



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

February 21, 2018

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

Provider #: 135014

Dear Mr. Smith:

On **February 16, 2018**, we conducted an on-site revisit and a complaint investigation 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 **January 4, 2018**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

F0000 -- S/S: -- -- Initial Comments

F0279 -- S/S: D -- 483.20(d);483.21(b)(1) -- Develop Comprehensive Care Plans

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 **March 3, 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' letter of **December 12, 2017**, following the survey of **November 9, 2017**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for a Civil Money Penalty, Denial of Payment for New Admissions effective **February 9, 2018** and termination of the provider agreement on **May 9 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 & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Peter Smith, Administrator
February 21, 2018
Page 3

If you believe the deficiencies have been corrected, you may contact please contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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>

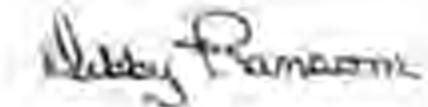
go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- 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 **March 3, 2018**. If your request for informal dispute resolution is received after **March 3, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

dr/dr
Enclosures

Peter Smith, Administrator
February 21, 2018
Page 4

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

PRINTED: 03/19/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/16/2018
NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS The following deficiencies were cited during the federal revisit and complaint survey conducted at the facility from February 15, 2018 to February 16, 2018. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Linda Kelly, RN Cecilia Stockdill, RN Survey Abbreviations: DON = Director of Nursing MDS = Minimum Data Set	{F 000}			
{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	{F 279}		3/6/18	

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

TITLE

(X6) DATE

Electronically Signed

02/27/2018

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.

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

PRINTED: 03/19/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/16/2018
NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
(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 279}	Continued From page 1 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 treatment under §483.10(c)(6). (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. (iv) In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (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. (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	{F 279}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/16/2018
NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
(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 279}	<p>Continued From page 2</p> <p>by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure care plans were appropriately developed and implemented for 1 of 5 sample residents (#2). This deficient practice created the potential for the resident to receive inappropriate or inadequate care and could result in a subsequent decline in the resident's health. Findings include:</p> <p>Resident #2 was admitted to the facility in April 2016 and readmitted on 3/27/17 with multiple diagnoses, including borderline personality disorder, dissociative identity disorder, dementia without behavioral disturbances, and schizophrenia.</p> <p>The most recent quarterly MDS assessment, dated 1/4/18, documented Resident #2 was cognitively intact and had delusions and hallucinations.</p> <p>The resident's care plan for "Schizoaffective disorder with history of testing acceptance of others, hallucinations, delusions, verbal aggression, and manipulation, Personality Disorder with history of testing relationships, and Bipolar" was initiated 4/12/16. Interventions included, "If hallucinations/delusions are not distressing...do not address them. If they appear distressing...speak calmly...and re-direct...to a safe low stimulating environment."</p> <p>Resident #2's care plan was not specific regarding hallucinations or delusions. It did not document the type of hallucinations or how the hallucinations and/or delusions may be distressing to the resident.</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 proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>Resident Specific</p> <p>Resident #2 had her Care Plan reviewed and revised by the Clinical Leadership team including licensed nurse and social worker oversight.</p> <p>Other Residents</p> <p>Residents with diagnosis of Hallucinations and Delusions are at risk for unclear Care Plans. Care Plans have been reviewed to add details of how their Hallucinations and/or Delusions are exhibited. The monitor is revised to include separate documentation.</p> <p>Facility Systems</p> <p>Education was provided to the Nurse Managers, SDC, MDS and Social Workers by the DNS and the Cascadia Clinical Resource to include but not</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/16/2018
NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
(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 279}	Continued From page 3 On 2/16/18 at 9:00 am, the Director of Social Services said hallucinations may be visual or auditory and they are different from delusions, which are fixed beliefs that are not true. The Director said Resident #2's care plan "could be" more specific about hallucinations and delusions. On 2/16/18 at 11:00 am, the DON and Clinical Resource nurse both said hallucinations are different from delusions and there are different types of hallucinations, visual, auditory, and/or tactile (touch). The Clinical Resource nurse said the care plan did not address the type of hallucination Resident #2 had experienced or how delusions were distressing to the resident.	{F 279}	limited to, specific monitoring of how each resident experiences their delusion, the type of hallucination the resident experiences, and how the delusion and/or hallucination may be distressing to the resident. The system is amended to include Clinical Leadership team which includes licensed nurses and social workers to review all new behavior Care Plans daily in the IDT meeting and validate care plans are specific and complete. Monitor The DNS and/or designee will audit behavior care plans for residents with changes in behaviors and/or at least 4 resident care plans weekly specifically for types of hallucinations and a description of how the resident experiences their delusions weekly x4 weeks, then 4 residents monthly x2 months. Starting the week of February 25th 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 monitoring after 12 weeks as it deems appropriate.		
{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--	{F 329}		3/6/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/16/2018
NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
(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 329}	Continued From page 4 (1) In excessive dose (including duplicate drug therapy); or (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 and staff interview, it was determined the facility failed to ensure resident specific behaviors were identified and	{F 329}	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/16/2018
NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
(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 329}	<p>Continued From page 5</p> <p>monitored. This was true for 1 of 5 residents (#2) reviewed for use of psychotropic medications. This failed practice created the potential for harm when the resident's antipsychotic and antidepressant medications were not adequately monitored. Findings include:</p> <p>Resident #2 was admitted to the facility in April 2016 and readmitted on 3/27/17 with multiple diagnoses, including borderline personality disorder, dissociative identity disorder, dementia without behavioral disturbances, and schizophrenia.</p> <p>The most recent quarterly MDS assessment, dated 1/4/18, documented Resident #2 was cognitively intact, had hallucinations and delusions, and had minimum signs of depression.</p> <p>Resident #2's recapitulation of physician orders "On or After Date: 02/16/18" included: * Abilify 30 milligrams (mg) daily for schizophrenia, ordered 11/7/17; * Loxapine 50 mg daily for schizoaffective disorder, ordered 3/27/17; * Loxapine 25 mg daily for schizophrenia, ordered 12/18/17; * Cymbalta 60 mg daily for major depression, ordered 12/11/17; * "Behavior Monitoring - Antipsychotic: Document Number of Episodes per shift of target behavior [SPECIFY] 1. Delusions/Hallucinations 2. Verbal aggression, name calling 3. accusing residents of trying to hurt her...;" * "Behavior Monitoring - Antidepressant: Document Number of Episodes per shift of target behavior 1. Dismissive behavior 2. Self deprecation 3. verbal aggression..."</p>	{F 329}	<p>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</p> <p>Resident #2 had her behavior monitors updated to be viewed correctly by the nurses for documentation, and the correct number of documentation places have been added to address all numbered behaviors.</p> <p>Other Residents</p> <p>Residents with behavior monitors were at risk for in accurate eMAR mapping or to not have the correct number of places to document addressing all listed behaviors/interventions. Behavior monitors have been reviewed by the Clinical Leadership team which includes licensed nurses and social workers with corrections made as indicated.</p> <p>Facility Systems</p> <p>Education was provided to the Nurse Managers, SDC, MDS and Social Workers by the DNS and the Cascadia</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/16/2018
NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
(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 329}	Continued From page 6 The resident's 4/12/16 care plan for schizoaffective disorder documented a history of "testing acceptance of others, hallucinations, delusion, verbal aggression, and manipulation, Personality Disorder with history of testing relationships, and Bipolar. Interventions included, "If hallucinations/delusions are not distressing...we do not address them. If they appear distressing...speak calmly...re-direct to a safe low stimulating environment, initiated 1/3/18." The care plan did not described which specific behaviors staff were to monitor. The 8/19/16 care plan for depression documented self deprecation, dismissive behavior, and threats to harm self if she did not get what she wanted. Resident #2's Medication Administration Records (MARs) for January 2018 and for February, from 2/1/18 through 2/15/18, documented the Abilify, Loxipine (both doses), and Cymbalta were administered as ordered. These MARs documented antipsychotic behavior monitoring was done for #1. Delusions/Hallucinations and #2. Verbal aggression, name calling, but #3 accusing residents of trying to hurt her, was not monitored; and that antidepressant behavior monitoring was not done in January or February 2018. In addition, delusions and hallucinations were monitored together, rather than as separate and distinct types of behavior. On 2/16/18 at 9:00 am, the Director of Social Services said that nursing staff monitored	{F 329}	Clinical Resource to include accurate directives and review for adding behavior monitors to the eMAR. The system is amended to include Clinical Leadership team to print a daily report of orders for review of the new orders and/or behavior monitors that are created to validate completeness and accurate mapping. Other Residents The DNS and/or designee will audit new behavior monitors for completeness and accurate mapping weekly x4 weeks, then monthly x2 months. Starting the week of February 25th 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 monitoring after 12 weeks as it deems appropriate.		

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

PRINTED: 03/19/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/16/2018
NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
(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 329}	Continued From page 7 behaviors and documented them in the MARS and/or in progress notes. On 2/16/18 at 11:00 am, the Clinical Resource nurse said Resident #2's antipsychotic behavior monitor for delusions and hallucinations should have been monitored separately and that target behavior #3 was missed completely because it was not added to the MARs. She said also that all of the antidepressant behavior monitors went into a completely different MAR and were not therefore not included for documentation in the resident's MARs.	{F 329}			

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

PRINTED: 03/19/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/16/2018
NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
(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>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal revisit and complaint survey conducted at the facility from February 15, 2018 to February 16, 2018. The deficiency F329 related to the complaint survey was put under survey 613S12 to appear on that survey's 2567.</p> <p>The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Linda Kelly, RN Cecilia Stockdill, RN</p>	F 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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.



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

May 25, 2018

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

Provider #: 135014

Dear Mr. Smith:

On **February 16, 2018**, an unannounced on-site complaint survey was conducted at Caldwell Care of Cascadia. The complaint was investigated during an on-site follow-up survey conducted February 15, 2018 through February 16, 2018.

The clinical records of the identified resident and four other residents' records were reviewed. The accounting records of the identified resident and two other residents were reviewed. The facility's Grievance files was reviewed.

The identified resident, the resident's interested party, and several other residents were interviewed. The local Ombudsman, several nurses, the Director of Nursing, two Social Workers, the Business Office Manager, and the Medical Records staff were interviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007712

ALLEGATION #1:

Residents' finances are not appropriately managed. Residents' trust funds are improperly managed by the facility which threatens the residents' insurance coverage. Someone other than the residents signs the residents' name when funds are withdrawn from their personal accounts.

FINDINGS #1:

The identified resident's trust fund and personal belongings list, as well as, two other residents' trust funds were reviewed. The facility's Grievance files did not include grievances regarding resident funds or billing processes.

The identified resident and two other residents were interviewed and expressed no concerns regarding the facility's management of their funds. The local Ombudsman said she had already investigated the identified resident's fund concerns and she could not prove the facility was at fault and the case had been resolved. The Business Office Manager and two Social Workers said when a resident requested personal funds, the resident signed the money request along with two separate staff members, before a check was made out and the staff member who cut the check was a different staff member. The Business Office Manager said the identified resident's fund had been managed appropriately, had provided the family with an accounting of the resident's funds and the resident did not have too much money in the account. The Business Office Manager said she was always cautious to make sure residents' with certain insurance coverage's did not have too much money in their accounts. The Business Office Manager said the facility had checks and balances built into the facility accounting practices. The Business Office Manager and two Social Workers said the identified resident's power of attorney assumed responsibility for the resident's funds and they had advised them to make sure items purchased met the guidelines under the resident's insurance coverage. Several other residents said they had no concerns with the facility managing their account funds.

Based on the investigative findings, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

An identified resident's psychotropic medications were not adequately monitored.

FINDINGS #2:

The identified resident and four other residents were observed for sedation.

The clinical records of the identified resident and four other residents' records were reviewed for behavior monitoring, including sedation.

The identified resident said she had no concerns with medications or over sedation.

Peter Smith, Administrator
May 25, 2018
Page 3 of 4

Based on the investigative findings, it was determined the allegation was substantiated for another resident. The other resident's psychotropic medications were not adequately monitored when the resident experienced delusions and hallucinations. A deficiency was cited at F329 as it relates to the failure of the facility to ensure antidepressant and anti-psychotic medications were effectively managed. Refer to the federal follow up survey report dated February 16, 2018.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation were cited on the federal follow up survey dated February 16, 2018.

ALLEGATION #3:

An identified resident's interested party had requested the resident's medication list and was denied access.

FINDINGS #3:

The clinical records of the identified resident and four other residents' records were reviewed for medical records requests and no concerns were identified. The facility's Grievance file was reviewed and no concerns regarding medical records request was identified.

Several residents said there were no concerns regarding medical records requests. Several nurses said if a resident's power of attorney or other authorized representative requested a medication list, they would be able to print it fairly quickly. The nurses said, if they requested a more in depth medical record request, then they would refer them to the medical records department. The Medical Records staff said they had not received a request by the identified resident's authorized representatives and medical requests were processed within regulation timelines.

Based on the above information, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

An identified resident's family was not allowed to take the resident out of the facility to go shopping.

Peter Smith, Administrator
May 25, 2018
Page 4 of 4

FINDINGS #4:

The clinical records of the identified resident and four other residents' records were reviewed and no concerns were identified regarding resident's rights. The facility's Grievance file did not document a concern with not allowing resident's to go out of the facility with family.

The identified resident had no concerns with outings with family or with shopping. Several other residents had no concerns with family outings or shopping. Two Social Workers said the facility arranged outings for residents. The Social Workers said that they had arranged an outing with the identified resident and his/her family, but one of the family members had gotten sick and the outing was canceled by the family. The Social Workers said they always offered to shop for residents if they can't get out, but residents were also offered to go out of the facility to shop via facility transportation.

Based on the investigative findings, it was determined the allegation could not be substantiated.

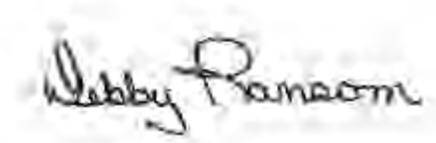
CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As the only substantiated allegation has already been addressed on the previously submitted Plan of Correction for the federal follow up survey dated February 16, 2018, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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

Sincerely,

A handwritten signature in black ink that reads "Debby Ransom". The signature is written in a cursive style and is positioned above the typed name and title.

Debby Ransom, RN, Chief
Bureau of Facility Standards

DR/lj