



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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

July 3, 2018

Mark Dudley, Administrator  
Weiser of Cascadia  
331 East Park Street  
Weiser, ID 83672-2053

Provider #: 135010

Dear Mr. Dudley:

On **June 15, 2018**, a survey was conducted at Weiser of Cascadia by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Mark Dudley, Administrator  
July 3, 2018  
Page 2 of 4

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 13, 2018**. Failure to submit an acceptable PoC by **July 13, 2018**, may result in the imposition of civil monetary penalties by **August 5, 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*.

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

**A Civil Monetary Penalty.**

**Denial of payment for new admissions effective September 15, 2018**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 15, 2018**, if substantial compliance is not achieved by that time.

Mark Dudley, Administrator  
July 3, 2018  
Page 3 of 4

Your facility's noncompliance with the following:

**F0883 -- S/S: F -- 483.80(d)(1)(2) -- Influenza And Pneumococcal Immunizations**

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

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents #2, #4, #7, #9, #12, #16, #19, #29 and #30 as identified on the enclosed Resident Identifier List.

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

**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.

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:

Mark Dudley, Administrator  
July 3, 2018  
Page 4 of 4

<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:

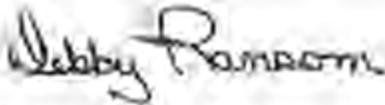
- BFS Letters (06/30/11)

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

This request must be received by **July 13, 2018**. If your request for informal dispute resolution is received after **July 13, 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/lj  
Enclosures

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from June 11, 2018 through June 15, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Edith Cecil, RN, Team Coordinator Cecilia Stockdill, RN Teri Hobson, RN</p> <p>Survey Abbreviations:</p> <p>CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease DON = Director of Nursing gm - gram I and A = Incidents and Accidents MAR = Medication Administration Record MDS = Minimum Data Set mcg = micrograms mg = milligram ml = milliliters PT = Physical Therapy RN = Registered Nurse tsp = teaspoon</p> <p>Definitions: Spasmodic torticollis - chronic neurological involuntary spasms of the neck. Spinal Stenosis - narrowing of the spinal canal Gout - A form of arthritis characterized by severe pain, redness and tenderness in joints.</p>	F 000			
F 583 SS=D	<p>Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)</p>	F 583		7/30/18	

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.

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 583	<p>Continued From page 1</p> <p>§483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.</p> <p>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and resident interview, it was determined the facility failed to ensure the resident's right to personal</p>	F 583	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 583	<p>Continued From page 2</p> <p>privacy was maintained during personal care. This was true for 1 of 1 resident (#1) observed during provision of personal care. The failure created the potential for Resident #1 to be embarrassed if her body was exposed to others unnecessarily. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 7/6/15 with diagnoses which included quadriplegia, dysphonia (difficulty speaking), and dysphagia (difficulty swallowing).</p> <p>Resident #1's annual MDS assessment, dated 6/4/18, documented Resident #1 was cognitively intact.</p> <p>On 6/12/18 at 8:53 AM, CNA #5 provided morning care for Resident #1. CNA #5 was on the window side of the bed, and Resident #1 was in bed with her pants down to her knees. The window curtain was open and Resident #1's peri area was exposed. CNA #5 applied stockings and braces to Resident #1's legs prior to dressing her. CNA #4 arrived to assist with the transfer to the wheelchair with the Hoyer lift. Resident #1 was exposed for 3-5 minutes. No attempt was made by either CNA to cover Resident #1 or close the window curtain.</p> <p>On 6/14/18 at 1:32 PM, Resident #1 stated she tolerated the curtain being open. She stated she did not like it though. When asked if she told anyone about the open curtain, she shook her head "no". and commented on how much she cared for facility staff.</p> <p>On 6/14/18 at 4:01 PM RN #2 stated she provided teaching on dignity and privacy to new</p>	F 583	<p>Care 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>F583 Privacy/Confidentiality of Records</p> <p>Resident Specific The ID team reviewed resident #1, and have taken the following action;</p> <p>Direct care staff re-educated to include, but not limited to, the closing of blinds during personal care to preserve dignity and respect.</p> <p>Other Residents The ID team interviewed other residents about privacy during personal cares. No other issues were identified.</p> <p>Facility Systems Licensed nurses and CNAs were re-educated regarding personal privacy by the DNS and/or designee to include but not limited to, the closing of the blinds during personal cares. The system is amended to include documentation of education upon hire and annually. Privacy question asked semi-annually to residents during Abaqis quality of care review and periodic observation for personal privacy.</p>		

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 583	Continued From page 3 hire staff. RN #2 stated the entire staff were expected to respect residents' privacy. RN #2 was not able to provide documentation regarding the teaching of personal privacy.	F 583	Monitor The DNS and/or designee will observe personal care on 5 residents weekly for 4 weeks, then every other week for 8 weeks. Starting the week of July 15, the observations will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		7/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 657	<p>Continued From page 4 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, policy and procedure review, and staff interview, it was determined the facility failed to ensure residents' care plans were revised and updated to maintain consistency and accuracy. This was true for 1 of 12 sample residents (#29) whose care plans were reviewed. This had the potential for harm if appropriate cares and/or services were not provided due to incorrect information on the care plan. Findings include:</p> <p>The facility's policy and procedure for Care Plans, dated 11/28/17, documented the following: * "A comprehensive care plan is developed consistent with the residents' specific conditions, risks, needs, behaviors, preferences and with standards of practice..." * The comprehensive care plan addresses services to "attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being." * The care plan is revised and updated to demonstrate the resident's current status.</p> <p>Resident #29 was admitted to the facility on 7/9/14 with multiple diagnoses, including age-related cognitive decline and dysphagia (a swallowing disorder).</p> <p>Resident #29's significant change MDS assessment dated 5/23/18 documented</p>	F 657	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Care 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>F657 Diet Texture</p> <p>Resident Specific Resident #29 has discharged from the facility.</p> <p>Other Residents The ID team reviewed other residents for CP to validate they match diets orders. Adjustments have been made as indicated.</p> <p>Facility Systems The Dietary Manager and ID team was re-educated regarding care plan updates to include but not limited to, updating care plan to match diet order. The system is</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 657	<p>Continued From page 5</p> <p>moderate cognitive impairment with signs and symptoms of delirium, a mechanically altered diet, and speech therapy was in place during May 2018.</p> <p>Resident #29's physician orders, active as of 6/13/18, documented a regular diet, pureed texture, regular consistency.</p> <p>Resident #29's care plan documented the following: * "Altered texture: nectar thick puree solids, pudding thick puree solids to be thinned to honey thick (as a max consistency) via cream whole milk, gravy/sauce or butter to improve bolus flow through esophagus per speech therapist recommendation, initiated on 5/11/18 and revised on 6/7/18. * Diet ordered by physician: regular diet, pureed texture, thin liquids, initiated on 7/16/14 and revised on 4/18/18.</p> <p>A Progress Note, dated 6/1/18 at 9:13 AM, documented Resident #29 had a change of condition with a downgrade in her diet due to the decline. Resident #29 had difficulty swallowing medications whole.</p> <p>On 6/13/18 at 2:20 PM, the speech therapist said Resident #29's diet should be pureed with thin liquids. The speech therapist said the order and care plan were not congruent, and Resident #29 should be on puree solids that are no thicker than honey thick. The speech therapist said the diet order and care plan were confusing.</p> <p>On 6/13/18 at 3:45 PM, RN #3 said Resident #29's care plan needed to be updated regarding</p>	F 657	<p>amended to include, review of diet change orders in clinical meeting and validation that the care plan is updated timely. Quarterly review of care plans will include diet/fluid texture/consistency validation.</p> <p>Monitor The Administrator and/or designee will audit diet orders and care plans for new admissions or order changes weekly for 4 weeks, then every other week for 8 weeks. Starting the week of July 15, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 657	Continued From page 6	F 657			
F 684 SS=E	<p>her diet order.</p> <p>Quality of Care CFR(s): 483.25</p> <p>§ 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 observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure professional standards of practice were met related to neuro checks after resident falls, medication management, management of respiratory symptoms and not following physician orders. This was true for 2 of 3 residents (#12 and #16) reviewed for falls when neurological checks were not completed after resident falls, 3 of 12 residents (#2, #20, and #30) whose medications were reviewed when the recommended dose of Tylenol was exceeded and the ordered dose was exceeded for a nasal spray and antacid medication, 1 of 1 resident (#4) reviewed for respiratory symptoms and 1 of 16 residents (#132) where the nurses failed to follow physician orders. This failed practice created the potential for harm should residents experience undetected changes in neurological status after a fall, adverse side effects from excessive doses of medication, and undetected signs and symptoms of worsening respiratory</p>	F 684	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Care 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>F684 Quality of Care</p> <p>Resident Specific The ID team reviewed resident #16 and 20 and they have had no change in neurological status. A medication variance report was completed for resident #2, no adverse side effects were noted from the additional antacid or nasal</p>	7/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 684	<p>Continued From page 7 status or hyperglycemia. Findings include:</p> <p>The facility's undated policy and procedure for nasal inhalers, sprays, and aerosols, documented the following:</p> <ul style="list-style-type: none"> <li>* Verify the physician's order, taking notice of the concentration of the medication and which nostril to treat.</li> <li>* Occlude one of the resident's nostrils, insert the tip into the open nostril and squeeze quickly and firmly one time.</li> <li>* Have the resident hold their breath for a few seconds then exhale through the mouth.</li> <li>* Repeat the ordered number of times in each nostril.</li> </ul> <p>The facility's policy and procedure for respiratory care, dated 11/28/17, documented the following:</p> <ul style="list-style-type: none"> <li>* "Depending on the type of respiratory services the resident receives, physician orders and the individualized respiratory care plan, documentation should include, as appropriate:" vital signs, respiratory rate, movement of the chest and respiratory effort, abnormal breath sounds, signs of dyspnea (shortness of breath), position change effects of breathing, the nature of sputum (mucous), signs of infection, changes in behavior that may signify hypoxia (low oxygen levels), and resident instruction regarding participating in respiratory treatments as appropriate.</li> <li>* "The attending practitioner is immediately notified of significant changes in condition, and the medical record reflects the notification, response and interventions implemented to address the resident's condition."</li> </ul> <p>The facility's policy and procedure for</p>	F 684	<p>spray. Resident #12 and 30's orders were amended so as not to exceed the max Tylenol dose of 3000mg no adverse reactions were identified. Resident #4 assessed and respiratory issues have resolved. Resident #132 MD was notified regarding the over range blood sugar.</p> <p>Other Residents Residents with falls requiring neuro checks within the last three weeks were reviewed for neuro check completion and if needed were assessed to determine if they have had any neurological changes. No change in neurological status was found.</p> <p>Residents with Tylenol (acetaminophen) orders or medications containing Tylenol, had the physician contacted and orders were updated to include a maximum dose of 3000 mg according to USA Food and Drug Administration (FDA) recommendations.</p> <p>Any residents exhibiting respiratory symptoms were placed on alert charting and respiratory status monitored.</p> <p>Diabetic resident's BG levels were reviewed for the last three weeks. MD notifications were made and standing orders for upper BG limits were signed.</p> <p>Facility Systems Current LNs were re-educated regarding professional standards by the DNS and/or designee to include but not limited to,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 684	<p>Continued From page 8</p> <p>Neurological Evaluation, dated 11/28/17, directed staff to perform neuro checks every 15 minutes for one hour, then every 30 minutes for one hour, then every hour for two hours, then every 4 hours "until [the] physician states it is no longer necessary or in 72 hours if [the] resident's condition is stable and showing no signs and symptoms of neurological injury."</p> <p>The facility's policy and procedure for Fall Response and Management, dated 11/28/17, directed staff to perform neuro checks per the physician's orders, or monitor every 15 minutes for 1 hour, then every 30 minutes for one hour, then every hour for 2 hours or until the resident's status stabilizes if the resident hit their head.</p> <p>According to the Lippincott NursingCenter website, accessed on 6/21/18, and the Nursing 2018 Drug Handbook, there are eight "Rights" of medication administration:</p> <ol style="list-style-type: none"> <li>1. Right patient.</li> <li>2. Right medication.</li> <li>3. Right dose.</li> <li>4. Right route.</li> <li>5. Right time.</li> <li>6. Right documentation.</li> <li>7. Right reason.</li> <li>8. Right response.</li> </ol> <p>1. Resident #2 was admitted to the facility on 1/19/16 with multiple diagnoses, including gastroesophageal reflux disease and acute sinusitis.</p> <p>Resident #2's physician orders, active as of 6/14/18, documented the following: * Fluticasone Propionate Suspension (a nasal</p>	F 684	<p>completion of neuro checks in full for any unwitnessed falls or fall with a head injury, clinical assessment with a change of condition to include monitoring of respiratory status when a resident is symptomatic, orders changes to reflect physician upper limit for BG levels, how to manage upon admission when parameters are not yet set, maximum dosage of Tylenol for 3000mg, and completion of medication variance reports as indicated. The system is amended to included follow-up in clinical meeting of new medications which contain Tylenol for inclusion of maximum dosing, BG level parameters being followed, neuro checks completed through 72 hours or until physician directs they no longer need to be completed, and review of progress notes for clinical assessment when residents exhibit respiratory symptoms or other changes.</p> <p>Monitor The DNS and/or designee will... Audit neuro checks for completion weekly for 4 weeks, then every other week for 8 weeks.</p> <p>Audit new physician orders for Tylenol and medications that contain Tylenol weekly for 4 weeks, then every other week for 8 weeks.</p> <p>Audit residents with change of condition for documentation of the clinical assessment to include monitoring of respiratory status as indicated weekly for</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 684	<p>Continued From page 9</p> <p>steroid spray) 50 mcg 2 sprays each nostril twice a day for chronic rhinosinusitis.</p> <p>* Mylanta Suspension 200-200-20 mg /5 ml 2 tsp every 6 hours as needed for stomach upset.</p> <p>Resident #2's June 2018 MAR documented the following:</p> <p>* The fluticasone nasal spray was administered each day from 6/1/18-6/14/18.</p> <p>* The Mylanta was administered on 6/8/18, 6/10/18, 6/12/18, and 6/14/18.</p> <p>On 6/14/18 at 9:19 AM, RN #1 administered medications to Resident #2. RN #1 administered two sprays of fluticasone nasal spray to Resident #2's right nostril and left nostril. RN #1 then administered three additional sprays of fluticasone to Resident #2's right nostril and two additional sprays to the left nostril. When asked how many sprays should be administered, RN #1 said it was two sprays in each nostril. When the surveyor brought it to RN #1's attention that she had administered 5 sprays in the right nostril and 4 sprays in the left nostril, RN #1 said "Oh."</p> <p>On 6/14/18 at 12:05 PM, RN #1 said sometimes it appeared Resident #2 did not sniff up all the nasal spray, so she gave more sprays. RN #1 said she normally would not give that many sprays.</p> <p>On 6/14/18 at 9:20 AM, RN #1 administered Advanced Antacid (a generic form of Mylanta) 30 ml to Resident #2.</p> <p>On 6/14/18 at 2:50 PM, RN #1 said the order for Mylanta was 2 tsp, which equaled 10 mls. RN #1 said she administered 30 mls of Mylanta to</p>	F 684	<p>4 weeks, then every other week for 8 weeks.</p> <p>Audit in clinical meeting diabetic patients for BG levels that exceed parameter and Physician notifications documentation weekly for 4 weeks, then every other week for 8 weeks.</p> <p>Reviews will start the week of July 15, the reviews will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 684	<p>Continued From page 10 Resident #2 and was thinking it was tablespoons.</p> <p>2. Resident #4 was admitted to the facility on 2/10/17 with multiple diagnoses, including heart failure and COPD (a lung disease).</p> <p>Resident #4's physician orders, active as of 6/15/18, documented the following:</p> <ul style="list-style-type: none"> <li>* Albuterol sulfate HFA aerosol solution 108 (an inhaled medication to open the resident's breathing tubes) inhale 1 puff every 6 hours as needed for shortness of breath.</li> <li>* Albuterol sulfate nebulization solution 2.5 mg/3 mls inhale 3 mls via nebulizer every 4 hours as needed for shortness of breath and wheezing.</li> <li>* Breo Ellipta 14 dose 100-25 mcg (an inhaled medication to open the resident' breathing tubes plus an inhaled steroid) inhale 1 puff once daily for shortness of breath/wheezing.</li> <li>* Tiotropium bromide monohydrate capsule 18 mcg (an inhaled medication to open the breathing tubes) inhale one capsule once daily for breathing.</li> </ul> <p>Resident #4's current care plan directed staff to administer nebulizer treatments as ordered and "Check breath sounds and monitor/document for labored breathing. Monitor/document for the use of accessory muscles while breathing."</p> <p>Resident #4's Progress Notes documented the following:</p> <ul style="list-style-type: none"> <li>* On 6/6/18 at 1:42 PM, he had a cough with expiratory wheezing, thick white to yellow sputum, he was "just not feeling good, weak, and with fatigue," and a chest x-ray was ordered by the physician.</li> <li>* On 6/8/18 at 3:42 PM, Resident #4 was</li> </ul>	F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 684	<p>Continued From page 11 improved with a "slight cough and some wheezing." The x-ray was done and the report was not back yet.</p> <p>* On 6/13/18 at 3:25 PM, Resident #4 was more confused for the past few days, complained of feeling weaker and needed more help. The chest x-ray was normal.</p> <p>There was no documentation Resident #4's lung sounds were re-assessed after 6/8/18. There was no documentation the oxygen saturation level was checked.</p> <p>Resident #4's MAR documented the following: * The Albuterol inhaler was last administered on 6/6/18 and was the only dose administered in May 2018 and June 2018. * The Albuterol via nebulizer was not administered in May or June 2018.</p> <p>On 6/12/18 at 9:37 AM, Resident #4 said he recently went to the emergency room due to a cough, he had a chest x-ray, and was still coughing.</p> <p>On 6/15/18 at 11:41 AM, LPN (Licensed Practical Nurse) #1 said Resident #4's lungs were clear with some wheezing. LPN #1 said the last Albuterol nebulizer was given in November 2017 and the last Albuterol inhaler was given on 6/6/18. LPN #1 said he had not listened to Resident #4's lungs on that morning. LPN #1 said the lung bases were a little diminished and sounded clear.</p> <p>On 6/15/18 at 11:24 AM, RN #2 said Resident #4 had wheezing and coughing on 6/6/18 and was given an antibiotic. RN #2 said the physician may</p>	F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 684	<p>Continued From page 12</p> <p>have seen Resident #4 on 6/14/18 at his office and she could call to find out if a note was available. The facility did not provide documentation of Resident #4 being evaluated by the physician on 6/14/18.</p> <p>On 6/15/18 at 12:10 PM, the DON said the staff usually checked oxygen saturation as part of vital signs and did not know why it was not recorded for Resident #4. The DON said she thought the nebulizer and inhaler would have been given when the resident was still complaining of coughing.</p> <p>3. Resident #16 was admitted to the facility on 1/3/18 with multiple diagnoses, including other abnormalities of gait and mobility and muscle wasting and atrophy.</p> <p>Resident #16's current care plan documented the following:</p> <ul style="list-style-type: none"> <li>* He was at high risk for falls and had a fall on 5/31/18.</li> <li>* Two person assist for transfers with a Hoyer lift.</li> <li>* Anticipate Resident #16's needs.</li> <li>* Ensure the call light was in reach.</li> <li>* Provide non-skid footwear, and the resident was to wear "gripper socks" while in bed.</li> <li>* PT (physical therapy)/OT (occupational therapy) to evaluate and treat as ordered or as needed.</li> <li>* Place the recliner chair controller in the side pocket of the chair for resident safety.</li> </ul> <p>A Fall Risk Assessment Tool, dated 4/3/18 at 6:19 PM, documented Resident #16's fall risk score was 5, which indicated he was at risk for falling.</p> <p>A Progress Note, dated 5/31/18 at 1:39 PM,</p>	F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 684	<p>Continued From page 13</p> <p>documented Resident #16 was adjusting his power recliner and could not take his finger off the control button. He was found on the floor, face down, in front of the power recliner. A 5-cm skin tear was present to the left forearm with mild bruising and a "small swollen area" was noted on the center of his forehead.</p> <p>An A and I Report, dated 5/31/18 at 11:15 AM, documented Resident #16 fell from his chair and was face down on the floor in front of the fully raised recliner.</p> <p>Resident #16's Neurological Assessment sheet, dated 5/31/18-6/1/18, documented neuro checks were performed at the following times: * On 5/31/18: 11:15 AM, 11:30 AM, 12:00 PM, 12:15 PM, 12:45 PM, 1:15 PM, 1:45 PM, 2:15 PM, 3:15 PM, 4:15 PM, 5:15 PM, 6:15 PM, 7:15 PM, and 11:15 PM. * On 6/1/18: 3:15 AM, 7:15 AM, 11:15 AM, and 7:00 PM. * On 6/2/18 at 11:00 AM and 10:00 PM.</p> <p>The neurological checks were not completed through 6/3/18 at 11:15 AM (72 hours).</p> <p>On 6/14/18 at 4:31 PM, the DON said the facility policy indicated neuro checks were for 72 hours, and the physician did not say the neuro checks were no longer necessary prior to that for Resident #16. The DON said there should have been one more day of neuro checks.</p> <p>4. Resident #30 was admitted to the facility on 2/26/18 with multiple diagnoses, including gangrene to his left below knee amputation surgical site and peripheral vascular disease.</p>	F 684			

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 684	<p>Continued From page 14</p> <p>Resident #30's Admission Physician orders, dated 2/26/18, documented he was to receive Norco 10/325 mg (hydrocodone/acetaminophen) 1 tablet by mouth every 6 hours as needed for pain. It was also noted Resident #30 was not to take Tylenol (acetaminophen) while he was taking the medication. The order documented the maximum dose of acetaminophen was 4000 mg in 24 hours.</p> <p>Resident #30's Physician order, dated 6/13/18, documented he was to receive Norco 10/325 mg 1 tablet by mouth every 6 hours as needed for pain. The order did not include the precaution for the maximum acetaminophen dosage in a 24 hour period.</p> <p>The website for the U.S Food and Drug Administration, announced new measures to reduce the risk of severe liver injury with acetaminophen on 1/13/11. On 7/28/11, the maker of Tylenol announced new instructions to lower the maximum daily dose from 4000 mg to 3000 mg.</p> <p>On 6/14/18 at 4:38 PM, the DON stated some of the physicians did not reduce the maximum dosage of acetaminophen from 4000 mg to 3000 mg.</p> <p>5. Resident #12 was admitted to the facility on 5/9/17 with multiple diagnoses which included spasmodic torticollis (extremely painful neck spasms), spinal stenosis ( narrowing of spinal canal), and gout.</p> <p>The USA Food and Drug Administration</p>	F 684			

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 684	<p>Continued From page 15</p> <p>announced on 1/13/11, new measures to reduce the risk of severe liver injury with Acetaminophen. On 7/28/11, the maker of Tylenol (acetaminophen) announced new instructions to lower the maximum daily dosage from 4000 mg to 3000 mg.</p> <p>A Medication Administration Record dated 6/1/18, documented Resident #20 received one Tylenol 325 mg tab, as needed, up to four times a day.</p> <p>A physician's order dated 5/9/17, documented Resident #12 was to not to receive more than a maximum dose of 4000 mg, of acetaminophen in 24 hours. This was not consistent with the 3000 mg limit recommended by the maker of Tylenol.</p> <p>6. Resident #20 was readmitted to the facility on 2/5/18 with multiple diagnoses which included repeated falls and an unsteady gait.</p> <p>Resident #20's admission MDS assessment dated 2/13/18, documented she was moderately cognitively impaired.</p> <p>a) A Post Fall Investigation dated 4/3/18 at 12:35 AM, documented Resident #20 was in bed under a weighted blanket. Resident #20 was out of bed when the floor alarm sounded. Resident #20 fell and hit her head on the corner of her night stand. Resident #20 was transported to a hospital emergency room on 4/3/18 at 1:00 AM and returned to the facility at 3:30 AM.</p> <p>Documentation of neurological checks for the fall dated 4/3/18 were not found in Resident #20's medical record.</p>	F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 684	<p>Continued From page 16</p> <p>b) A Post Fall Investigation, dated 4/21/18 at 9:45 PM, documented Resident #20 stood up from her wheelchair and fell on her right side. She hit her head on the door frame. She sustained a bump on her right forehead and two small skin lacerations on her arm.</p> <p>Resident #20's Neurological Check form, dated 4/21/18, documented completed neurological assessments performed by nursing on 19 of 24 opportunities. The other 5 neuro checks lacked each the following:</p> <ul style="list-style-type: none"> <li>* Pupil Response</li> <li>* Eye Response</li> <li>* Level of Consciousness</li> <li>* Motor Response</li> </ul> <p>c) A Post Fall Investigation, dated 4/30/18 at 7:30 PM, documented Resident #20 was found on the floor in her room. She was on her right side and found to have a cut over her right eye. She stated she hurt her head.</p> <p>A Neurological Check form, dated 4/30/18, documented neurological assessments were completed nursing staff from 4/30/18 at 7:45 PM through 5/1/18 at 7:45 AM. Resident #20 did not receive neurological checks for 72 hours. There was no physician order to stop the neurological checks earlier than 72 hours.</p> <p>On 6/15/18 at 11:36 AM, the DON stated she was aware that some neurological checks were incomplete.</p> <p>The facility's policy and procedure for Diabetes</p>	F 684			

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 684	<p>Continued From page 17</p> <p>Mellitus, dated 10/31/17, documented the following:</p> <ul style="list-style-type: none"> <li>* Notify the physician for blood sugar levels below or above the established ranges and carry out any new orders.</li> <li>* Monitor the resident and notify the physician if the blood sugar level is above 240 despite extra insulin being administered.</li> <li>* Document in the chart the physician was notified of the change in condition and/or the diagnostic results, and any new orders.</li> </ul> <p>7. Resident #132 was admitted to the facility on 6/6/18 with multiple diagnoses, including Type 2 diabetes mellitus.</p> <p>Resident #132's physician orders, active as of 6/14/18, documented the following:</p> <ul style="list-style-type: none"> <li>* Blood sugar checks four times a day and as needed.</li> <li>* Basaglar KwikPen (Insulin Glargine) inject 30 units at bedtime.</li> <li>* Insulin Lispro inject 14 units with meals.</li> <li>* Insulin Lispro inject per sliding scale: if blood sugar "Greater than 350 give 5 units and call MD..."</li> </ul> <p>Resident #132's current care plan directed staff to administer diabetes medication as ordered and monitor/document/report to the physician for signs/symptoms of hyperglycemia (elevated blood sugar).</p> <p>Resident #132's Weights and Vitals Summary documented blood sugar readings as follows:</p> <ul style="list-style-type: none"> <li>* 6/6/18 at 10:14 PM = 359</li> <li>* 6/7/18 at 7:55 AM = 307</li> <li>* 6/7/18 at 12:06 = 324</li> </ul>	F 684			

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 684	Continued From page 18 * 6/7/18 at 4:49 PM = 413 * 6/7/18 at 5:03 PM = 413  Resident #132's June 2018 MAR documented the following: * On 6/6/18 at 5:00 PM, Insulin Lispro inject per sliding scale: if blood sugar "Greater than 350 give 5 units and call MD..." was initialed "NN," "DPQ," and "R." There was no documentation of units administered. * On 6/7/18 at 8:00 AM, the blood sugar was 307 and 4 units of insulin were administered. * On 6/7/18 at 12:00, the blood sugar was 324 and 4 units of insulin were administered. * On 6/7/18 at 5:00 PM, the blood sugar was 413 and 5 units of insulin were administered.  Resident #132's Progress Notes documented the following: * On 6/6/18 at 9:35 PM: He arrived at the facility at approximately 7:10 PM via facility van. He was "very hungry" and a meal was provided. * On 6/7/18 at 12:18 PM: Blood sugars since admission were 304-359. * On 6/7/18 at 10:00 PM: His blood sugar was 413, insulin was administered, and the physician was notified. An order was received to increase the Basaglar insulin to 30 units at bedtime. *There was no documentation the physician was notified when the blood sugar was 359 on 6/6/18 at 10:14 PM.  On 6/14/18 at 10:29 AM, the DON said she did not see it documented that the physician was notified of the blood sugar of 359 on 6/6/18 at 10:14 PM, and the nurse should have notified the doctor.	F 684			
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		7/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 686 SS=G	Continued From page 19 CFR(s): 483.25(b)(1)(i)(ii)  §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policies, resident records, and I and A Reports, it was determined the facility failed to prevent the development and worsening of a pressure ulcer. This was true for 1 of 1 sampled residents (#29) reviewed for pressure ulcers. This deficient practice caused harm to Resident #29 when she developed a blister on her coccyx (tailbone area) that deteriorated and became an unstageable pressure ulcer. Findings include:  The facility's policy and procedure for Prevention and Treatment of Pressure Ulcers and Other Skin Alterations, dated 11/28/17, documented the following: * Residents at risk for developing pressure ulcers are identified by using the Braden Scale. * Interventions for pressure ulcers and other wound and skin issues are developed by	F 686	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Care 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.  F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer  Resident Specific Resident #29 has discharged from the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 686	<p>Continued From page 20</p> <p>collaborating with the interdisciplinary team and are implemented to identify, prevent, or decrease the risk of developing pressure and/or non-pressure wounds.</p> <p>* Basic or routine care could include but was not limited to: redistribute pressure, minimize moisture contact with the skin and keep the skin clean, "provide appropriate, pressure-redistributing, support surfaces," providing surfaces that are not irritating to skin, and "maintain or improve nutrition and hydration status, where feasible."</p> <p>Resident #29 was admitted to the facility on 7/9/14 with multiple diagnoses, including other abnormalities of gait and mobility, and muscle wasting atrophy.</p> <p>Resident #29's quarterly MDS assessment, dated 4/26/18, documented she was at risk for developing pressure ulcers and no pressure ulcers were present.</p> <p>Resident #29's Braden Scale for Predicting Pressure Sore risk, dated 5/1/18 at 11:33 AM, documented a moderate risk for developing pressures sores.</p> <p>Resident #29's significant change MDS assessment, dated 5/23/18, documented she was at risk for developing pressure ulcers and had one unstageable pressure ulcer measuring "2.0" (length) by "2.0" (width) by "0.2" deep.</p> <p>Resident #29's physician orders documented a dressing change to the coccyx and low air loss mattress to the bed were ordered on 5/22/18.</p>	F 686	<p>facility.</p> <p>Other Residents The ID team reviewed other residents for skin integrity issues and the potential need to upgrade mattress. Adjustments have been made as indicated.</p> <p>Facility Systems License staff are re-educated by the DNS and/or designee on prevention of pressure ulcer development and/or deterioration to include but not limited to document skin issues, to identify when a possible upgrade in mattress/offloading surface is required, documentation of treatments performed, documentation of off-loading when skin issues are present. The system is amended to include review of aggressive treatment alternatives for blisters and preventative measures for at risk Braden scores.</p> <p>Monitor The DNS and/or designee will audit skin issues and or those with at risk Braden scores for appropriate preventative and/or treatment measures weekly for 4 weeks, then every other week for 8 weeks. Starting the week of July 15, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 686	<p>Continued From page 21</p> <p>Resident #29's current care plan directed staff to provide the following interventions:</p> <ul style="list-style-type: none"> <li>* Assess skin weekly and as needed, and was initiated on 7/9/14.</li> <li>* A pressure relieving mattress to the bed and a pressure reducing cushion to the wheelchair, and was initiated on 2/16/17.</li> <li>* Reposition the resident in bed during rounds and as needed, and was initiated on 2/11/15.</li> <li>* When out of bed, change the resident's position by "toileting, uploading, shifting weight, ambulating or return to bed for rest. When in bed, turn and reposition q (every) 2 hours," and was initiated on 7/30/15.</li> </ul> <p>The following interventions were initiated on 5/22/18:</p> <ul style="list-style-type: none"> <li>* Assess for pain every shift/as needed before changing the dressing, and give medication per the physician's order as needed.</li> <li>* Complete the Daily Monitoring Pressure Ulcer Report.</li> <li>* "Encourage frequent position changes every 2 hours."</li> <li>* "Follow physician's orders for skin care and treatment (Utilize Best Practice Guidelines)."</li> <li>* "Specialty mattress-air mattress."</li> </ul> <p>* Resident #29 out of bed only for meals, initiated on 5/25/18.</p> <p>Resident #29's Weekly Skin Checks documented the following:</p> <ul style="list-style-type: none"> <li>* On 5/15/18 at 9:27 PM: No skin conditions, changes, ulcers, or injuries.</li> <li>* On 5/22/18 at 12:27 PM: An open wound on the coccyx with slough (yellow, devitalized tissue).</li> <li>* On 5/29/18 at 11:36 PM: "Skin warm, dry and</li> </ul>	F 686			

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 686	<p>Continued From page 22</p> <p>very fragile. Cont[inue] present treatment to wound on coccyx, dressing clean dry and intact." * On 6/6/18 at 3:17 AM: "Skin warm and dry but at times moist due to incontinence. Coccyx area red ..." * On 6/12/18 at 11:17 PM: "Skin warm, dry and very fragile. Wound on coccyx covered with dressing. Dressing clean, dry and intact."</p> <p>Resident #29's Weekly Skin Alteration Reports documented the following: * On 5/11/18 at 1:46 PM: A fluid-filled blister below the coccyx, circular in shape and measuring 2 cm in diameter. It was first observed on 5/11/18. * On 5/25/18 at 1:46 PM: A 2 cm by 2 cm wound on the coccyx was first observed on 5/18/18, it was healing slowly, and calcium alginate and Biatain dressing were continued daily.</p> <p>Resident #29's Weekly Pressure Ulcer BWAT Reports documented the following: * On 5/21/18 at 10:36 AM: A new onset pressure ulcer on the coccyx, measuring 2 cm (length) by 2 cm (width) by 0.2 cm (depth) and was unstageable. The ulcer was first observed on 5/11/18 and required the following treatment: wound cleanser, skin prep to surround tissue, Biatain alginate to the wound bed, and cover with a Biatain foam dressing. * On 5/28/18 at 10:36 AM: The pressure wound on the coccyx measured 2 cm by 2.1 cm by 0.8 cm and was Stage 2. Wound care was updated to Silvasorb ointment on the wound bed and cover with an Alevyn dressing. * On 5/31/18 at 1:57 PM: The pressure wound to the coccyx measured 2 cm by 1.8 cm by 0.5 cm and was Stage 2. The wound was "healing</p>	F 686			

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 686	<p>Continued From page 23</p> <p>nically, bed visible, beefy red. Size decreasing..."</p> <p>*On 6/7/18 at 1:57 PM: The pressure wound to the coccyx measured 1.2 cm by 1.6 cm by 0.4 cm and was Stage 2. The Treatment/Evaluation of Effectiveness was to continue the current plan of care.</p> <p>Resident #29's I and A Reports documented the following:</p> <p>* An I and A Investigation, dated 5/11/18, documented a small fluid-filled blister was discovered below the coccyx, the site was cleansed, and a dressing was applied. The event was described as a shear/rub causing a blister. It was recommended to use a cushioned dressing and change the dressing routinely.</p> <p>* On 5/21/18, a stage 3 pressure sore measuring 2 cm by 2 cm by 0.2 cm was present on the coccyx. The Pressure Ulcer Investigation documented the following: "[A] clear blister on [the] coccyx [was] reported on 5/13/18, [a] foam/sponge drsg (dressing) [was] applied and staff cont[inue] turning q 2 hours. Family to come and pick up recliner. Over [the] wkend (weekend) [the] wound changed to [a] pressure wound 2 cm-2cm by 0.2 cm with off white slough across [the wound] bed. Surrounding tissue [was] intact, no adipose tissue (fat) noted between skin and bone, tissue loose and moveable." It was recommended to use a dressing, remove the recliner, use an air mattress, change the wheelchair, provide incontinence care, reposition side to side, and "strongly encourage fluids."</p> <p>Resident #29's Progress Notes documented the following:</p> <p>* On 5/11/18 at 1:13 PM, a small fluid-filled blister was noted below the coccyx measuring 2 cm in</p>	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 686	<p>Continued From page 24</p> <p>diameter and was circular in shape.</p> <p>* On 5/11/18 at 4:53 PM, a fluid-filled blister was noted in the coccyx area, and it appeared to be caused by the incontinence brief pinching the tissue. The area was cleansed and a Biatain dressing was applied. The wound measured 2.1 cm by 1.8 cm.</p> <p>* On 5/14/18 at 8:47 AM, the fluid-filled blister remained and was discussed by the event committee. The area was cleansed and a cushioned dressing was applied. "Will continue to monitor and change dressing via altered skin evaluations. Nurse supervisor to do this."</p> <p>* On 5/15/18 at 1:30 PM, A blister was present on the buttock area and it measured 1.2 cm by 1 cm. The site was cleansed and a foam dressing was applied. An order was requested for physical therapy because the resident was no longer bearing weight during transfers. She required one person assistance to transfer a month prior.</p> <p>* On 5/16/18 at 7:17 PM, the physician was notified regarding the blister on the buttocks and continued care with a cushioned dressing. The nurse supervisor was to change the dressing.</p> <p>* On 5/21/18 at 1:36 PM, staff reported a change in the coccyx wound over the weekend. The wound depth had increased to 0.2 cm and it was 2 cm in length. The wound bed was filled with slough except for a small area at the base of the wound. The wound was round, "crater-like with definite edges, no undermining." Wound care was provided including wound cleanser, skin prep to the surrounding intact tissue, Biatain Alginate to the wound bed, and a Biatain sponge dressing was applied to cover the wound. "Will inform Dr (doctor) of change."</p> <p>* On 5/22/18 at 9:20 AM, the event committee discussed the blister to the coccyx that was</p>	F 686			

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 686	Continued From page 25 noted on 5/11/18 and a foam dressing was applied. The area was now an unstageable pressure ulcer. The family was to remove the resident's recliner from her room, treatments were in place for wound care, and an air mattress was to be applied to the bed. The dietician was to review nutritional interventions and the wheelchair cushion was changed. The care plan was updated and physician were to be notified. * On 5/22/18 at 5:15 PM, the slough was separating from the wound bed on the right side, pink tissue was visible underneath, and the wound measured 2 cm by 2 cm and was a Stage 2 pressure wound. * On 5/28/18 at 10:36 AM, the pressure ulcer on the coccyx measured 2 cm by 2.1 cm by 0.8 cm and was Stage 2. The dressing was updated to Silvasorb ointment on the wound bed and Alevyn dressing to cover the wound. * On 5/30/18 at 1:32 PM, the resident cried out "quite often," ate poorly, and was medicated with hydrocodone (narcotic pain medication) twice for pain. The dressing was changed on the coccyx by the nurse supervisor. * On 5/31/18 at 1:57 PM, the pressure ulcer to the coccyx measured 2 cm by 1.8 cm by 0.5 cm. The wound was healing "nicely," the wound bed was visible and "beefy red." * On 6/1/18 at 12:44 PM, a new order was received for a Fentanyl (narcotic pain medication) patch 25 mcg. * On 6/1/18 at 2:24 PM, the wound dressing was changed, the wound was "red and beefy," the edge of the wound was pink, and the wound bed measured ".02" deep. * On 6/4/18 at 4:03 PM, the pressure ulcer continued to improve with Silvasorb and an Alevyn dressing, and it measured 1.8 cm by 1.4	F 686			

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 686	<p>Continued From page 26</p> <p>cm by 0.6 cm.</p> <p>* On 6/6/18 at 10:24 AM, the wound dressing regimen was changed to include Alginate to a small area on the right side of the wound bed due to slough, and the wound measured 1.7 by 1.8 by 0.4 cm.</p> <p>* On 6/6/18 at 11:06 AM, there was a care plan conference that discussed the resident was declining, now required total assistance for cares, exhibited worrying, nervousness, and yelling, and increased antidepressant medication in May. A medication patch was ordered for pain management. Resident #29's family member believed she was "trying to pass away." She lost 6.2 pounds in a month, oral intake was "refused to 25%," and nutrition interventions were in place. Other than getting up for meals, Resident #29 was on bed rest and the coccyx wound was being monitored for healing.</p> <p>* On 6/7/18 at 1:57 PM, the coccyx wound measured 1.2 cm by 1.6 cm by 0.4 cm and was Stage 2.</p> <p>* On 6/10/18 at 11:08 AM, the dressing was changed to the coccyx and the area was red with signs of healing. Silvasorb was applied to the wound and an Alevyn dressing was applied. Hydrocodone was administered twice for pain and the Fentanyl patch was continued.</p> <p>* On 6/11/18 at 3:09 PM, the dressing was changed to the coccyx. The wound bed was "red and beefy" without slough and the edge was pink. New tissue was noted throughout the wound. The current dressing order was continued.</p> <p>* On 6/12/18 at 2:20 PM, the dressing was changed and the wound measured 1.2 cm by 2 cm by 0.4 cm. The wound bed was "red, beefy" and signs of healing were present.</p>	F 686			

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 686	Continued From page 27  Resident #29's May 2018 TAR (Treatment Administration Record) documented a daily dressing change to the coccyx was performed each day from 5/22/18 through 5/31/18, except for 5/29/18.  Resident #29's June 2018 TAR documented a daily dressing change to the coccyx was performed each day from 6/1/18 through 6/5/18 and on 6/11 and 6/12/18.  On 6/12/18 at 1:52 PM, RN #2 was observed changing the dressing on Resident #29's coccyx. An ulcer was present that measured 1.2 cm by 2 cm by 0.4 cm. RN #2 said the wound was healing.  On 6/13/18 at 1:59 PM, CNA #3 said Resident #29 was more alert at the end of April and would feed herself. CNA #3 said they reposition Resident #29 every two hours and it should be documented but it was not.  On 6/13/18 at 2:48 PM, RN #2 said Resident #29 was doing fairly well until she got a blister on her bottom. It started as a clear blister and she did not know what caused it. The cushion was changed in her wheelchair in case it had pinched her skin, and a dressing was applied to the coccyx. RN #2 said the next time she saw the wound it was an open wound with slough. RN #2 said she applied silver alginate, and in two days the slough was gone and it was a stage 2 ulcer. The dressing was then changed to Silvasorb and Alevyn. RN #2 said a blister could be from pressure, and when it was first brought to her attention that Resident #29 had a blister on her	F 686			

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 686	Continued From page 28 coccyx the staff was instructed to change the cushion in her wheelchair and keep the wrinkles out of her sheets. RN #2 said the first time she saw Resident #29's blister she thought it from being pinched, and she assumed if she put a clear dressing on it would absorb and she depended on the nurses to check on it. RN #2 said the next time she saw the blister it was an ulcer and she was not aware until sometime after the weekend that it had changed. RN #2 said she thought it was appropriate to initiate the air mattress 11 days after the blister was noticed on Resident #29's coccyx, after it became an unstageable ulcer.  On 6/14/18 at 1:48 PM, RN #3 said CNAs do not document repositioning residents every two hours, and the only way to know it was done was by observation.  On 6/15/18 at 9:23 AM, the DON said when Resident #29 developed a blister on her coccyx, the blanket and chair were removed. The DON said there were concerns about the incontinence briefs causing the blister, and they tried putting her in bed to keep pressure off the area. The DON said a good mattress was being used and the blister was not thought to be pressure related, and once the wound was determined to be pressure related an air mattress was implemented. The DON said an incident form was completed when the skin issue was first noticed, then another incident form was done when the wound changed.	F 686			
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents.	F 689		7/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 689	<p>Continued From page 29</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, policy review, and record review, it was determined the facility failed to provide sufficient supervision to meet resident's needs. This was true for 2 of 3 residents (#4 and #20) reviewed for supervision and accidents. Resident #20 was harmed when she sustained multiple injuries requiring medical evaluation and care when the facility failed to implement interventions to prevent reoccurring falls. Resident #4 had multiple falls related to failure to implement the plan of care, ensure the bariatric extenders were locked . Findings include:</p> <p>The facility's policy and procedure for Fall Response and Management dated 11/28/17, directed staff to implement immediate interventions to prevent a repeat fall, to complete a post-fall investigation and event report, to review the post-fall evaluation and investigation, determine the cause, and to revise the care plan with interventions.</p> <p>The facility's policy and procedure for Accidents and Supervision to Prevent Accidents, dated 11/18/17, documented the following: *The facility staff observed, identified, and resolved potential hazards in the environment, while they took into consideration the unique</p>	F 689	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Care 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>F689 Free of Accident Hazards/Supervision/Devices</p> <p>Resident Specific The ID team reviewed Resident #20 and 4's fall history for root cause, plan of care to prevent other falls was updated as indicated. Reviewed any further fall investigations for completion and completed if needed to physician notification.</p> <p>Other Residents The ID team reviewed other residents for implementations of interventions post fall,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 689	<p>Continued From page 30</p> <p>characteristics and abilities of each resident.</p> <p>* The staff examined hazard and accident risk information for potential causes of accidents, and created interventions to reduce the risk of the hazard.</p> <p>* The facility monitored to confirm interventions were in place, evaluated interventions for efficacy, and changes and/or replaced interventions that were not effective.</p> <p>* The facility provided sufficient supervision to avoid accidents.</p> <p>The above policies were not followed. Examples include:</p> <p>1. Resident #20 was readmitted to the facility 2/5/18 with multiple diagnoses which included repeated falls, dysphagia (a swallowing disorder), unsteady gait, and osteoporosis.</p> <p>An admission MDS assessment dated 2/13/18, documented Resident #20 was moderately cognitively impaired.</p> <p>Resident #20 experienced four falls in April 2018.</p> <p>a) A Post Fall Investigation, dated 4/3/18 at 12:35 AM, documented Resident #20 was in bed under a weighted blanket. Resident #20 got out of bed and the floor alarm sounded. Resident #20 fell and hit her head on the corner of her night stand.</p> <p>A Progress Note dated 4/3/18 at 12:35 AM, documented Resident #20 had an unwitnessed fall. She was found in her room at 12:35 AM, lying on her left side. Resident #20 was bleeding from a laceration to her left forehead. Resident #20 complained of left hip pain and neck pain.</p>	F 689	<p>investigation completion, and physician notification within the last three weeks. Adjustments have been made as indicated.</p> <p>Facility Systems The IDT team are educated on fall prevention, interventions, and investigation. Re-education was provided by the Administrator to include but not limited to, implementing a new and different intervention based on root cause after each fall, completion of investigations, physician notification, and monitoring of plan implementation. The system is amended to include review of falls in clinical meeting for root-cause, completion of investigations, physician notification, care plan updates, implementation of the plan, documentation, and update to the plan as indicated.</p> <p>Monitor The Administrator and/or designee will audit fall investigations and plan implementation weekly for 4 weeks, then every other week for 8 weeks. Starting the week of July 15, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 689	<p>Continued From page 31</p> <p>She was sent to the emergency room. A Progress Note dated 4/3/18 at 3:30 AM documented Resident #20 returned to the facility at 3:30 AM with negative x-ray results and that her "head was glued and ster stripped." A progress note dated 4/4/18 at 10:02 AM, documented Resident #20 sustained a laceration to her left forehead and bruising to her left face as result of the 4/3/18 fall.</p> <p>A Resident Monitoring Tool dated 4/3/18, documented Resident #20 was observed at 12:15 AM and 12:30 AM in bed and asleep.</p> <p>An Event Committee Follow Up Note dated 4/3/18 at 10:02 AM, documented Resident #20 was wearing regular socks, and the facility would re-educate staff to provide Resident #20 with no-skid socks.</p> <p>A care plan, dated 2/5/18, documented Resident #20 had no-skid socks were initiated on 2/26/18.</p> <p>b) A Post Fall Investigation dated 4/21/18 at 9:45 PM, documented Resident #20 stood up from her wheelchair and fell on her right side. She hit her head on the door frame, sustained a bump on her right forehead, and sustained two small skin lacerations on her arm.</p> <p>A progress note dated 4/22/18 at 9:00 AM, documented Resident #20 was transported to a clinic due to complaints of side pain. The physician diagnosed a right rib fracture and pneumonia.</p> <p>A Resident Monitoring Tool dated 4/21/18, documented Resident #20 was not monitored</p>	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 689	<p>Continued From page 32 with 15-minute checks from 6:00 PM to 10:00 PM.</p> <p>An Event Committee Follow Up Note, dated 4/23/18 at 9:37 AM, documented checks would be done every 15 minutes from 6:00 PM to 6:00 AM.</p> <p>Resident #20's care plan dated 2/5/18, directed staff to perform 15-minute checks from 6:00 PM to 6:00 AM, and was initiated on 2/26/18.</p> <p>c) A Post Fall Investigation dated 4/26/18 at 7:45 PM, documented Resident #20 was found in a seated position near her bed. Resident #20 stood up at the bedside from her wheelchair and the wheelchair rolled backwards. She was uninjured. Resident #20 was last seen at 7:00 PM.</p> <p>A Resident Monitoring tool dated 4/26/18, documented Resident #20 was in the bathroom and engaged with staff from 7:30 PM to 8:15 PM. The documentation was written over to say "in bed" and engaged with staff. This was inconsistent with the Post Fall Investigation which stated Resident #20 was last seen by staff at 7:00 PM.</p> <p>Resident #20's care plan dated 2/5/18, documented anti-roll back brakes were initiated for Resident #20 on 4/27/18.</p> <p>d) A Post Fall Investigation dated 4/30/18 at 7:30 PM, documented Resident #20 had an unwitnessed fall with significant injury. Resident #20 was found on the floor in her room. She was on her right side and found to have a cut over her right eye. She stated she hurt her head. She had</p>	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 689	<p>Continued From page 33 been in her wheelchair.</p> <p>A Resident Monitoring tool dated 4/30/18, documented Resident #20 was seated in her chair from 6:30 PM until her fall at 7:45 PM. Resident #20 was engaged with staff while seated in her chair at 7:00 PM.</p> <p>On 6/14/18 at 9:43 AM, the DON stated to prevent falls, the facility would place the resident on the Falling Star Program, place them on every 15-minute checks, and/or use a weighted blanket to help residents feel safer in bed.</p> <p>2. Resident #4 was admitted to the facility on 2/10/17 with multiple diagnoses, including a history of falling, other abnormalities of gait and mobility, and vascular dementia without behavioral disturbance.</p> <p>Resident #4's annual MDS assessment, dated 12/26/17, documented a moderate cognitive impairment, setup help only with transfers, one person physical assistance with ambulation, and one fall since the prior assessment.</p> <p>Resident #4's quarterly MDS assessment, dated 3/22/18, documented a moderate cognitive impairment, two person physical assistance with transfers, one person physical assistance with ambulation, and two or more falls since the prior assessment.</p> <p>Resident #4's current care plan documented he was at risk for falls, and had a history of multiple falls. Interventions initiated on 2/20/17 and revised on 9/30/17 included the following: * Assess his fall risk, completing assessments to</p>	F 689			

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 689	<p>Continued From page 34</p> <p>identify the risk for falls.</p> <ul style="list-style-type: none"> <li>* Ensure the call light is within reach and encourage him to use it.</li> <li>* Encourage him to request assistance with ambulating.</li> </ul> <p>* Follow the facility fall protocol was initiated on 2/20/17.</p> <p>* The falling star program to identify his fall risk was initiated on 2/20/17 and revised on 4/24/18.</p> <p>* Non-skid footwear, non-skid socks was initiated on 2/20/17 and revised on 1/3/18.</p> <p>* PT to evaluate and treat and non-skid strips by the bed were initiated on 1/3/18.</p> <p>* Self-locking brakes to his wheelchair and non-skid strips on the bathroom floor were initiated on 3/21/18.</p> <p>* Encourage him to sit in the wheelchair while bedding is changed was initiated on 6/5/18.</p> <p>Resident #4's I and A reports documented the following:</p> <ul style="list-style-type: none"> <li>* A fall on 1/2/18 at 9:15 PM when he was in the wheelchair, attempted to remove his socks, and his feet slipped.</li> <li>* A fall on 2/8/18 at 7:00 AM when he fell out of bed while trying to reach the television's remote control.</li> <li>* A fall on 3/20/18 at 10:25 AM when he was unattended in the bathroom and lost his balance after standing up from the toilet.</li> <li>* A fall on 3/20/18 at 9:05 PM, when he</li> </ul>	F 689			

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 689	<p>Continued From page 35</p> <p>attempted to self-transfer from the wheelchair to bed, forgot to lock the wheelchair brakes, and the wheelchair slid out of under him.</p> <p>* A fall on 6/5/18 at 5:15 AM when he was sitting on the edge of the bed as the CNA changed the bedding and he slipped off the edge of the bed.</p> <p>Resident #4's Progress Notes documented the following:</p> <p>* On 1/3/18 at 9:18 AM: He fell on 1/2/18 at 9:15 PM when standing by his bed to turn down the bedding. He was wearing socks and no shoes. Non-skid strips were added by the bed, non-skid socks were provided, and therapy was to continue.</p> <p>* On 2/9/18 at 7:04 AM: A large abrasion and red area were present on his abdomen. Neuro checks were "good" and he continued to self-transfer.</p> <p>On 2/9/18 at 2:38 PM: An environmental review was performed by the maintenance supervisor, and it was found "the bariatric extenders were not locked into place. Will educate housekeepers and all staff when moving bed from one room to another to ensure [the] frame [is] locked into position on bariatric beds."</p> <p>* On 3/20/18 at 11:20 AM: The nurse was notified at 10:25 AM that the resident was found sitting on the bathroom floor, and he said he slipped when getting up from using the bathroom. Staff reported the resident was depressed the day before and was "slightly confused."</p> <p>* On 3/20/18 at 9:05 PM: He was found on the floor between the wheelchair and bed, and said he attempted to transfer from the wheelchair to the bed, forgot to lock the wheelchair brakes, and the wheelchair rolled out from under him. He was</p>	F 689			

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 689	<p>Continued From page 36</p> <p>asked to wait for assistance with transfers.</p> <p>* On 3/21/18 at 9:34 AM: The event committee discussed the falls on 3/20/18. Non-skid strips were added to the floor in front of the toilet, self-locking brakes were added to the wheelchair, therapy was to continue, and the resident was educated to wait for assistance with transfers.</p> <p>* On 6/5/18 at 7:09 AM: He was assisted to the floor by a CNA as she was changing his bed.</p> <p>* On 6/5/18 at 7:29 AM: The nurse was called to the resident's room and the resident was "sitting/kneeling on his knees." He was assisted back to bed with 3 person assistance and a Hoyer lift.</p> <p>* on 6/5/18 at 9:02 AM: The event committee discussed the fall on 6/5/18. Resident #4 slid off the side of the bed and the CNA assisted him to his knees. Staff were inserviced regarding having the resident sit in the wheelchair while changing the bedding, the resident was encouraged to sit in the wheelchair while staff change his bedding, and therapy was continue.</p> <p>On 6/12/18 at 9:38 AM, Resident #4 said a couple of weeks ago and his legs "gave out," and he had fallen quite a bit since being admitted to the facility.</p> <p>On 6/15/18 at 10:54 AM, CNA #6 said Resident #4 had fallen, one time from his chair and one time out of bed. CNA #6 said staff was helping him in the morning, made sure he was scooted back in his bed, therapy was working with him, and the staff walked with him at meal times.</p> <p>On 6/15/18 at 11:24 AM, RN #2 said Resident #4 had fallen, he slid to the floor during the previous week and he was kneeling next to his bed. RN #2</p>	F 689			

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 689	Continued From page 37 said the CNA was there when the resident slid to the floor, and RN #2 thought he was out too far on the bed. Staff were educated that sitting on the edge of the bed was not the best place for the resident when making the bed. RN #2 said Resident #4 had issues with spontaneity, non-skid strips were added next to the toilet, and the resident was educated about wearing non-skid socks. RN #2 said there was another fall when Resident #4's wheelchair rolled out from under him, and non-rolling brakes were added to the wheelchair.  On 6/15/18 at 12:10 PM, the DON said Resident #4 fell on 1/2/18 and the physician should have been notified. The DON acknowledged there were blank areas on the Accident and Investigations and said there were blank areas that should have been filled in. The DON said staff were inserviced after the fall on 2/8/18 to make sure Resident #4 could reach the remote control.	F 689			
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)  §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-  §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the	F 693		7/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 693	<p>Continued From page 38 resident; and</p> <p>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and review of clinical records and policies, it was determined the facility failed to ensure adequate care and treatment was provided to 1 of 2 sample residents (#182) reviewed for medications through a feeding tube. This failure created the potential for harm if complications developed from improper feeding tube practices. Findings include:</p> <p>The facility's policy and procedure for Administering of Medication through an Enteral Feeding Tube, dated 5/28/15, directed staff that if a pump was not being used, check the tube for placement and patency using a 60 ml syringe, then flush with 15 to 30 mls of warm tap water prior to administering medication.</p> <p>Resident #182 was admitted to the facility on 5/31/18 with multiple diagnoses, including pneumonitis due to inhalation of food and vomit and dysphagia (a swallowing disorder).</p> <p>Resident #182's physician orders, dated 6/14/18 at 5:46 PM, documented the following: * docusate sodium tablet (a stool softener) give 100 mg through the tube twice a day.</p>	F 693	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Care 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>F693 Tube Feeding Mgmt</p> <p>Resident Specific DNS and/or designee assessed and verified resident's #182 feeding tube placement no adverse outcomes were identified. Resident no longer has a G-tube as it was removed on 6/26/18 by Weiser Memorial Hospital.</p> <p>Other Residents DNS and/or designee reviewed other residents with feeding tubes in place and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 693	<p>Continued From page 39</p> <p>* Mucinex Fast-Max Congest Cough (a decongestant) 2.5-5-100 mg/5 ml give 10 ml through the tube twice a day.</p> <p>* Apixaban (Eliquis) tablet (a blood thinner) give 2.5 mg through the tube twice a day.</p> <p>Resident #182's current care plan documented he had a feeding tube related to dysphagia and directed staff to do the following: Monitor/document/report to physician as needed: aspiration (inhaling material into lungs), fever, shortness of breath, tube dislodged, infection of the tube site, self-removal of the tube, disturbance or malfunction of the tube, abnormal breathing or lung sounds, abnormal lab results, abdominal pain, distension, or soreness, constipation or impaction, diarrhea, nausea/vomiting, or dehydration.</p> <p>On 6/14/18 at 5:30 PM, RN #5 was observed administering medication to Resident #182 through his feeding tube. RN #5 briefly turned the valve on the stopcock to the feeding tube, observed a small amount of mostly clear liquid return in the tube and turned the stopcock back. RN #5 then administered the following medications through the feeding tube: docusate 10 mls, Mucinex 10 mls, and Eliquis 2.5 mg. RN #5 did not verify placement or patency of the feeding tube prior to administering medications through the tube.</p> <p>On 6/14/18 at 5:56 PM, RN #5 said she should have checked placement of the feeding tube prior to giving medications, and sometimes she just watched the tube to check placement by turning the stopcock to see return (of stomach contents).</p>	F 693	<p>verified placement.</p> <p>Facility Systems Current licensed nurses are educated to medication administration via feeding tube. Re-education was provided by DNS and/or designee to include but not limited to, how to verify placement. The system is amended to include skills checks for medication nurses and routine observation of medication administration through peg tube with medication administration audits.</p> <p>Monitor The DNS and/or designee will observe verification of peg tube with medication administration weekly for 4 weeks, then every other week for 8 weeks. Starting the week of July 15, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 759 SS=D	<p>Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)</p> <p>§483.45(f) Medication Errors. The facility must ensure that its-</p> <p>§483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure the medication error rate was less than 5%. This was true for 2 of 25 medications (8%) which affected 1 of 7 residents (#2) whose medication passes were observed. This failure created the potential for harm when Resident #2 received doses in excess of physician orders for a nasal spray and antacid. Findings include:</p> <p>The facility's undated policy and procedure for nasal inhalers, sprays, and aerosols, documented the following: * Verify the physician's order, taking notice of the concentration of the medication and which nostril to treat. * Occlude one of the resident's nostrils, insert the tip into the open nostril and squeeze quickly and firmly one time. * Have the resident hold their breath for a few seconds then exhale through the mouth. * Repeat the ordered number of times in each nostril.</p> <p>Resident #2 was admitted to the facility on 1/19/16 with multiple diagnoses, including gastroesophageal reflux disease and acute sinusitis.</p>	F 759	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Care 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>F759 Med Error Rate</p> <p>Resident Specific Resident #2 was assessed and have no adverse reaction to medication error. A medication variance report was completed.</p> <p>Other Residents This has the potential to effect all residents who receive medications.</p> <p>Facility Systems Current LN's educated on eight rights of medication administration. Re-education</p>	7/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 759	<p>Continued From page 41</p> <p>Resident #2's physician orders, active as of 6/14/18, documented the following:</p> <ul style="list-style-type: none"> <li>* Fluticasone Propriionate Suspension (a nasal steroid spray) 50 mcg 2 sprays each nostril twice a day for chronic rhinosinusitis.</li> <li>* Mylanta Suspension 200-200-20 mg/5 ml give 2 tsp every 6 hours as needed for stomach upset.</li> </ul> <p>Resident #2's June 2018 MAR documented the following:</p> <ul style="list-style-type: none"> <li>* The fluticasone nasal spray was administered each day from 6/1/18-6/14/18.</li> <li>* The Mylanta was administered on 6/8/18, 6/10/18, 6/12/18, and 6/14/18.</li> </ul> <p>On 6/14/18 at 9:19 AM, RN #1 administered medications to Resident #2. RN #1 administered two sprays of fluticasone nasal spray to Resident #2's right nostril and left nostril. RN #1 then administered three additional sprays of fluticasone to Resident #2's right nostril and two additional sprays to the left nostril. When asked how many sprays should be administered, RN #1 said it was two sprays in each nostril. When the surveyor pointed out to RN #1 that she administered 5 sprays in right nostril and 4 sprays in the left nostril, RN #1 said "Oh."</p> <p>On 6/14/18 at 12:05 PM, RN #1 said sometimes Resident #2 appeared like he didn't sniff up all the nasal spray so she gave more sprays. RN #1 said she normally would not give that many sprays.</p> <p>On 6/14/18 at 9:20 AM, RN #1 administered Advanced Antacid (a generic form of Maalox) 30 mls to Resident #2.</p>	F 759	<p>was provided by DNS and/or designee to include but not limited to;</p> <ol style="list-style-type: none"> <li>1. Right Patient</li> <li>2. Right medication</li> <li>3. Right dose</li> <li>4. Right route</li> <li>5. Right time</li> <li>6. Right documentation</li> <li>7. Right reason</li> <li>8. Right response</li> </ol> <p>The system is amended to include medication nurse skills checks for medication pass to include but not limited to nasal sprays and liquid medications and routine observations of medication administration audits.</p> <p>Monitor The DNS and/or designee will observe two licensed nurse medication administrations weekly for 4 weeks, then every other week for 8 weeks. Starting the week of July 15, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 759	Continued From page 42	F 759			
F 761 SS=E	<p>On 6/14/18 at 2:50 PM, RN #1 said the order for Mylanta was 2 tsp, which equaled 10 mls. RN #1 said she administered 30 mls of Mylanta to Resident #2 and was thinking it was tablespoons.</p> <p>Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)</p> <p>§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure expired medications were not available</p>	F 761		7/30/18	
			This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 761	<p>Continued From page 43</p> <p>for administration to residents. This was true for 1 of 2 medication storage rooms with expired Pneumococcal vaccine. This failed practice had the potential to effect 12 of 12 sampled residents who could receive expired medications (#2, #3, #4, #7, #8, #9, #16, #19, #20, #29, #30, and #132) and other 23 residents who resided in the facility. This failed practice created the potential for harm should residents receive expired vaccinations with decreased efficiency. Findings include:</p> <p>The facility Medication Management policy dated 11/28/17, documented medications were discarded by the expiration date unless indicated by the pharmacy and/or the manufacturer's instructions to discard sooner.</p> <p>On 6/14/18 at 10:58 AM, a medication room was inspected with RN #4. An unopened multi-dose vial of Pneumococcal vaccine with an expiration date of 9/27/17, was found in the refrigerator. At the time of inspection, RN #4 verified the expiration date and disposed of the expired medication.</p> <p>On 6/14/18 at 11:08 AM, the DON stated it was the staff and administration's responsibility to monitor for expired medications.</p> <p>Residents #2, #3, #4, #7, #8, #9, #16, #19, #20, #29, #30, and #132 and the other 23 residents residing in the facility were at risk of receiving expired Pneumococcal vaccine.</p>	F 761	<p>Care 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>F761 Label/Store Drug and Biologicals</p> <p>Resident Specific No specific residents were identified.</p> <p>Other Residents Has the potential to effect any resident receiving pneumococcal vaccine</p> <p>Facility Systems Medication storage areas are inspected monthly and PRN for expired medications and removed if any found for destruction. The system is amended to include the refrigerated medications and review of expiration dates during medication administration audits.</p> <p>Monitor The DNS and/or designee will audit medication storage to include the refrigerator monthly for 3 months. Starting the week of July 15, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 761	Continued From page 44	F 761	frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 883 SS=F	<p>Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)</p> <p>§483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-</p> <ul style="list-style-type: none"> <li>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</li> <li>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</li> <li>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</li> <li>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following: <ul style="list-style-type: none"> <li>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and</li> <li>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</li> </ul> </li> </ul> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p>	F 883	<p>Date of Compliance July 30, 2018</p>	7/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 883	<p>Continued From page 45</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, policy review, and record review, it was determined the facility failed to ensure a) implementation of an immunization program to ensure residents' Pneumococcal (bacterial) pneumonia vaccine status were being tracked with receiving or declining the Pneumococcal vaccines PCV 13 and PPSV 23, consistent with current Centers for Disease Control and Prevention (CDC) recommendations, and b) residents who consented to administration of the Pneumococcal vaccinations, received the vaccinations. This is true for 9 of 9 residents (#2, #4, #7, #9, #12, #16, #19, #29, and #30) reviewed for Pneumococcal vaccinations, and</p>	F 883	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Care 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>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 883	<p>Continued From page 46</p> <p>had the potential to impact the other 26 residents residing in the facility. These deficient practices placed residents at risk of developing Pneumococcal pneumonia and developing subsequent serious, potentially life threatening, complications. Findings include:</p> <p>The Centers for Disease Control and Prevention (CDC) website, updated 11/22/16, documented recommendations for Pneumococcal vaccination (PCV 13 or Prevnar 13®, and PPSV 23 or Pneumovax 23®) for all adults 65 years or older:</p> <p>* Adults who were 65 years or older, who had not previously received PCV 13, should receive a dose of PCV 13 first, should follow 1 year later by a dose of PPSV 23.</p> <p>* If the patient already received one or more doses of PPSV 23, the dose of PCV 13 should be given at least 1 year after they received the most recent dose of PPSV 23.</p> <p>The facility's policy and procedure Patient Immunization Program dated 4/27/15, documented the facility would ensure all patients were offered appropriate Pneumococcal vaccinations in accordance with recommendations set forth by the Centers for Disease Control (CDC).</p> <p>The facility's policy Pneumococcal Program dated 10/31/17, documented vaccinations were available that could prevent two kinds of pneumonia: Pneumococcal conjugate vaccine (PCV 13 or Prevnar 13) and Pneumococcal polysaccharide vaccine (PPSV 23 or Pneumovax 23) included the following:</p>	F 883	<p>F883 Influenza and Pneumococcal Immunizations</p> <p>Resident Specific Residents #7, 12, 2, 9, 19, 30, 29, 16, 4 were re-offered pneumococcal vaccination and provided if they chose.</p> <p>Other Residents Reviewed all current residents for consent or declination of pneumococcal vaccination. Provided pneumococcal vaccination to those who consented.</p> <p>Facility Systems Infection control nurse and/or designee established a spreadsheet to track pneumococcal vaccination consent, provision, re-offerings, and next due date. The system is amended to include review of pneumococcal vaccinations that are due with the quarterly MDS. Vaccinations will be provided as resident consents. Results will be trended through Infection Control committee meeting and presented to QAPI.</p> <p>Monitor DNS and/or designee will audit immunizations monthly for 3 months. Starting the week of July 15, the audit will be documented on the PI audit tool and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance</p>		

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 883	<p>Continued From page 47</p> <p>* If not previously received, the facility would provide residents the PCV 13 vaccine upon admission. The facility would follow in at least 8 weeks for high risk residents, and in at least 1 year for other residents, with the Pneumococcal PPSV 23.</p> <p>* If a resident was previously vaccinated with either PCV 13 or PPSV 23, then the facility would follow with the alternate immunization upon admission.</p> <p>* Residents should receive both Pneumococcal immunizations in at least weeks apart for high risk residents and in at least 1 year for other residents.</p> <p>* Revaccination of PPSV 23 is recommended in at least 5 years after PPSV 23.</p> <p>The above policy was not followed. Examples include:</p> <p>a) Resident #7 was admitted to the facility on 12/8/10 with multiple diagnoses, including dementia, seizure disorder, anxiety, and depression.</p> <p>Resident #7's Quarterly MDS assessment dated 4/4/18 documented Resident #7 was offered and declined the Pneumococcal vaccination.</p> <p>The facility Vaccine Information Sheet Acknowledgement and Consent dated 10/11/17, documented Resident #7 wanted to receive the Pneumococcal vaccination. Resident #7's record did not contain documentation she received the Pneumovax consented to on 10/11/17.</p> <p>The facility Audit Report for Vaccinations dated</p>	F 883	July 30, 2018		

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 883	<p>Continued From page 48</p> <p>6/13/18, documented Resident #7 received the Pneumovax (PPSV 23), on 1/1/08.</p> <p>Resident #7's order summary report dated 6/13/18, did not include a standing order for the Pneumococcal vaccination.</p> <p>b) Resident #12 was readmitted to the facility on 12/16/15 with multiple diagnoses, including pneumonia, anxiety, and depression.</p> <p>An MDS dated 4/12/18, documented Resident #12 was given the Pneumococcal vaccination.</p> <p>A Vaccine Information Sheet Acknowledgement and Consent dated 10/11/17, documented Resident #12 consented to receiving the Pneumococcal vaccines.</p> <p>The facility Immunization Report dated 6/2/18, documented Resident #12 received a Pneumovax (PPSV 23) on 11/1/17. The reason PPSV 23 was administered prior to the PCV 13 vaccine was not documented.</p> <p>c) Resident #2 was admitted to the facility on 1/19/16, with multiple diagnoses including chronic obstructive pulmonary disease and depression.</p> <p>A Physician order, dated 1/19/16, documented Resident #2 "may have Pneumovax vaccine if no history of vaccine."</p> <p>Resident #2's quarterly MDS assessment, dated 6/6/18, documented Resident #2 was "up to date" with the Pneumococcal vaccination.</p>	F 883			

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 883	<p>Continued From page 49</p> <p>Resident #2's signed Vaccine Information Sheet Acknowledgement and Consent, dated 10/11/17, documented he would like to receive the Pneumococcal Vaccine. The form documented Resident #2 was provided with vaccine information on 10/11/17. The consent did not provide the dates the vaccines were administered prior to admission.</p> <p>Resident #2's Immunization Report, date range 6/1/00 -6/30/18, documented a Pneumovax dose was provided on 1/1/02.</p> <p>d) Resident #9 was admitted to the facility on 8/6/14 with multiple diagnoses including diabetes mellitus and chronic kidney disease.</p> <p>A Physician order, dated 8/6/14, documented Resident #9 "may have Pneumovax vaccine if no history of vaccine."</p> <p>Resident #9's quarterly MDS assessment, dated 4/6/18, documented Resident #9 was offered and declined the Pneumococcal vaccination.</p> <p>Resident #9's signed Vaccine Information Sheet Acknowledgement and Consent, dated 10/11/17, documented he did not wish to receive the Pneumococcal Vaccine at that time. The form documented Resident #9 was provided with vaccine information on 10/11/17. The consent did not document when, or if, the vaccine was administered prior to admission.</p> <p>Resident #9's Immunization Report, date range 6/6/13 -6/30/18, documented a Pneumovax dose was administered on 11/6/14. The Immunization Report also documented Resident #9 refused</p>	F 883			

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 883	<p>Continued From page 50</p> <p>Prevnar 13 but did not document a date of the refusal.</p> <p>e) Resident #19 was admitted to the facility on 2/2/18 with multiple diagnoses including cerebral palsy and lumbar fracture.</p> <p>Resident #19's Physician order, dated 2/2/18, documented "Do not give Pneumovax vaccine."</p> <p>Resident #19's quarterly MDS assessment, dated 5/2/18, documented Resident #19 was "up to date" with the Pneumococcal vaccination.</p> <p>Resident #19's signed Vaccine Information Sheet Acknowledgement and Consent, dated 2/2/18, documented he did not wish to receive the Pneumococcal Vaccine at that time. The form did not document if vaccine information was provided or when, or if, the vaccine was administered prior to admission.</p> <p>f) Resident #30 was admitted to the facility on 2/26/18, with multiple diagnoses including gangrene to his left below the knee amputation surgical site and peripheral vascular disease.</p> <p>A Physician order, dated 2/26/18, documented Resident #30 "may have Pneumovax vaccine if no history of vaccine."</p> <p>Resident #30's quarterly MDS assessment, dated 5/29/18, documented Resident #30 was "up to date" with the Pneumococcal vaccination.</p> <p>Resident #30's signed Vaccine Information Sheet Acknowledgement and Consent, dated 2/26/18, documented he did not wish to receive the</p>	F 883			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 883	<p>Continued From page 51</p> <p>Pneumococcal Vaccine at that time. The form did not document if vaccine information was provided or when, or if, the vaccine was administered prior to admission.</p> <p>g) Resident #29 was admitted to the facility on 7/9/14, with multiple diagnoses, including chronic atrial fibrillation (irregular heart rhythm) and hypertensive (high blood pressure) chronic kidney disease.</p> <p>Resident #29's physician orders, active as of 6/13/18, documented "May have flu shot annually in season. Influenza vaccine 0.5 ml injected IM (intramuscular) annually as prophylaxis for influenza" and "May have Pneumovax Vaccine if no history of vaccine."</p> <p>Resident #29's Significant Change MDS assessment, dated 5/23/18, documented the Pneumococcal vaccination was up to date.</p> <p>Resident #29's immunization report documented the Pneumococcal vaccine, historical type unknown, was given on 4/18/13.</p> <p>There was no documentation that efforts were made to provide additional doses of the pneumonia vaccine.</p> <p>h) Resident #16 was admitted to the facility on 1/3/18 with multiple diagnoses, including unspecified atrial fibrillation and COPD.</p> <p>Resident #16's physician orders, active as of 6/14/18, documented "May have flu shot annually in season if not allergic to eggs. Influenza</p>	F 883			

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 883	<p>Continued From page 52</p> <p>vaccine 0.5 ml injected IM (intramuscular) annually as prophylaxis for influenza" and "May have Pneumovax Vaccine if no history of vaccine."</p> <p>Resident #16's quarterly MDS assessment, dated 4/18/18, documented the Pneumococcal vaccine was up to date.</p> <p>Resident #16's Immunization Report documented the Pneumococcal PPSV 23 vaccine was administered on 1/1/13.</p> <p>There was no documentation that efforts were made to provide additional doses of the pneumonia vaccine.</p> <p>i) Resident #4 was admitted to the facility on 2/10/17 with multiple diagnoses, including heart failure and COPD.</p> <p>Resident #4's physician orders, active as of 6/15/18, documented "May have Pneumovax Vaccine if no history of vaccine."</p> <p>Resident #4's quarterly MDS assessment, dated 3/22/18, documented the Pneumococcal vaccine was up to date.</p> <p>Resident #4's Immunization Report documented the Pneumococcal vaccine, historical type unknown, was given on 9/30/14.</p> <p>There was no documentation that efforts were made to provide additional doses of pneumonia vaccine.</p> <p>On 6/13/18 at 2:21 PM, RN #2 stated she was</p>	F 883			

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

PRINTED: 07/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</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 883	Continued From page 53 unable to show a system in place for tracking immunizations.  On 6/13/18 at 3:19 PM, the DON stated residents were admitted to the facility with an order or standing order for immunization. She stated the facility had a check system in place, which was the MDS assessments.	F 883			