



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RUSS 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  
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July 1, 2018

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

Provider #: 135090

Dear Mr. Roedel:

On **June 13, 2018**, a survey was conducted at Shaw Mountain Of Cascadia by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 11, 2018**. Failure to submit an acceptable PoC by **July 11, 2018**, may result in the imposition of penalties by **July 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; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **July 18, 2018 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **September 11, 2018**. A change in the seriousness of the deficiencies on **July 28, 2018**, may

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result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 13, 2018** includes the following:

Denial of payment for new admissions effective **September 13, 2018**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 13, 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, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may 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. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **September 11, 2018** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **July 11, 2018**. If your request for informal dispute resolution is received after **July 11, 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/  
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/13/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET</b> <b>BOISE, ID 83712</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during a complaint survey conducted at Shaw Mountain of Cascadia from June 11, 2018 to June 13, 2018.  The surveyors conducting the survey were:  Teresa Kobza, RDN, LD, Team Coordinator Susan Devereaux, RN  Abbreviations:  ADL = Activities of Daily Living cm = Centimeter CNA = Certified Nursing Assistant DNS = Director of Nursing LPN = Licensed Practical Nurse MDS = Minimum Data Set PCC = Point Click Care (electronic medical record documentation system) POA = Power of Attorney RN = Registered Nurse	F 000			
F 606 SS=E	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4)  §483.12(a) The facility must-  §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure	F 606		7/18/18	

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

TITLE

(X6) DATE

Electronically Signed

07/11/2018

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 606	<p>Continued From page 1</p> <p>body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.</p> <p>§483.12(a)(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. This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of personnel files, policy review, and staff interview, it was determined the facility failed to ensure it followed its policy which required two reference checks and a background check, and abuse training be completed prior to a potential employee starting work in the facility. This was true for 2 of 4 new employees (Staff #A and Staff #B) whose personnel files were reviewed. The failure placed 6 of 6 (#3 - #8) sample residents residing in the facility and the other 74 residents residing in the facility, under Staff #A's and Staff #B's care, at increased risk neglect and abuse. Findings include:</p> <p>The facility's Preventing Abuse Policy and Procedure, dated 10/1/17, documented the following "Screening 11. Complete background checks of new employees and returning employees prior to hire/rehire. Background checks should include:</p> <p>a. Check the Omnibus Reconciliation Act (OBRA) Nurse Aide Registry to ensure OBRA certification, prior to the employment of a nursing assistant;</p> <p>b. Search against the National Wants and Warrants database in accordance with State</p>	F 606	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Shaw Mountain of Cascadia does not admit that the deficiencies listed on the CMS Form 2567 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>F606 CORRECTIVE ACTION: Staff #A and B currently have their background checks, reference checks, and abuse training verification on site.</p> <p>IDENTIFICATION OF OTHER RESIDENTS AFFECTED: Current residents and new admissions have the potential to be affected. Personnel files were reviewed to validate evidence of background checks, reference checks, and abuse training.</p>		

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F 606	<p>Continued From page 2 requirements;</p> <p>c. Fraud and Abuse Central Information System (FACIS) check, as appropriate</p> <p>d. Motor vehicle report check</p> <p>e. Fingerprint check, where required by law."</p> <p>On 6/13/18 at 12:34 PM, six new employee personnel files were reviewed for criminal background checks, licensure and certification verification, abuse and neglect education, and reference checks as follows:</p> <p>On 6/13/18 at 12:34 PM the Human Resources (HR) Director stated she did not have complete employee records of contract agency staff present in the facility. The HR Director stated she could call the agency and acquire the information needed. The HR Director stated the contract agency service would not allow their employees to work for their companies without the verification of a criminal background check, reference checks, and training in abuse and neglect.</p> <p>a. Staff #A, a contract agency CNA, first worked in the facility on 4/14/18 and the facility did not have a personnel file to review.</p> <p>b. Staff #B, a contract agency CNA, did not have a personnel file for review and first worked in the facility on 2/24/18.</p> <p>On 6/13/18 at 1:35 PM, the Executive Director stated contract agency CNAs had the information and the contact company just did not always provide the facility with the information.</p> <p>These deficient practices had the potential to</p>	F 606	<p>Adjustments were made as indicated.</p> <p><b>SYSTEMIC CHANGES/PREVENTION MEASURES:</b> The HR director, Nurse Manager, and Staffing Coordinator are educated by the Administrator to obtain employee records to include but not limited to, verification of completed background check, reference checks, and documentation of the employee abuse training. The system is amended to validate prior to contract agency working within the facility their documentation is available.</p> <p><b>MONITORING OF CORRECTIVE ACTION:</b> A weekly audit on contract employee's records will be completed by the Administrator, HR Director, and/or designee. Documentation will be place on the QAPI audit tool starting the week of July 15. 1:1 remediation will be provided for any negative findings. QAPI committee will review results of findings to validate compliance with facility policy, as well as state, and federal regulations until deficiency is no longer a concern to the QAPI committee.</p> <p><b>DATE OF COMPLIANCE:</b> JULY 17, 2018</p>		

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F 606	Continued From page 3 negatively impact Residents #3 - #8, and the other 74 who resided in the facility.	F 606			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(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 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.  §483.12(c)(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 staff interview and review of clinical records, facility policies, State Survey Agency Reportable Incidents Database, and skin event	F 609	F609 CORRECTIVE ACTION: As noted in the CMS-2567, resident #8	7/18/18	

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F 609	<p>Continued From page 4</p> <p>assessments, it was determined the facility failed to report allegations of potential abuse or neglect to the State Survey Agency within 2 to 24 hours. The lack of reporting placed 1 of 8 residents (#8) reviewed for abuse/neglect at risk of undetected abuse or neglect. Findings include:</p> <p>The facility's Federal Abuse, Neglect and Exploitation Definitions Policy and Procedure, dated 10/1/17, documented injuries of unknown source were defined as injuries that were unwitnessed and could not be explained by the resident. The policy documented injuries were suspicious based on the number of injuries observed at one particular point in time not the number of incidence of injuries over time and the location to include but not limited to, extensive bruising on body parts, fractures, black eyes, and cigarette burns.</p> <p>The facility's Detecting Abuse, Neglect, Misappropriation and Injuries of Unknown Origin, dated 10/31/17, documented the following "report a suspicion of crime to the state survey agency... Per the Elder Justice Act ... if serious bodily injury, report the suspicion immediately, but not later than 2 hours after forming the suspicion... not result in serious bodily injury, report the suspicion not later than 24 hours..."</p> <p>Resident #8 was readmitted to the facility on 2/3/17 with diagnoses which included vascular dementia without behavioral disturbances.</p> <p>A quarterly MDS assessment, dated 6/11/18, documented Resident #8 had a severe cognitive impairment. The MDS documented she was totally dependent or required extensive</p>	F 609	<p>had a head to toe skin check completed on 4/27/18 by the DNS and RCM. In addition, a 100% skin sweep was completed on the 300 hall. Skin event and investigations were completed on all findings. No additional reporting is required.</p> <p>IDENTIFICATION OF OTHER RESIDENTS AFFECTED: Current residents and new admissions have the potential to be affected. A skin sweep is completed for current residents. New skin conditions are documented, investigated, and reported as indicated. In addition, incident reports for alterations in skin integrity issues will be reviewed post survey exit (June 14 to present). Abuse reporting will be completed as indicated.</p> <p>SYSTEMIC CHANGES/PREVENTION MEASURES: ID team is re-educated to abuse reporting by Director of Clinical Operations to include but not limited to, skin integrity impairments, residents with low BIMs scores, witness statement process, investigation communication and documentation, resolution of conflict in data collection, and regulatory directions for reporting.</p> <p>Staff are re-educated to abuse reporting by the Director of Nursing Services and/or designee to include but not limited to timely reporting of injuries or change in skin condition.</p>		

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F 609	<p>Continued From page 5</p> <p>assistance of 1 to 2 staff members with all cares except eating.</p> <p>The care plan addressing Resident #8's skin impairments, dated 1/9/17, documented Resident #8 experienced skin impairments such as bruising or skin tears. Resident #8 had 12 skin impairments on her care plan documented as "resolved" or "canceled" and 2 active skin impairments dated 4/27/18. The active skin impairments documented Resident #8 had sustained a bruise near her right eye which, was 5 by 4 cm, and scattered bruising on her right forearm and right hand, with no dimensions documented.</p> <p>Resident #8 had three incidences which were not reported to the State Survey Agency as follows:</p> <p>* A Skin Event Assessment, dated 4/27/18, documented Resident #8 had scattered bruising of 30 by 12 cm to her right forearm and right hand. The assessment documented the bruises were varying in size, shape, and color. The assessment documented the bruises were "in various stages of healing." The assessment documented the resident was unable to say what happened and did not "always" understand what was being asked.</p> <p>* A Skin Event Assessment documented a 3 by 2.5 cm bruise to Resident #8's right temporal area was discovered on 4/25/18 and the assessment was initiated on 4/27/18. Five witness statements were completed by nursing staff which documented the following:</p> <p>- An undated witness statement documented</p>	F 609	<p>The system is amended to include review of resident BIMs score with the incident report in clinical, as well as investigating until conflict in information is resolved and documented.</p> <p><b>MONITORING OF CORRECTIVE ACTION:</b> The Administrator and/or designee will review incident reports for reporting requirements to include but not limited to skin integrity impairments that may constitute abuse. Documentation will be place on the QAPI audit tool starting the week of July 15. 1:1 remediation will be provided for any negative findings. QAPI committee will review results of findings to validate compliance with facility policy, as well as state, and federal regulations until deficiency is no longer a concern to the QAPI committee.</p> <p><b>DATE OF COMPLIANCE:</b> JULY 17, 2018</p>		

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F 609	<p>Continued From page 6</p> <p>Resident #8's bruise to her right temporal face was present during the previous shift and it was reported to an LPN by the off-going RN. The date of the incident on the witness statement was documented as 4/23/18. The statement documented the source of the bruise was unable to be determined.</p> <ul style="list-style-type: none"> <li>- An undated witness statement documented the right side of Resident #8's face was observed with a bruise on 4/24/18.</li> <li>- An undated witness statement documented Resident #8's bruise to her right temporal area was reported to the LPN during report from the off-going RN on Wednesday morning. The statement documented the source of the bruise was unable to be determined.</li> <li>- A witness statement, dated 4/27/18, documented Resident #8 was assisted out of bed by a staff member and the staff member asked Resident #8 what happened to her head and Resident #8 stated she hit her head with her call light.</li> <li>- A witness statement, dated 4/30/18, documented an RN asked Resident #8 how she sustained the injury to her head on 4/26/18 and Resident #8 stated she hit herself with a call light.</li> </ul> <p>The witness statements included conflicting documentation as to the source of the bruise being from a call light or unknown source.</p> <p>* A Skin Event Assessment, dated 5/23/18, documented Resident #8 had a laceration on her forehead "halfway between her eyebrow and her hair line" to the left side of her head. The assessment documented the laceration was "approximately 0.25 cm by 0.50 cm. The assessment documented the resident was</p>	F 609			

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F 609	Continued From page 7 unable to describe what happened. The assessment documented Resident #8 had fragile skin and Resident #8 possibly scratched herself.	F 609			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  §483.12(c)(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 staff interview and review of clinical records, facility policy, State Survey Agency Reportable Incidents Database, and skin event	F 610	F610 CORRECTIVE ACTION: As noted in the CMS-2567, Resident #1	7/18/18	

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F 610	<p>Continued From page 8</p> <p>investigations, it was determined the facility failed to investigate and/or thoroughly investigate, injuries of unknown source as allegations of potential abuse or neglect. This was true for 2 of 8 sample residents (#7 and #8) residing in the facility reviewed for abuse/neglect, and for 1 of 2 (#1) sample residents no longer residing in the facility reviewed for abuse/neglect. The deficient practice created the potential for Resident #7 and Resident #8, to experience ongoing abuse/neglect without detection. Findings include:</p> <p>The facility's Federal Abuse, Neglect and Exploitation Definitions Policy and Procedure, dated 10/1/17, documented injuries of unknown source were defined as injuries that were unwitnessed and could not be explained by the resident. The policy documented injuries were suspicious based on the number of injuries observed at one particular point in time not the number of incidence of injuries over time and the location to include but not limited to, extensive bruising on body parts, fractures, black eyes, and cigarette burns.</p> <p>1. Resident #8 was readmitted to the facility on 2/3/17, with diagnoses which included vascular dementia without behavioral disturbances.</p> <p>A quarterly MDS assessment, dated 6/11/18, documented Resident #8 had severe cognitive impairment. The MDS documented she was totally dependent or required extensive assistance of 1 to 2 staff members with all cares except eating.</p> <p>The care plan addressing Resident #8's skin</p>	F 610	<p>no longer resides at the facility.</p> <p>Resident #7 <input type="checkbox"/> Additional documentation is summarized in the incident investigation file to resolve conflict of dates, location, and source of abrasion/scab.</p> <p>Resident #8 <input type="checkbox"/> Additional documentation is summarized in the incident investigation file to include a conclusion as to the source of the bruising ruling out abuse.</p> <p><b>IDENTIFICATION OF OTHER RESIDENTS AFFECTED:</b> Current residents and new admissions have the potential to be affected. Incident reports for alterations in skin integrity issues will be reviewed post survey exit (June 14 to present). Additional documentation is summarized in the incident investigation file validate abuse has been ruled out.</p> <p><b>SYSTEMIC CHANGES/PREVENTION MEASURES:</b> The clinical staff and ID team is educated to perform thorough investigations by Director of Clinical Operations and/or designee to include but not limited to complete assessment, detailed incident report, investigative interview process, determining root cause, plan for prevention, conclusion, resolution of conflict in data collection, monitoring, and ruling out of abuse.</p>		

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F 610	<p>Continued From page 9</p> <p>impairments, dated 1/9/17, documented Resident #8 experienced skin impairments such as bruising or skin tears. Resident #8 had 12 resolved or canceled skin impairments on her care plan and 2 active skin impairments dated 4/27/18. The active skin impairments documented Resident #8 had sustained a bruise near her right eye which was 5 by 4 cm, and scattered bruising on her right forearm and right hand, with no dimensions documented.</p> <p>Resident #8 had three incidences which were not thoroughly investigated as follows:</p> <p>* A Skin Event Assessment, dated 4/27/18, documented Resident #8 had scattered bruising of 30 by 12 cm to her right forearm and right hand. The assessment documented the bruises were varying in size, shape, and color. The assessment documented the bruises were "in various stages of healing." The assessment documented Resident #8 was unable to say what happened and did not always understand what was being asked. The assessment documented staff planned to apply lotion to her extremities as a preventative plan. The clinical record failed to document a thorough investigation, to include: assessment of Resident #8's arm and hand and staff and resident interviews. Resident #8's record did not show implementation of preventative measure to protect her from further injury. The investigation did not include a conclusion as to the source of the bruising, witness statements, staff interviews, or resident interviews to determine the origin of the bruise, or a complete investigation to rule out potential abuse or neglect. Resident #8's clinical record did not contain progress notes identifying the</p>	F 610	<p>The system is amended to include an ID team review of incident reports in clinical meeting to validate they are thorough, a root cause has been determined, and the report is completed timely. A follow-up IDT note will be completed to determine root cause and plan for prevention.</p> <p><b>MONITORING OF CORRECTIVE ACTION:</b> Administrator and/or designee will review completed incident reports for thorough investigation. Documentation will be placed on the QAPI audit tool starting the week of July 15. 1:1 remediation will be provided for any negative findings. QAPI committee will review tracking and trending results of findings to validate compliance with facility policy, as well as state, and federal regulations until deficiency is no longer a concern to the QAPI committee.</p> <p><b>DATE OF COMPLIANCE:</b> JULY 17, 2018</p>		

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F 610	<p>Continued From page 10 progression of the bruises.</p> <p>* A Skin Event Assessment documented a 3 by 2.5 cm bruise to Resident #8's right temporal area was on discovered on 4/25/18 and the assessment was initiated on 4/27/18. Five witness statements were completed by nursing staff which documented the following:</p> <ul style="list-style-type: none"> <li>- An undated witness statement documented Resident #8's bruise to her right temporal face was present during the previous shift and reported to the LPN by the off-going RN. The date of the incident on the witness statement was documented as 4/23/18. The statement documented the source of the bruise was unable to be determined.</li> <li>- An undated witness statement documented Resident #8's face was observed with a bruise on the right side on 4/24/18.</li> <li>- An undated witness statement documented Resident #8's bruise to her right temporal area was reported to the LPN during report from the off-going RN on Wednesday morning. The statement documented the source of the bruise was unable to be determined.</li> <li>- A witness statement, dated 4/27/18, documented Resident #8 was assisted out of bed by a staff member and the staff member asked Resident #8 what happened to her head and Resident #8 stated she hit her head with her call light. The date the incident occurred was not documented in the witness statement.</li> <li>- A witness statement, dated 4/30/18, documented an RN asked Resident #8 how she sustained the injury to her head on 4/26/18 and Resident #8 stated she hit herself with a call light. The date the incident occurred was not</li> </ul>	F 610			

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F 610	<p>Continued From page 11 documented in the witness statement.</p> <p>The witness statements documented conflicting dates the bruise was first observed and had conflicting documentation as to the source of the bruise being from a call light or an unknown source. The witness statements did not include all staff member who had contact with Resident #8 between 4/22/18-4/27/18 to determine the source of the bruise.</p> <p>Resident #8's progress notes did not contain documentation of the bruise to her right temporal area prior to 4/27/18.</p> <p>Resident #8's clinical record did not include documentation of a thorough investigation, to include, an assessment of Resident #8's temporal bruising and complete staff and resident interviews. Additionally, Resident #8's clinical record did not include evidence of implementation of preventative measure to protect her from further injury. A complete investigation to rule out potential abuse or neglect was not completed.</p> <p>* A Skin Event Assessment, dated 5/23/18, documented Resident #8 had a laceration on her forehead "halfway between her eyebrow and her hair line" on the left side of her head. The assessment documented the laceration was approximately 0.25 cm by 0.50 cm. The assessment documented Resident #8 was unable to describe what happened. The assessment documented Resident #8 had fragile skin and possibly scratched herself. Resident #8's clinical record did not include documentation of a thorough investigation, to include,</p>	F 610			

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F 610	<p>Continued From page 12</p> <p>assessment of the laceration, staff and resident interviews, and evidence of implementation of preventative measure to protect her from further injury. The investigation did not include a conclusion as to the source of the laceration. Resident #8's clinical record did not contain progress notes identifying the progression of the laceration. A complete investigation to rule out potential abuse or neglect was not completed.</p> <p>On 6/13/18 at 11:25 AM, the DNS stated the facility did not investigate the laceration to the forehead or the scattered bruising on Resident #8's right arm and hand because they did not feel the injuries met the criteria of unknown source based on the location and size of the injuries. The DNS stated an injury of unknown source was an injury that could not be explained by the resident and that the facility could not determine the cause. The DNS stated Resident #8 had a history of her arms bruising in the past and the scattered bruises equaled a 30 by 12 cm area. The DNS stated this was not consider extensive bruising or a large number of bruises over a point in time. The DNS stated the skin event did not include dimensions of the bruises. The DNS stated the temporal bruise documentation could have been better and she could not explain the different dates from the investigation. The DNS stated two staff members asked Resident #8 what happened and they got the same story and the facility determined that to be the cause of the injury. The DNS stated the size of the laceration on Resident #8's head was too small to investigate further. The DNS stated the facility concluded Resident #8 scratched herself.</p> <p>2. Resident #7 was admitted to the facility on</p>	F 610			

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F 610	<p>Continued From page 13</p> <p>2/27/18, with diagnoses which included hemiparesis (paralysis of one side the body) and cerebrovascular disease affecting the left side.</p> <p>A quarterly MDS assessment, dated 5/31/18, documented Resident #7 had severe cognitive impairment. The MDS documented she was totally dependent or required extensive assistance of 1 to 2 staff members with all cares.</p> <p>The care plan addressing Resident #7's skin impairments, dated 2/27/18, documented Resident #7 experienced skin impairments such as bruising or skin tears. Resident #7 had 3 resolved skin impairments on her care plan and 1 active skin impairment on her care plan. One of the resolved skin impairments dated 4/27/18, documented Resident #7 had sustained a 0.7 by 1.6 cm "abrasion/scab" on her right forehead.</p> <p>Resident #7 had one incident which was not thoroughly investigated as follows:</p> <p>* A Skin Event Assessment, dated 4/27/18, documented a 0.7 by 1.6 cm "scab" was discovered on Resident #7's right forehead on 4/27/18 at 5:00 PM.</p> <p>An Investigation Summary submitted to the State Survey Agency, documented the incident occurred on 4/23/18. The summary documented a 0.7 by 1.6 cm "scab" was discovered on 4/27/18 during a skin check. The scab was brown in color and firm. The summary documented the scab/ abrasion was first identified on 4/23/18 and Resident #7's family was notified of the abrasion. The summary documented Resident #7's family stated the abrasion was present on Resident #7</p>	F 610			

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F 610	<p>Continued From page 14 for a few weeks. Twelve witness statements were included with the summary which documented the following:</p> <ul style="list-style-type: none"> <li>- Three undated witness statements documented Resident #7's face was observed without abrasions. The dates on the witness statement were not documented.</li> <li>- An undated witness statement documented Resident #7's face was observed without abrasions on 4/22/18 from 6 PM to 10 PM. The date on the witness statement was not documented.</li> <li>- An undated witness statement documented Resident #7's abrasion was noticed on the night shift of 4/22/18. The statement did not document the source of the abrasion.</li> <li>- An undated witness statement documented Resident #7 had a scab/abrasion her right forehead. The date the incident occurred was not documented in the witness statement. The statement documented Resident #7 stated she obtained the abrasion/ scab due to a fall.</li> <li>- An undated witness statement documented Resident #7 was observed with a scab/abrasion on her right forehead on Wednesday, 4/24/18. The statement documented CNA staff stated, '[I]ts been there since Sunday.' (4/22/18). The date the incident occurred was not documented in the witness statement. The statement documented the source of the abrasion was unknown.</li> <li>- An undated witness statement documented Resident #7's face was observed with a "scab" to her right side on 4/24/18.</li> <li>- A witness statement, dated 4/27/18, documented Resident #7's face was observed with a "bruise" on her forehead. The date the</li> </ul>	F 610			

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F 610	<p>Continued From page 15</p> <p>incident occurred was not documented in the witness statement.</p> <p>- A witness statement, dated 4/27/18, documented staff completed a skin check on 4/27/17 at 5:00 PM and an abrasion was noted on Resident #7's right forehead. The date the incident occurred was not documented in the witness statement.</p> <p>- A witness statement, dated 4/30/18, documented an RN spoke with Resident #7's family and Resident #7's family stated she first noticed the abrasion 1-2 weeks ago, but was not 'sure.' The statement documented Resident #7 would give answers to questions "to get someone to stop asking questions. She also said [Resident #7] does not always answer truthfully." The date the incident occurred was not documented in the witness statement.</p> <p>- A witness statement, dated 4/30/18, documented the staff member did not come into contact with Resident #7 until 4/29/18.</p> <p>The witness statements documented conflicting dates the abrasion/scab was first observed and had conflicting documentation as to its source. The witness statements did not include all staff members who had contact with Resident #7 between 4/22/18-4/27/18 to determine the source of the abrasion/scab. The investigation summary did not take into account Resident #7's recollection of the events or investigate if Resident #7 sustained an unwitnessed and undocumented fall.</p> <p>Resident #7's progress notes did not contain documentation of the abrasion/scab to the right forehead before 4/27/18.</p>	F 610			

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F 610	<p>Continued From page 16</p> <p>Resident #7's clinical record did not include documentation of a thorough investigation, to include, an assessment of the abrasion/scab, complete staff and resident interviews, and preventative measure to protect the resident from further injury.</p> <p>On 6/13/18 at 11:04 AM, the DNS stated the facility investigated the abrasion/scab to Resident #7's forehead. The DNS stated the dates on the investigation were incorrect. The DNS said she could not explain the reason the witness statements conflicted with the conclusion of the investigation which documented the incident occurred 4/23/18. The DNS stated the progress notes did not contain documentation of the injury prior to 4/27/18. The DNS stated Resident #7's injury could not have been related to a fall as Resident #7's last reported fall was 4/2/18. The DNS stated she could not be sure Resident #7 had not experienced an unreported fall between 4/2/18 and the discovery of the abrasion/scab. The DNS stated the injury occurred prior to 4/27/18 and it was not documented in the progress notes because a CNA did not report it to an RN. The DNS stated the CNA was educated on reporting immediately. Documentation of the education was requested and not provided for review.</p> <p>3. Resident #1 was admitted to the facility of 1/15/16 with diagnoses which included hemiplegia and hemiparesis, and cerebrovascular disease.</p> <p>An admission MDS assessment, dated 5/17/18, documented Resident #1 was cognitively intact. The MDS documented he was totally dependent</p>	F 610			

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F 610	<p>Continued From page 17 or required extensive assistance of 1 to 2 staff members with all cares.</p> <p>The care plan addressing Resident #1's skin impairments, dated 1/15/16, documented Resident #1 experienced skin impairments such as bruising, abrasions, and rashes. Resident #1 had 9 resolved or canceled skin impairments on his care plan. One of the resolved skin impairments and canceled skin impairments was investigated by the facility on 4/21/18. The care plan was updated on 4/26/18 which documented Resident #1 sustained a 0.5 by 0.1 cm "abrasion/scab" above his left eye and a 3 by 1.5 cm bruise above his left eye.</p> <p>Resident #1 had two incidences which was not thoroughly investigated as follows:</p> <p>* A Skin Event Assessment, dated 4/21/18, documented a 0.5 by 0.1 cm "abrasion/scab" above Resident #1's left eye and a 3 by 1.5 cm bruise above his left eye were discovered.</p> <p>An Investigation Summary reported to the State Survey Agency documented the incident occurred on 4/21/18. The summary documented a skin event occurred in a shower room on 4/21/18. The summary documented a CNA was transporting Resident #1 out of the shower room and utilized one hand to hold the door open while attempting to push Resident #1's chair through the threshold. The summary documented Resident #1's chair rotated towards the wall and his head made contact with the "grab" bar. Seven witness statements were included with the summary including the following:</p>	F 610			

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F 610	<p>Continued From page 18</p> <ul style="list-style-type: none"> <li>- An undated witness statement documented on 4/21/18 a CNA was "pushing" Resident #1 out of the shower room when his head hit the "grab" bar. The statement documented the CNA told the nurse the chair was 'hard to drive' and the CNA 'couldn't control it.'</li> <li>- A witness statement, dated 4/30/18, documented the DNS spoke with the RN who was working on 4/21/18. The statement documented the RN stated she cleansed Resident #1's cut above the left eye. The statement documented Resident #1's son reported a previous injury to Resident #1's nose.</li> <li>- An undated witness statement documented Resident #1 was provided a shower by contract agency staff member, CNA #1, on 4/21/18 at 1:30 PM. The statement documented CNA #1 was assisting Resident #1 out of the shower room and the shower chair "swerved" and Resident #1's head hit the "assist bar" on the wall. The statement document CNA #1 reported this to the nurse "right away."</li> </ul> <p>The April 2018 ADL Report, documented Resident #1 was provided a shower on 4/21/18 by CNA #2.</p> <p>The witness statements and Resident #1's ADL Report documented conflicting data on who provided Resident #1's shower on 4/21/18. The investigation summary did not include an interview with Resident #1 or CNA #2.</p> <p>Resident #1's progress notes did not contain documentation of the abrasion/scab above his left eye before 4/25/18.</p> <p>Resident #1's clinical record did not include</p>	F 610			

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F 610	<p>Continued From page 19</p> <p>documentation of a thorough investigation, to include, assessment of the abrasion/scab, complete staff and resident interviews, and preventative measure to protect the resident from further injury. A complete investigation to rule out potential abuse or neglect was not completed.</p> <p>* A Multidisciplinary Conference, dated 4/26/18, documented Resident #1's family stated Resident #1 was "hit" in the nose with a Hoyer lift and the family did not feel the situation was addressed appropriately.</p> <p>* A witness statement, dated 4/30/18, documented the DNS spoke with the RN who was working on 4/21/18. The statement documented the RN stated she cleansed Resident #1's cut above the left eye. The statement documented Resident #1's son reported a previous injury to Resident #1's nose.</p> <p>Resident #1's clinical record did not include documentation of an investigation related to a Hoyer lift hitting Resident #1 in the nose,</p> <p>On 6/12/18 at 5:43 PM, CNA #2 stated contract agency CNAs were using facility CNAs' PCC access codes to chart cares they were providing to residents. CNA #2 said this was done at the direction of the DNS. CNA #2 stated access codes were not provided to agency CNAs for a few days after they were hired, which was the reason they had to share.</p> <p>On 6/12/18 at 6:04 PM, the DNS stated if a family member brought a concern forward about an incident such as a Hoyer lift hitting a resident in the face, the facility would investigate the</p>	F 610			

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F 610	<p>Continued From page 20</p> <p>allegation. The DNS stated the resident did not have an injury on his nose and they did not feel an incident occurred that required investigation. The DNS stated when a resident had an injury of unknown origin or a new "skin event" the staff should be completing a Skin Event Evaluation, witness statements, neurological evaluations if applicable, progress note documentation, and 72-hour alert monitoring. The DNS stated staff were to ensure practitioner orders are applicable, the care plan is updated, and the POA and physician are notified. The DNS stated the Unit Managers were to ensure this system was followed. The DNS stated CNA #1 showered Resident #1 on 4/21/18 and she was unsure how the documentation showed CNA #2 performed the task. The DNS stated agency CNAs had access to PCC "immediately."</p> <p>On 6/13/18 at 1:05 PM, CNA #3 stated she was an agency CNA who worked in the facility. CNA #3 stated she started working a few months ago and her duties at the facility were to shower residents, assist with ADLs, and other needs. CNA #3 stated she did not have access to PCC as soon as she started working. CNA #3 stated she had been working approximately 4 days in the facility before she had access to chart in PCC using her own name. CNA #3 stated during the 4 day time period another CNA charted the cares she completed.</p> <p>On 6/13/18 at 1:35 PM, the DNS and the Executive Director stated CNA #1 performed the shower on 4/21/18 and they could not explain the reason CNA #2 was documented as providing the shower. The DNS did not know the reason agency CNAs thought she instructed them to</p>	F 610			

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F 610 F 684 SS=D	Continued From page 21 share PCC access information. Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Checklist for Skin Impairments, skin event assessments, State Survey Agency Reportable Incidents Database, and resident records, and staff interviews, it was determined the facility failed to ensure professional standards of practice were followed related to non-pressure related skin management. This was true for 2 of 8 sample residents (#7 and #8) residing in the facility reviewed for incidents and accidents and 1 of 2 (#1) sample residents no longer residing in the facility. This failed practice created the potential for harm when injuries of unknown source were not documented when discovered, subsequently monitored and included in residents' care plans, and treatment was delayed. Findings include:  The facility's undated Checklist for Skin Impairments, documented the following process for staff to follow.  * Skin Event Assessment completed within 8 hours of the shift.	F 610  F 684	          F684 CORRECTIVE ACTION: As noted in the CMS-2567, resident #1 no longer resides at the facility.  Resident #7 and 8 non-pressure areas are healed. Standard of practice does not allow for any additional documentation. IDENTIFICATION OF OTHER RESIDENTS AFFECTED: Current residents and new admissions have the potential to be affected. Review of residents with skin integrity is completed to include care plan, at risk interventions implemented, assessment upon identification and at least weekly, monitoring, skin/body audit weekly by licensed nurse, and physician update with non-healing and/or resolution. Adjustments are made as indicated.  SYSTEMIC CHANGES/PREVENTION MEASURES:	7/18/18	

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F 684	<p>Continued From page 22</p> <ul style="list-style-type: none"> <li>* Witness statements completed</li> <li>* Neurological evaluation if applicable</li> <li>* Progress note documentation</li> <li>* Alert charting creating for 72 hours</li> <li>* Orders placed if applicable</li> <li>* Care plan updated with weekly skin assessments</li> <li>* POA notified</li> <li>* Physician notified</li> </ul> <p>1. Resident #8 was readmitted to the facility on 2/3/17, with diagnoses which included vascular dementia without behavioral disturbances.</p> <p>A quarterly MDS assessment, dated 6/11/18, documented Resident #8 had a severe cognitive impairment. The MDS documented she was totally dependent or required extensive assistance of 1 to 2 staff members with all cares except eating.</p> <p>a. Resident #8's Weekly Skin Assessments were not completed as directed in her care plan.</p> <p>Resident #8's care plan, dated 1/9/17, documented staff members were to assess Resident #8's skin weekly.</p> <p>The May 2018 ADL Report, documented staff were to assess Resident #8's skin weekly on Friday. The report did not include documentation a skin assessment was completed on Friday, 5/25/18.</p> <p>On 6/12/18 at 6:33 PM, the DNS stated she expected skin assessments to be completed weekly. The DNS stated if a skin assessment was not completed the RN needed to document</p>	F 684	<p>Licensed nurses are re-educated to alteration in skin integrity program by the Director of Nursing Services and/or designee to include but not limited to, care plan, at risk interventions implemented, assessment upon identification and at least weekly, monitoring, skin/body audit weekly by licensed nurse, and physician update with non-healing and/or resolution. The system is amended to include licensed nurse review of residents requiring skin assessments for their shift. Report of missing assessments for the previous day will be reviewed in clinical meeting. 1:1 remediation will occur for patterns of missed assessments.</p> <p><b>MONITORING OF CORRECTIVE ACTION:</b> The Director of Nursing Services and/or Designee will complete audits twice weekly to validate the skin integrity program is complete for residents with alterations. Documentation will be place on the QAPI audit tool starting the week of July 15. 1:1 remediation will be provided for any negative findings. QAPI committee will review tracking and trending results of findings to validate compliance with facility policy, as well as state, and federal regulations until deficiency is no longer a concern to the QAPI committee.</p> <p><b>DATE OF COMPLIANCE:</b> JULY 17, 2018</p>		

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F 684	<p>Continued From page 23</p> <p>a reason in the resident's medical record.</p> <p>b. The care plan was not updated when Resident #8 developed skin impairments as follows:</p> <p>The care plan area addressing Resident #8's skin impairments, dated 1/9/17, documented Resident #8 experienced skin impairments such as bruising or skin tears. Resident #8 had 12 resolved or canceled skin impairments on her care plan and 2 active skin impairments dated 4/27/18.</p> <p>A Skin Event Assessment, dated 5/23/18, documented Resident #8 had a laceration on her forehead "halfway between her eyebrow and her hair line" to the left side of her head.</p> <p>Resident #8's care plan did not reflect the laceration to her left forehead, dated 5/23/18.</p> <p>On 6/13/18 at 12:35 PM, the DNS stated the laceration was not added to Resident #8's care plan.</p> <p>c. Resident #8 had three incidences which were not sufficiently monitored as follows:</p> <p>* A Skin Event Assessment, dated 4/27/18, documented Resident #8 had scattered bruising of 30 by 12 cm to her right forearm and right hand. The assessment documented the bruises were varying in size, shape, and color. The assessment documented the bruises were "in various stages of healing." The assessment documented the resident was unable to say what happened and did not always understand what was being asked.</p>	F 684			

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F 684	<p>Continued From page 24</p> <p>Resident #8's clinical record did not contain 72 hour alert charting in the progress notes identifying the progression of the bruises, as instructed in the facility's Checklist for Skin Impairments.</p> <p>Resident #8's 4/1/18 - 6/13/18 Weekly Skin Monitoring of the right forearm and hand was to be completed weekly until the skin impairment resolved. The monitoring was to assess the healing status of the bruises. The monitoring on 5/4/18 was completed by a CNA and not a licensed nurse. The monitoring was not completed for the week of 5/20/18 through 5/26/18.</p> <p>* A Skin Event Assessment documented a 3 by 2.5 cm bruise to Resident #8's right temporal area was on discovered on 4/25/18 and the assessment was initiated on 4/27/18. An undated witness statement documented Resident #8's bruise to her right temporal face was present during the previous shift was reported to the LPN by the off-going RN. The date of the incident on the witness statement was documented as 4/23/18. The statement documented the source of the bruise was unable to be determined.</p> <p>The care plan addressing Resident #8's skin impairments, dated 1/9/17, documented Resident #8 experienced skin impairments such as bruising or skin tears. Resident #8 had an active skin impairment dated 4/27/18, she had sustained a bruise near her right eye which was 5 by 4 cm.</p> <p>Resident #8's progress notes first documented</p>	F 684			

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F 684	<p>Continued From page 25</p> <p>the bruise to the right temporal area on 4/27/18. The witness statement noted above documented the date of the bruise as 4/23/18. The bruise near Resident #8's right eye was not documented in the progress notes when it was observed, as instructed in the Checklist for Skin Impairments</p> <p>Resident #8's Skin Event Assessment documented the size of the wound was 3 by 2.5 cm. Her Care Plan documented the size of the temporal wound as 5 by 4 cm. The actual size of the wound was unclear.</p> <p>Resident #8's 4/1/18 - 6/13/18 Weekly Skin Monitoring of the right temporal area was to be completed weekly until the skin impairment resolved. The monitoring was to assess the healing progression of the wound. The monitoring on 5/4/18 was completed by a CNA and not a licensed nurse. The monitoring was not completed for the week of 5/20/18 through 5/26/18.</p> <p>* A Skin Event Assessment, dated 5/23/18, documented Resident #8 had a laceration on her forehead "halfway between her eyebrow and her hair line" on the left side of her head. The assessment documented the laceration was approximately 0.25 cm by 0.50 cm. The assessment documented Resident #8 was unable to describe what happened. The assessment documented Resident #8 had fragile skin and possibly scratched herself.</p> <p>Resident #8's clinical record did not contain 72 hour alert charting in the progress notes identifying the progression of the laceration.</p>	F 684			

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F 684	<p>Continued From page 26</p> <p>Resident #8' record did not include weekly skin assessments of the 5/23/18 laceration to her left forehead.</p> <p>On 6/12/18 at 6:33 PM, the DNS stated the temporal bruise documentation could have been better. The DNS stated she expected staff to document skin impairments in the progress notes and to complete alert charting for 72 hours.</p> <p>2. Resident #7 was admitted to the facility on 2/27/18 with diagnoses which included hemiparesis (paralysis of one side of the body) and cerebrovascular disease affecting the left side.</p> <p>A quarterly MDS assessment, dated 5/31/18, documented Resident #7 had a severe cognitive impairment. The MDS documented she was totally dependent or required extensive assistance of 1 to 2 staff members with all cares.</p> <p>The care plan area addressing Resident #7's skin impairments, dated 2/27/18, documented Resident #7 experienced skin impairments such as bruising or skin tears. Resident #7 had 3 resolved skin impairments on her care plan and 1 active skin impairment on her care plan. One of the resolved skin impairments dated 4/27/18, documented Resident #7 had sustained a 0.7 by 1.6 cm "abrasion/scab" on her right forehead which resolved on 5/14/18. The active skin impairment, dated 5/21/18 documented a laceration on Resident #7's right foot 1 by 1.3 cm.</p> <p>Resident #7 had two incidences which were not sufficiently monitored as follows:</p>	F 684			

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F 684	<p>Continued From page 27</p> <p>* A Skin Event Assessment, dated 4/27/18, documented a 0.7 by 1.6 cm "scab" was discovered on Resident #7's right forehead on 4/27/18 at 5:00 PM.</p> <p>Resident #7's clinical record did not contain 72 hour alert charting in the progress notes identifying the progression of the laceration.</p> <p>Resident #7's 4/1/18 - 5/31/18 Weekly Skin Monitoring of the abrasion to the right forehead was to be completed weekly until the skin impairment resolved. The monitoring on 5/7/18 and 5/14/18 was completed by a CNA and not a licensed nurse.</p> <p>* A Skin Event Assessment, dated 5/18/18, documented a 1 by 1.3 cm abrasion on Resident #7's right foot below her big toe.</p> <p>Resident #7's progress notes did not contain 72 hour alert charting, as instructed in the Checklist for Skin Impairments, identifying the progression of the abrasion on 5/19/18.</p> <p>Resident #7's 5/1/18 - 6/13/18 Weekly Skin Monitoring of the abrasion to the right foot was to be completed weekly until the skin impairment resolved. The monitoring was not completed for the week of 5/20/18 through 5/26/18.</p> <p>On 6/13/18 at 11:04 AM, the DNS stated the facility investigated the abrasion/scab to Resident #7's forehead. The DNS stated the dates on the investigation were incorrect and she could not explain the reason the witness statements conflicted with the conclusion of the investigation which determined the incident occurred on</p>	F 684			

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F 684	<p>Continued From page 28</p> <p>4/23/18. The DNS stated the progress notes did not contain documentation of the injury prior to 4/27/18. The DNS stated the care plan for the toe injury was not updated as quickly as it should have been and the weekly skin assessments were not initiated. The DNS stated the 72 hour alert charting should be completed, and weekly assessments of the healing progression of the wound should be completed as well.</p> <p>3. Resident #1 was admitted to the facility of 1/15/16 with diagnoses which included hemiparesis and cerebrovascular disease.</p> <p>An admission MDS assessment, dated 5/17/18, documented Resident #1 was cognitively intact. The MDS documented he was totally dependent or required extensive assistance of 1 to 2 staff members with all cares.</p> <p>a. The care plan was not updated when Resident #1 developed a rash as follows:</p> <p>The care plan area addressing Resident #1's skin impairments, dated 1/15/16, documented Resident #1 experienced skin impairments such as bruising, abrasions, and rashes. Resident #1 had 9 resolved or canceled skin impairments on his care plan. One of the resolved/canceled skin impairments was investigated by the facility on 4/21/18. The care plan was updated on 4/26/18 which documented Resident #1 sustained a 0.5 by 0.1 cm "abrasion/scab" to the side of Resident #1's left eyebrow and a 3 by 1.5 cm bruise above his left eyebrow.</p> <p>A Skin Event Assessment documented red spots scattered over Resident #1's right lower extremity</p>	F 684			

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F 684	<p>Continued From page 29</p> <p>was on discovered on 3/5/18 and the assessment was initiated on 3/14/18.</p> <p>Resident #1's care plan was not updated to reflect the rash to his right lower extremity.</p> <p>On 6/13/18 at 12:35 PM, the DNS stated the rash was not added to Resident #1's care plan.</p> <p>b. Resident #1 had two incidents which were not sufficiently monitored as follows:</p> <p>* A Skin Event Assessment documented red spots scattered over Resident #1's right lower extremity was on discovered on 3/5/18 and the assessment was initiated on 3/14/18.</p> <p>A fax to the physician, dated 3/7/18, documented Resident #1 had a rash on his right lower leg.</p> <p>Resident #1's progress notes did not contain documentation of the discovery of the rash on prior to 3/14/18, or evidence staff completed alert charting for 72 hours following the discovery of the rash.</p> <p>A 3/14/18 physician's order documented Resident #1 was to receive Hydrocortisone 1% twice a day for 10 days on his right lower leg for a rash.</p> <p>* A Skin Event Assessment, dated 4/21/18, documented discovery of a 0.5 by 0.1 cm "abrasion/scab" to the side of Resident #1's left eyebrow and a 3 by 1.5 cm bruise above his left eyebrow.</p> <p>Resident #1's 4/1/18 - 5/31/18 Weekly Skin</p>	F 684			

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F 684	Continued From page 30 Monitoring of the abrasion to the side of his eyebrow and the bruise above his left eyebrow was to be completed until the skin impairment resolved. The monitoring was not completed the week of 5/22/18 through 5/28/18.  The care plan was not updated at the time of the injury on 4/21/18.  Resident #1's progress notes did not contain documentation of the discovery of the abrasion/bruise above his left eyebrow prior to 4/25/18 or evidence staff completed alert charting for 72 hours following the injury.  On 6/12/18 at 6:04 PM, the DNS stated when a resident had an injury of unknown origin or a new "skin event" the staff should complete a Skin Event Evaluation, gather witness statements, complete neurological evaluations if applicable, document the event in the resident's progress note, complete 72-hour alert monitoring, ensure orders were applicable, update the care plan with weekly skin monitoring, and notify the POA and physician. The DNS stated the Unit Managers were to ensure this system was followed. The DNS stated she did not know the reason the rash was not documented in Resident #1's record prior to 3/14/18 and she could not explain the conflicting dates between the fax and on the skin event assessment. The DNS stated the skin program was assessed during this timeframe because of issues that were brought to light. The DNS could not explain the 7 day delay in the treatment being ordered for Resident #1's rash.	F 684			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		7/18/18	

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F 689	<p>Continued From page 31</p> <p>§483.25(d) Accidents. The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents received sufficient supervision to prevent falls and safety equipment was monitored as necessary to reduce potential injuries from falls. This was true for 1 of 4 residents (#7) reviewed for supervision and accidents. These failed practices placed residents at risk of bone fractures and other injuries related to fall. Findings include:</p> <p>Resident #7 was admitted to the facility on 2/27/18 with diagnoses which included and hemiparesis (paralysis of one side of the body) and cerebrovascular disease affecting the left side.</p> <p>A quarterly MDS assessment, dated 5/31/18, documented Resident #7 had a severe cognitive impairment. The MDS documented she was totally dependent or required extensive assistance of 1 to 2 staff members with all cares.</p> <p>The care plan area addressing Resident #7's risk for falls, dated 2/27/18, documented Resident #7 required an air mattress with bolsters on each side to assist with positioning in bed. The care plan did not include setting related to the degree</p>	F 689	<p>F689 CORRECTIVE ACTION: Resident #7 care plan updated to include air mattress setting, physician order includes air mattress setting for licensed nurse documentation and monitoring. Resident had a fall risk assessment in her record at the time of survey that indicated she was a fall risk.</p> <p>IDENTIFICATION OF OTHER RESIDENTS AFFECTED: Current residents with air mattresses have their care plans reviewed to include air mattress settings, physician orders are obtained with air mattress settings, and that licensed nurses monitor the function and settings. Adjustments have been made as indicated.</p> <p>SYSTEMIC CHANGES/PREVENTION MEASURES: Licensed nurses were educated on fall prevention and safety equipment monitoring by the Director of Nursing Services to include but not limited to, obtaining a physician order for proper air mattress settings, establishing a license</p>		

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F 689	<p>Continued From page 32 of inflation for the air mattress.</p> <p>Resident #7's physician orders did not specify settings for her air mattress.</p> <p>Resident #7's clinical record did not contain a fall risk assessment. On 6/13/18 at 11:04 AM, the DNS stated it was not the facility's practice to complete fall risk assessments for residents which included a risk score.</p> <p>A Fall Assessment, dated 4/2/18, documented Resident #7 experienced an unwitnessed fall out of her bed. The assessment documented Resident #7 verbalized she "slid out of bed due to air mattress...has tendency to have an easy slide potential."</p> <p>A Fall Assessment, dated 6/4/18, documented Resident #7 experienced an unwitnessed fall out of her bed. The assessment documented Resident #7 was found on the floor after rolling out of bed.</p> <p>Resident #7's clinical record did not include a daily or shift monitoring of her air mattress settings.</p> <p>On 6/13/18 at 11:04 AM, the DNS stated Resident #7's bed setting was calculated based on her weight. The DNS stated the settings of the air mattress should be located in the care plan. The DNS stated the facility was not currently monitoring Resident #7's air mattress to ensure the mattress settings were correct as a fall prevention measure.</p>	F 689	<p>nurse monitor to document the settings, and including setting on the care plans. The system is amended to include verification of new air mattress orders to include settings, care plan, and monitor in clinical meeting.</p> <p><b>MONITORING OF CORRECTIVE ACTION:</b> The Director of Nursing Services and/or Designee will complete audits weekly to validate the air mattress process is complete to include monitoring. Documentation will be place on the QAPI audit tool starting the week of July 15. 1:1 remediation will be provided for any negative findings. QAPI committee will review tracking and trending results of findings to validate compliance with facility policy, as well as state, and federal regulations until deficiency is no longer a concern to the QAPI committee.</p> <p><b>DATE OF COMPLIANCE:</b> JULY 17, 2018</p>		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		7/18/18	

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F 842	Continued From page 33  §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.  §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized  §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors,	F 842			

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F 842	<p>Continued From page 34</p> <p>and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, review of the State Survey Agency Reportable Incidents Database, and record review, it was determined the facility failed to keep accurate and complete clinical records for each resident. This was true for 3 of 10 sample residents (#1, #7, and #8) whose records were reviewed. The deficient practice created the potential for harm when clinical</p>	F 842	<p>F842</p> <p>CORRECTIVE ACTION: As noted on the CMS-2567 resident #1 no longer resides at the facility.</p> <p>Resident #7 and 8 non-pressure areas are healed. Standard of practice does not allow for any additional documentation.</p>		

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F 842	<p>Continued From page 35 information was not accurate and complete. Findings include:</p> <p>The facility's undated Checklist for Skin Impairments, documented the following process for staff to follow.</p> <ul style="list-style-type: none"> <li>* Skin Event Assessment completed within 8 hours of the shift.</li> <li>* Witness statements completed</li> <li>* Neurological evaluation if applicable</li> <li>* Progress note documentation</li> <li>* Alert charting creating for 72 hours</li> <li>* Orders placed if applicable</li> <li>* Care plan updated with weekly skin assessments</li> <li>* POA notified</li> <li>* Physician notified</li> </ul> <p>1. Resident #8 was readmitted to the facility on 2/3/17, with diagnoses which included vascular dementia without behavioral disturbances.</p> <p>A quarterly MDS assessment, dated 6/11/18, documented Resident #8 had a severe cognitive impairment. The MDS documented she was totally dependent or required extensive assistance of 1 to 2 staff members with all cares except eating.</p> <p>a. Resident #8's current care plan, dated 1/9/17, documented staff members were to assess Resident #8's skin weekly. The May 2018 ADL Report, documented staff were to assess Resident #8's skin weekly on Friday. The report did not include documentation a skin assessment was completed on Friday, 5/25/18.</p>	F 842	<p>IDENTIFICATION OF OTHER RESIDENTS AFFECTED: Current residents and new admissions have the potential to be affected. Standard of practice does not allow for any additional documentation. Residents with new treatments are identified for potential delay in treatment. Adjustments are made as indicated.</p> <p>See F684 for professional standards implementation</p> <p>SYSTEMIC CHANGES/PREVENTION MEASURES: Clinical staff that document in the electronic medical record are educate to keeping an accurate and complete medical record by the Director of Nursing Services and/or designee to include but not limited to timely skin/body audits, care plan updates, accurate measurements, timely transcription, and HIPAA integrity to not sharing login information and to log out of the electronic record when completed.</p> <p>The system is amended to include F684 clinical meeting process and validation of documentation by facility staff/agency to residents assigned.</p> <p>MONITORING OF CORRECTIVE ACTION: The Medical Record Director, Human Resource, and/or Designee will complete audits of 5 staff per week to validate</p>		

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F 842	<p>Continued From page 36</p> <p>On 6/12/18 at 6:33 PM, the DNS stated she expected skin assessments to be completed weekly. The DNS stated if a skin assessment was not completed the RN needed to document a reason in the resident's medical record.</p> <p>b. The care plan was not updated when Resident #8 developed skin impairments as follows:</p> <p>The care plan area addressing Resident #8's skin impairments, dated 1/9/17, documented Resident #8 experienced skin impairments such as bruising or skin tears. Resident #8 had 12 resolved or canceled skin impairments on her care plan and 2 active skin impairments dated 4/27/18.</p> <p>A Skin Event Assessment, dated 5/23/18, documented Resident #8 had a laceration on her forehead "halfway between her eyebrow and her hair line" to the left side of her head.</p> <p>Resident #8's care plan did not reflect the laceration to her left forehead, dated 5/23/18.</p> <p>On 6/13/18 at 12:35 PM, the DNS stated the laceration was not added to Resident #8's care plan.</p> <p>c. Resident #8 had three Skin Event Assessments which did not include documentation consistent with the facility's Checklist for Skin Impairments and included conflicting information, as follows:</p> <p>* A Skin Event Assessment, dated 4/27/18, documented Resident #8 had scattered bruising of 30 by 12 cm to her right forearm and right</p>	F 842	<p>accuracy in documentation for residents assigned. Additional audits are performed under F684. Documentation will be placed on the QAPI audit tool starting the week of July 15. 1:1 remediation will be provided for any negative findings. QAPI committee will review tracking and trending results of findings to validate compliance with facility policy, as well as state, and federal regulations until deficiency is no longer a concern to the QAPI committee.</p> <p>DATE OF COMPLIANCE: JULY 17, 2018</p>		

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F 842	<p>Continued From page 37</p> <p>hand. The assessment documented the bruises were varying in size, shape, and color. The assessment documented the bruises were "in various stages of healing." The assessment documented the resident was unable to say what happened and did not always understand what was being asked.</p> <p>Resident #8's clinical record did not contain 72 hour alert charting in the progress notes identifying the progression of the bruises.</p> <p>Resident #8's 4/1/18 - 6/13/18 Weekly Skin Monitoring of the right forearm and hand was to be completed weekly until the skin impairment resolved. The monitoring was not completed for the week of 5/20/18 through 5/26/18.</p> <p>* A Skin Event Assessment documented a 3 by 2.5 cm bruise to Resident #8's right temporal area was on discovered on 4/25/18 and the assessment was initiated on 4/27/18. An undated witness statement documented Resident #8's bruise to her right temporal face was present during the previous shift and was reported to the LPN by the off-going RN. The date of the incident on the witness statement was documented as 4/23/18. The statement documented the source of the bruise was unable to be determined.</p> <p>The care plan addressing Resident #8's skin impairments, dated 1/9/17, documented Resident #8 experienced skin impairments such as bruising or skin tears. Resident #8 had an active skin impairment dated 4/27/18, she had sustained a bruise near her right eye which was 5 by 4 cm.</p>	F 842			

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F 842	<p>Continued From page 38</p> <p>Resident #8's progress notes first documented the bruise to the right temporal area on 4/27/18. The witness statement noted above documented the date of the bruise as 4/23/18. The bruise near Resident #8's right eye was not documented in the progress notes when it was observed, as instructed in the Checklist for Skin Impairments</p> <p>Resident #8's Skin Event Assessment documented the size of the wound was 3 by 2.5 cm. Her Care Plan documented the size of the temporal wound as 5 by 4 cm. The actual size of the wound was unclear.</p> <p>Resident #8's 4/1/18 - 6/13/18 Weekly Skin Monitoring of the right temporal area was to be completed weekly until the skin impairment resolved. The monitoring was to assess the healing progression of the wound. The monitoring was not completed for the week of 5/20/18 through 5/26/18.</p> <p>* A Skin Event Assessment, dated 5/23/18, documented Resident #8 had a laceration on her forehead "halfway between her eyebrow and her hair line" on the left side of her head. The assessment documented the laceration was approximately 0.25 cm by 0.50 cm. The assessment documented Resident #8 was unable to describe what happened.</p> <p>Resident #8's clinical record did not contain 72 hour alert charting in the progress notes identifying the progression of the laceration.</p> <p>Resident #8' record did not include weekly skin assessments of the 5/23/18 laceration to her left forehead.</p>	F 842			

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F 842	<p>Continued From page 39</p> <p>On 6/12/18 at 6:33 PM, the DNS stated the temporal bruise documentation could have been better. The DNS stated she expected staff to document skin impairments in the progress notes and to complete alert charting for 72 hours.</p> <p>2. Resident #7 was admitted to the facility on 2/27/18 with diagnoses which included hemiparesis (paralysis of one side of the body) and cerebrovascular disease affecting the left side.</p> <p>A quarterly MDS assessment, dated 5/31/18, documented Resident #7 had a severe cognitive impairment. The MDS documented she was totally dependent or required extensive assistance of 1 to 2 staff members with all cares.</p> <p>The care plan area addressing Resident #7's skin impairments, dated 2/27/18, documented Resident #7 experienced skin impairments such as bruising or skin tears. Resident #7 had 3 resolved skin impairments on her care plan and 1 active skin impairment on her care plan. One of the resolved skin impairments dated 4/27/18, documented Resident #7 had sustained a 0.7 by 1.6 cm "abrasion/scab" on her right forehead which resolved on 5/14/18. The active skin impairment, dated 5/21/18 documented a laceration on Resident #7's right foot 1 by 1.3 cm.</p> <p>a. Resident #7 had three Skin Event Assessments which did not include documentation consistent with the facility's Checklist for Skin Impairments and included conflicting information, as follows:</p>	F 842			

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F 842	<p>Continued From page 40</p> <p>* A Skin Event Assessment, dated 4/27/18, documented a 0.7 by 1.6 cm "scab" was discovered on Resident #7's right forehead on 4/27/18 at 5:00 PM.</p> <p>Resident #7's clinical record did not contain 72 hour alert charting in the progress notes identifying the progression of the laceration.</p> <p>* A Skin Event Assessment, dated 5/18/18, documented a 1 by 1.3 cm abrasion on Resident #7's right foot below her big toe.</p> <p>Resident #7's progress notes did not contain 72 hour alert charting, as instructed in the Checklist for Skin Impairments, identifying the progression of the abrasion on 5/19/18.</p> <p>Resident #7's 5/1/18 - 6/13/18 Weekly Skin Monitoring of the abrasion to the right foot was to be completed weekly until the skin impairment resolved. The monitoring was not completed for the week of 5/20/18 through 5/26/18.</p> <p>On 6/13/18 at 11:04 AM, the DNS stated the care plan for the toe injury was not updated as quickly as it should have been and the weekly skin assessments were not initiated. The DNS stated the 72 hour alert charting should be completed, and weekly assessments of the healing progression of the wound should be completed, as well.</p> <p>3. Resident #1 was admitted to the facility on 1/15/16 with diagnoses which included hemiparesis and cerebrovascular disease.</p> <p>An admission MDS assessment, dated 5/17/18,</p>	F 842			

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F 842	<p>Continued From page 41</p> <p>documented Resident #1 was cognitively intact. The MDS documented he was totally dependent or required extensive assistance of 1 to 2 staff members with all cares.</p> <p>a. The care plan was not updated when Resident #1 developed a rash as follows:</p> <p>The care plan area addressing Resident #1's skin impairments, dated 1/15/16, documented Resident #1 experienced skin impairments such as bruising, abrasions, and rashes. Resident #1 had 9 resolved or canceled skin impairments on his care plan.</p> <p>A Skin Event Assessment documented red spots scattered over Resident #1's right lower extremity was discovered on 3/5/18 and the assessment was initiated on 3/14/18.</p> <p>Resident #1's care plan was not updated to reflect the rash to his right lower extremity.</p> <p>On 6/13/18 at 12:35 PM, the DNS stated the rash was not added to Resident #1's care plan.</p> <p>b. Resident #1 had two Skin Event Assessments which did not include documentation consistent with the facility's Checklist for Skin Impairments and included conflicting information, as follows:</p> <p>* A Skin Event Assessment documented red spots scattered over Resident #1's right lower extremity was on discovered on 3/5/18 and the assessment was initiated on 3/14/18.</p> <p>A fax to the physician, dated 3/7/18, documented Resident #1 had a rash on his right lower leg.</p>	F 842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/13/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET</b> <b>BOISE, ID 83712</b>		
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F 842	<p>Continued From page 42</p> <p>Resident #1's progress notes did not contain documentation of the discovery of the rash on prior to 3/14/18, or evidence staff completed alert charting for 72 hours following the discovery of the rash.</p> <p>A 3/14/18 physician's order documented Resident #1 was to receive Hydrocortisone 1% twice a day for 10 days on his right lower leg for a rash.</p> <p>* A Skin Event Assessment, dated 4/21/18, documented discovery of a 0.5 by 0.1 cm "abrasion/scab" to the side of Resident #1's left eyebrow and a 3 by 1.5 cm bruise above his left eyebrow.</p> <p>Resident #1's 4/1/18 - 5/31/18 Weekly Skin Monitoring of the abrasion to the side of his eyebrow and the bruise above his left eyebrow was to be completed until the skin impairment resolved. The monitoring was not completed the week of 5/22/18 through 5/28/18.</p> <p>The care plan was not updated at the time of the injury on 4/21/18.</p> <p>Resident #1's progress notes did not contain documentation of the discovery of the abrasion/bruise above his left eyebrow prior to 4/25/18 or evidence staff completed alert charting for 72 hours following the injury.</p> <p>On 6/12/18 at 6:04 PM, the DNS stated when a resident had an injury of unknown origin or a new "skin event" the staff should complete a Skin Event Evaluation, gather witness statements,</p>	F 842			

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F 842	<p>Continued From page 43</p> <p>complete neurological evaluations if applicable, document the event in the resident's progress note, complete 72-hour alert monitoring, ensure orders were applicable, update the care plan with weekly skin monitoring, and notify the POA and physician. The DNS stated the Unit Managers were to ensure this system was followed. The DNS stated she did not know the reason the rash was not documented in Resident #1's record prior to 3/14/18 and she could not explain the conflicting dates on the fax and skin event assessment.</p> <p>4. Documentation of services provided to residents when a staff member was not working in the building as follows:</p> <p>a. The April 2018 ADL Report, documented Resident #7 was provided a shower on 4/6/18 by CNA #4.</p> <p>The facility's as worked report for 4/6/18 did not document CNA #4 as working. The facility's schedule did not document CNA #4 as working on 4/6/18.</p> <p>On 6/13/18 at 1:35 PM, the DNS and the Executive Director stated they did not know how CNA #4 could provide services such as a shower when the staff member was not working in the facility.</p> <p>b. Documentation of services provided to the resident when a staff member was not working in the building as follows:</p> <p>The April 2018 ADL Report, documented Resident #8 was provided a shower on 4/6/18 by</p>	F 842			

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F 842	<p>Continued From page 44 CNA #4.</p> <p>The facility's as worked Report for 4/6/18 did not document CNA #4 as working. The facility's schedule did not document CNA #4 as working on 4/6/18.</p> <p>On 6/13/18 at 1:35 PM, the DNS and the Executive Director stated they did not know how CNA #4 could provide services such as a shower when the staff member was not working in the facility.</p> <p>c. An Investigation Summary to the State Survey Agency documented Resident #1 experienced a skin event in a shower room on 4/21/18. The summary documented a CNA was transporting Resident #1 out of the shower room and utilized one hand to hold the door open while attempting to push Resident #1's chair through the threshold. The summary documented Resident #1's chair rotated towards the wall and his head made contact with the "grab" bar. Seven witness statements were included with the summary including an undated witness statement which, documented Resident #1 was provided a shower by agency CNA #1 on 4/21/18 at 1:30 PM. The statement documented CNA #1 was assisting Resident #1 out of the shower room and the shower chair "swerved" and Resident #1's head hit the "assist bar" on the wall. The statement document CNA #1 reported this to the nurse "right away."</p> <p>The April 2018 ADL Report, documented Resident #1 was provided a shower on 4/21/18 by CNA #2.</p>	F 842			

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F 842	<p>Continued From page 45</p> <p>The witness statement and Resident #1's ADL Report documented conflicting data on who provided Resident #1's shower on 4/21/18</p> <p>On 6/12/18 at 5:43 PM, CNA #2 stated contract agency CNAs were using facility CNAs' PCC access codes to chart cares they were providing to residents. CNA #2 said this was done at the direction of the DNS. CNA #2 stated access codes were not provided to agency CNAs for a few days after they were hired, which was the reason they had to share.</p> <p>On 6/12/18 at 6:04 PM, the DNS stated CNA #1 showered Resident #1 on 4/21/18 and she was unsure how the documentation showed CNA #2 performed the task. The DNS stated agency CNAs had access to PCC "immediately."</p> <p>On 6/13/18 at 1:05 PM, CNA #3 stated she was an agency CNA who worked in the facility. CNA #3 stated she started working a few months ago and her duties at the facility were to shower residents, assist with ADLs, and other needs. CNA #3 stated she did not have access to PCC as soon as she started working. CNA #3 stated she had been working approximately 4 days in the facility before she had access to chart in PCC using her own name. CNA #3 stated during the 4 day time period another CNA charted the cares she completed.</p> <p>On 6/13/18 at 1:35 PM, the DNS and the Executive Director stated CNA #1 performed the shower on 4/21/18 and they could not explain the reason CNA #2 was documented as providing the shower. The DNS did not know the reason agency CNAs thought she instructed them to</p>	F 842			

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/13/2018</b>
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F 842	Continued From page 46 share PCC access information.	F 842			



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
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January 7, 2019

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

Provider #: 135090

Dear Mr. Roedel:

On **June 13, 2018**, an unannounced on-site complaint survey was conducted at Shaw Mountain of Cascadia. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007725**

**Allegation #1**

A resident required two person assist for transfers, but it was witnessed only one staff person completed transfers when two were required. Staff were not properly trained in the use of gait belts and resident transfers or resident positioning during transfers, and the investigation completed by the facility was thorough regarding the fall and subsequent fracture.

**Findings #1:**

An onsite complaint investigation was conducted from 6/11/18 to 6/13/18, at the facility. Eight residents' records were reviewed and observations were conducted during transfers and ambulation of residents. Two of the observations conducted included residents who required two-person assist with transfers.

Five nurse aides, three licensed nurses, a nurse practitioner, nursing administration, and two residents were interviewed regarding safety practices and abuse training and had no identified concerns with staff or their safety.

During the two observations, in which nursing staff completed the two person transfer, it was determined the nurse aides used gait belts correctly, stood by the residents for assistance, placed the residents' walkers in the appropriate location, applied wheelchair brakes appropriately to prevent the wheelchair from moving while the residents were transferred to and from the wheelchair, nursing staff gave the residents' instructions during the transfers, and provided mechanical assistance appropriately.

General observations throughout the facility were completed and residents were observed ambulating with or without assistive devices and residents transferred from wheelchairs to chairs in common areas. During these observation, it was determined residents were transferred or ambulated safely and there were no identified concerns or unsafe practices.

During the investigation, the nursing staff's personnel files/training records were reviewed. There was documented evidence nurse staff's competencies were completed. There were no concerns regarding the training of nursing staff.

General observations during the three days throughout the facility's hallways, common areas and dining rooms, there was sufficient number of staff available to answer call lights and assist residents according to their care plan. Interviews with nurse aides, licensed nurses and residents confirmed there was sufficient nursing staff to provide the care that residents required per their care plan. Review of the nursing staff schedules for the last six months revealed stable staffing levels.

Review of an investigation completed by the facility with subsequent interviews of all staff present in the room during the incident, did not support the allegation investigations were incomplete or covering up any inadequacies related to staff support.

Based on the investigative findings the allegation was substantiated. The facility was cited at F689 related to a safety concern with the monitoring of the resident's use of an air mattress which resulted in a fall.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #2:

The Reporting Party was concerned that staff had packed up the resident's belongings prior to the Reporting Party's arrival at the facility, and that there were missing personal items.

Findings #2:

An onsite complaint investigation was conducted from 6/11/18 to 6/13/18, at the facility. Three nurse aides, two licensed nurses, the Social Services Director, and Director of Nursing were interviewed regarding the resident's personal belongings. Documents reviewed included incident reports, resident council meeting minutes, and grievances for the previous six months. Two alert and oriented residents were interviewed regarding the safety of their personal belongings.

During the interviews neither resident had any concerns regarding missing personal belongings or clothing since their admission to the facility. Review of the facility's grievance file documented the facility replaced clothing and sundries for residents who had reported items missing. There was no evidence grievances were not resolved.

Interviews were conducted with nursing staff, the Social Worker, and Director of Nursing regarding missing items of residents. The interviews revealed that the missing lamp had been located and the Reporting Party was notified. Nursing staff were unable to locate the candy or plaque. Interview with nursing staff that packed the resident's personal belongings into a couple of boxes revealed only a portion of the belongings had been boxed prior to the Reporting Party arriving at the facility.

Review of documentation provided by the facility revealed the resident's belongings were allowed to stay in the room for an extended period of time. The Reporting Party informed the facility that she would have to obtain a U-Haul trailer to transport the resident's personal belongings. During an interview with the Reporting Party, she stated that since removing the resident's personal belongings from the facility, review of the items has not yet occurred.

The allegation the facility failed to respect the resident's property and that the Reporting Party's wishes were not respected could not be substantiated. There was insufficient evidence to establish that the facility acted inappropriately in response to the subject of the allegation and no deficiencies were written.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Benjamin Roedel, Administrator  
January 7, 2019  
Page 4 of 4

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 black ink, appearing to read "Laura Thompson", is positioned above the typed name.

Laura Thompson, RN, Supervisor  
Long Term Care Program

LT/lj



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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June 13, 2019

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

Provider #: 135090

Dear Mr. Roedel:

On **June 11, 2018** through **June 13, 2018**, an unannounced on-site complaint survey was conducted at Shaw Mountain of Cascadia. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007827**

**ALLEGATION #1:**

Residents were injured at the facility and the injuries were not investigated appropriately.

**FINDINGS #1:**

During the survey eight resident records, which included two closed record, were reviewed for Quality of Care and abuse. Interviews were conducted with residents and family members. Staff members were interviewed and observed during interactions with residents. Facility abuse allegations, grievances, and Resident Council minutes were also reviewed.

One resident 's record, admitted January 2016, documented the resident had multiple skin impairments to include bruising and lacerations. The record documented the resident was completely dependent on 1 to 2 staff for all cares. The resident had an abrasion and bruise above the left eye investigated by the facility. The investigation did not include documentation of an assessment of the injury, interviews with staff and residents who witnessed the injury, and preventative measures to protect the resident from further injury. Several nurses and several residents stated they remembered the incident and were present at the time and were not interviewed by facility administration as part of the investigation.

Another resident, admitted in 2/2017, had documentation in their record they had severe cognitive

impairment and were totally dependent on staff for cares. The resident had three incidents documented in their record which included scatter bruising to her right forearm and hand, a bruise to the right temporal area, and cut on her forehead.

The investigations did not include a conclusion as to the source of the bruising or cut, witness statements, staff interviews, or resident interviews to determine the origin of the bruise, or a complete investigation to rule out potential abuse or neglect.

The Director of Nursing Services (DNS) stated an injury of unknown source was an injury that could not be explained by the resident and that the facility could not determine the cause. The DNS stated when a resident had an injury of unknown origin or a new "skin event" the staff should be completing a Skin Event Evaluation, witness statements, neurological evaluations if applicable, progress note documentation, and 72-hour alert monitoring. The DNS stated staff were to ensure practitioner orders are applicable, the care plan is updated, and the POA and physician are notified. The DNS stated the Unit Managers were to ensure this system was followed.

Based on the results of the investigation, the allegation was substantiated. Deficiencies were cited at F606, F609, F610, and F684 as it related to the failure of the facility to investigate allegations of potential abuse.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #2:

The facility had inconsistent and/or incorrect documentation in resident records.

#### FINDINGS #2:

During the investigation observations were conducted, 10 resident records were reviewed including two closed records, and interviews were conducted with residents and family members. Staff members were also interviewed about charting in the medical records.

One resident's record, admitted January 2016, had documentation which was inconsistent with an investigation summary.

An Investigation Summary reported to the State Survey Agency documented the resident sustained injuries and an investigation was started. The investigation documented a CNA assisted the resident out of the shower and the resident was hurt in the process. The resident's Activities of Daily Living Report, documented the resident's shower was provided by a different CNA at the time of the incident. The information was conflicting.

Another resident, admitted in 2/2017, had progress notes which documented a bruise was found to the

Benjamin Roedel, Administrator  
June 13, 2019  
Page 3 of 3

right temporal area on 4/27/18. The resident's record included a witness statement which documented the date of the bruise as 4/23/18. The bruise near the resident's right eye was not documented in the progress notes when it was observed, per the facility ' s policy and procedures.

The resident's record also included a Skin Event Assessment which documented the size of the wound was 3 cm by 2.5 cm. Her Care Plan documented the size of the wound as 5 cm by 4 cm. It was unclear from the documentation the size of the wound.

Staff stated the facility's Director of Nursing Services directed them to share their charting access passwords and codes until new staff members were provided access to the electronic charting system.

The Director of Nursing Services stated she was unsure how the charting in resident records was inaccurate and stated the CNAs had immediate access to the charting system upon hire.

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F842 as it related to the failure of the facility to provide accurate medical records.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

If you have 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,

Laura Thompson, RN, Supervisor  
Long Term Care Program

LT/lj