly MDS assessment, dated 1/8/18, documented she had severely impaired cognition, moderate depression, and physical aggression towards others 1-3 days out of the past 7 days which did not interfere with her care. No other behavioral symptoms were documented on the MDS. Resident #24's behavior care plan, dated	{F 329}	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Clearwater 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. F329 Unnecessary Drugs Resident Specific The ID team reviewed resident #22 and 24 behavioral plans, target behaviors, and medication use. They have been updated as indicated to include the physician directives for drug use, target behaviors that result in danger/distress to themselves or others, and person-centered behavioral interventions. Other Residents The ID team reviewed other resident target behaviors to validate physician directives for use were indicated.		

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{F 329}	<p>Continued From page 19</p> <p>11/22/17, documented a behavioral concern of repeatedly trying to self-transfer and stand up from her chair, with a goal that Resident #24 would have fewer attempts to "stand for no purpose."</p> <p>Resident #24's Behavior Symptom Monitoring Flow Record for December 2017 documented the resident was being monitored for self-isolation, increased episodes of crying, irritability, standing/self-transferring, climbing out of bed, exit seeking, and physical aggression. From 12/1/17 through 12/7/17, the only behavior documented was "irritability." From 12/8/17 through 12/12/17, the behavior of "standing/self-transferring" was triggered daily.</p> <p>On 12/12/17 at 8:00 am, Resident #24's NN documented she was "constantly moving," required 1:1 attention, and complained of lower abdominal pain. The NN documented the resident had not had a bowel movement in 3 days, and bowel medications were administered.</p> <p>The next entry in Resident #24's NN was dated 12/12/17, no time specified. The note documented the physician was contacted due to the resident's "anxiety, agitation, confusion, poor mentation" and that the facility was waiting for lab results to rule out a urinary tract infection. The note documented the physician ordered a one-time dose of Depakote 250 mg.</p> <p>On 12/12/17, no time specified, Resident #24's Behavior note documented, "IDT met to discuss [Resident #24's] recent behavior change. She has become increasingly agitated and irritable. She also has been trying to stand and</p>	{F 329}	<p>Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nurses and resident liaison is re-educated to psychotropic drug management by the DON and/or SDC to include but not limited to, accurately reflecting the physicians rationale for use on the behavior monitor, validate medications are only used for behaviors when residents are a danger to themselves or others, they may not be utilized as chemical restraints, and interventions are person-centered. The system is amended to include review of target behaviors post admission and with order changes to validate documentation supports resident is a danger to themselves or others and that person-center behavioral interventions are addressed.</p> <p>Monitor The DON, resident liaison and/or designee will audit new admission records and residents with psychoactive medication changes for appropriate target behavior monitoring and person-centered interventions weekly for 12 weeks. Starting the week of February 4, 2018 the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI 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 20</p> <p>self-transfer not being able to verbalize why (Has no purpose)...[Physician's name] was called ...gave an order for Depakote twice daily and decreased the Zoloft to see if it helps her. She also had a urine test done for possible UTI, awaiting [culture and sensitivity] ..."</p> <p>On 12/12/17 Resident #24's physician's orders documented a reduction in her Zoloft dose to 50 mg daily, and a routine dose of Depakote 250 mg twice per day was initiated for a diagnosis of dementia with behaviors. The physician's order documented, "please monitor behavior and report observation." The order did not specify what behavior the Depakote was ordered to treat. A 12/12/17 physician's progress note documented, "The patient has had increasing agitation and figitness (sic) in the last few days."</p> <p>From 12/13/17 through 12/15/17, Resident #24's Behavior Symptom Flow Record documented the resident experienced 5 episodes of tearfulness, "continuous" irritability on three shifts, "continuous" standing/self-transferring on 4 shifts with occasional episodes on 2 other shifts, and "continuous" climbing out of bed on 3 shifts with occasional episodes on 3 other shifts. From 12/16/17 through 12/31/17, multiple to constant episodes of standing and self-transferring were the only behaviors documented in the flow record, aside from self-isolation and exit seeking on day shift 12/25/17, and 3 instances of climbing out of bed on day shift 12/27/17.</p> <p>From 1/1/18 through 1/11/18, Resident #24's Behavior Symptom Flow Record documented the resident was standing/self-transferring on all shifts except 1/2/18 day shift.</p>	{F 329}	Date of Compliance February 8, 2018		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 329}	<p>Continued From page 21</p> <p>On 1/8/18, Resident #24's physician's orders documented an increase in the frequency of her Depakote dose from twice daily to three times daily, for dementia with behaviors.</p> <p>On 1/11/18, Resident #24's Behavior Meeting note documented, "...has behaviors of increased irritability, self-transfer, physical aggression, and exit seeking. Since 1/2/18 [Resident #24] has been irritable 44 times, tried to self-transfer and stand up 89 times...causes of behavior are confusion...other causes may be internal (pain, anxiety, depression) due to dementia. Resident is unable to tell us why she cannot stay still or keep from trying to self-transfer..."</p> <p>On 1/23/18 at 8:30 am, Resident #24 was observed sitting at breakfast in her wheelchair. Resident #24 responded to rote social questions, but did not respond to more specific inquiries. She was slowly attempting to move her wheelchair backwards. At 10:45 am, Resident #24 was sitting quietly with an attendant in a ball toss activity.</p> <p>On 1/23/18 at 12:30 pm, the DON stated in late November 2017, Resident #24 had become increasingly tearful so the physician increased her Zolofit dose. The DON stated, "Then she had increased agitation and mania, so the Depakote was started." The DON stated he was not sure what the target behaviors prompting either the initiation or increase of the Depakote were, other than frequent attempts to stand unassisted. The DON stated the physician had said the resident "might be bipolar."</p>	{F 329}			

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{F 329}	<p>Continued From page 22</p> <p>On 1/23/18 at 2:00 pm, Resident #24's physician stated he had ruled out a diagnosis of bipolar disorder for Resident #24, but the resident had a long-standing history of depression, which had been treated with Zoloft. The physician stated that in late November or early December of 2017, the resident expressed increased feelings of depression during an examination, so he increased her Zoloft dose. The physician stated the facility began to report the resident was increasingly "aggressive and agitated" following the dose increase, and "described her behavior as being almost manic." The physician stated based on these reports, he decreased the resident's Zoloft dose and started her on Depakote. The physician stated he increased the frequency of the Depakote dose because he felt the resident had become "calmer and more at peace." The physician stated the reports of increased behavior were verbal reports from the facility, and he did not know the facility had been monitoring a target behavior of standing or self-transferring in conjunction with psychotropic medication use. The physician stated, "I ordered the Depakote for irritability and striking out. Not for standing. Depakote will not do anything for that."</p> <p>2. Resident #22 was admitted to the facility on 10/3/17 with diagnoses which included dementia with behaviors.</p> <p>Resident #22's quarterly MDS dated 1/10/18 documented he had severely impaired cognition, minimal depression, and no behavioral symptoms.</p> <p>Resident #22's physician's orders included</p>	{F 329}			

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{F 329}	<p>Continued From page 23</p> <p>Depakote 250 mg each morning and 500 mg at bedtime for dementia with behaviors, beginning 10/19/17.</p> <p>Resident #22's Behavior and Mood Management care plan, revised 12/1/17, documented the resident had a behavioral problem of, "self-transferring (standing up with no purpose) continually without asking for help, " and a behavioral goal of "reduced episodes" of that behavior.</p> <p>Resident #22's Behavior Symptom Monitoring Flow Record for December 2017 and January 2018 documented behavioral symptoms of, "Repeatedly trying to stand up for no reason," and, "self-transfers" for which the pharmacological intervention was documented as, "Depakote" and "Pain meds as ordered."</p> <p>On 12/15/17, Resident #22's Behavior progress note documented, "...Resident #22 does tend to try and stand up repeatedly and self-transfer. It happens almost daily. He is pleasant and has had no agitation..."</p> <p>On 1/23/18 at 12:30 pm, the DON stated the target behavior for Resident #22's Depakote use was "falls."</p> <p>On 1/23/18 at 2:00 pm, Resident #22's physician stated the resident had been started on the Depakote in his previous residence, when he had began striking out at his spouse. The physician stated, "That was completely out of character for him, and part of the reason he was admitted to the nursing home. In the time he has been in the facility, his target behaviors have improved</p>	{F 329}			

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{F 329}	Continued From page 24 significantly, and we have already been able to decrease the dose. I believe I will be able to taper him of of the medication very soon." The physician stated the Depakote was not ordered to address the resident's behavior of repeatedly standing, and would not be effective at addressing such a behavior.	{F 329}			