



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RUSS BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR  
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3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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November 21, 2018

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

Provider #: 135090

Dear Mr. Roedel:

On **November 9, 2018**, a survey was conducted at Shaw Mountain of Cascadia by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

Benjamin Roedel, Administrator  
November 21, 2018  
Page 2 of 4

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 3, 2018**. Failure to submit an acceptable PoC by **December 3, 2018**, may result in the imposition of penalties by **December 24, 2018**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **December 14, 2018 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **February 7, 2019**. A change in the seriousness of the deficiencies on **December 24, 2018**, may result in a change in the remedy.

Benjamin Roedel, Administrator  
November 21, 2018  
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **February 9, 2019** includes the following:

Denial of payment for new admissions effective **February 9, 2019**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 9, 2019**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **February 9, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

Benjamin Roedel, Administrator  
November 21, 2018  
Page 4 of 4

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

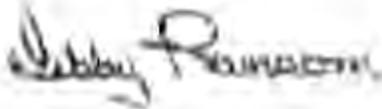
- BFS Letters (06/30/11)

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

This request must be received by **December 3, 2018**. If your request for informal dispute resolution is received after **December 3, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



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

dr/lj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/09/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification and complaint survey conducted November 5, 2018 to November 9, 2018.  The surveyors conducting the survey were:  Jenny Walker, RN, Team Coordinator Presie Billington, RN Kristy Flodquist, RN  ABBREVIATIONS:  ADL = Activities of Daily Living CNA = Certified Nursing Assistant DNS = Director of Nursing Services LPN = Licensed Practical Nurse LCSW = Licensed Clinical Social Worker MDS = Minimum Data Set RCM = Resident Care Manager RN = Registered Nurse	F 000			
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)  §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and resident interview, it was determined the facility failed to ensure residents	F 558	CORRECTIVE ACTION: Resident #63 no longer resides at the facility. Prior to resident discharge care	12/13/18	

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

TITLE

(X6) DATE

Electronically Signed

12/03/2018

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 558	<p>Continued From page 1</p> <p>with impaired vision were accommodated during meals. This was true for 1 of 1 resident (Resident #63) who had impaired vision. This failure created the potential for harm should the resident experience frustration and decreased nutritional intake related to the dining experience. Findings include:</p> <p>Resident #63 was admitted to the facility on 10/4/18, with multiple diagnoses including diabetes mellitus and macular degeneration (loss of vision due to damage on part of the eye).</p> <p>Resident #63's admission MDS assessment, dated 10/11/18, documented she was cognitively intact and required set-up for eating.</p> <p>On 11/6/18 at 12:18 PM, Resident #63 was observed sitting on the edge of her bed, with her meal tray on her bedside table in front of her. On her plate were mashed sweet potatoes, green beans, and sliced meat with gravy. Resident #63 had an unopened bottle of milk and a bowl of dessert covered with clear plastic. When Resident #63 was asked what was on her plate, Resident #63 looked at her plate, and said she did not know, everything was blurry. Resident #63 said she had only 10 -15% of her vision remaining.</p> <p>On 11/6/18 at 1:39 PM, Resident #63 said she was blind and could only see the outline of people. Resident #63 said when staff delivered her meal, she asked where and what was on her plate. Resident #63 stated the staff said "It's your breakfast or dinner," but did not specify as to where or what food items were on her plate.</p>	F 558	<p>plan was reviewed and updated by IDT to assure accommodations for visual impairment were met during meals.</p> <p><b>IDENTIFICATION OF OTHER RESIDENTS AFFECTED:</b> All other residents with impaired vision have the potential to be affected. The IDT review all MDS assessments for residents with highly impaired vision to ensure accommodations are met during meals and adjustments to their plan of care are made as needed.</p> <p><b>SYSTEMIC CHANGES/PREVENTION MEASURES:</b> IDT to review in clinical meeting all residents upon admission, and with any changes in condition, with impaired vision to ensure accommodations are met during meals. The RCM to update the resident's person-centered care plan as indicated. Direct care staff are educated on accommodations for visual impairments during meal times and ensuring person center comprehensive care plans are developed and addressing resident dining needs. Re-education provided by DNS/Designee to include but not limited to, accommodations for visual impairments during meal times and the development of person-centered care plans.</p> <p><b>MONITORING OF CORRECTIVE ACTION:</b> A weekly audit on reasonable accommodations to meet the needs for</p>		

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F 558	Continued From page 2 On 11/8/18 at 3:51 PM, the DNS said Resident #63 had Macular Degeneration and expected the nursing staff to explain to her what items were on her plate at each meal.	F 558	visually impaired residents will be completed by DNS and/or designee. Documentation will be place on the QAPI audit tool starting the week of December 13, 2018. 1:1 remediation will be provided for any negative findings. QAPI committee will review results of findings to validate compliance with facility policy, as well as state, and federal regulations until deficiency is no longer a concern to the QAPI Committee.		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)  §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every	F 565		12/13/18	

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F 565	<p>Continued From page 3 request of the resident or family group.</p> <p>§483.10(f)(6) The resident has a right to participate in family groups.</p> <p>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on Resident Council Meeting minutes, Resident Group interview, staff interview, and policy review, it was determined the facility failed to address Resident Council concerns and provide a resolution of their concerns. This was true for 16 of 16 residents (#3, #7, #8, #16, #17, #27, #29, #32, #33, #34, #45, #63, #69, #72, #77, and #80) in the Resident Group interview and those residents in the facility whose views and concerns were represented by the Resident Group. This failure had the potential to cause psychosocial harm for residents frustrated by the perception their concerns were not valued or addressed by the facility. Findings include:</p> <p>The facility's Complaints and Grievances policy, dated 11/28/17, documented Complaints and Grievances were acknowledged, investigated, and the complainant apprised of progress toward a resolution and appropriate corrective action was taken if confirmed.</p> <p>Resident Council minutes July 2018 through October 2018 documented residents' concerns and the facility's response. Examples include:</p>	F 565	<p><b>CORRECTIVE ACTION:</b> Activity Director, Administrator, and Director of Nursing will review the past four months of concerns expressed in resident council by December 13,2018. Each resident's concern expressed in resident council concern to be addressed through grievance process and followed up by the IDT.</p> <p><b>IDENTIFICATION OF OTHER RESIDENTS AFFECTED:</b> All residents that attend resident council have the potential to be affected. Activity Director, Administrator, and Director of Nursing will review the past four months of concerns expressed in resident council by December 13,2018. Each concern will be added to the grievance report. The reports to be entered into the grievance system and followed-up by IDT. The Administrator / designee will investigate and follow-up with the residents for resolution.</p> <p><b>SYSTEMIC CHANGES/PREVENTION</b></p>		

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F 565	<p>Continued From page 4</p> <p>a. Resident Council minutes, dated 7/17/18, documented "Call lights were beginning to become an issue, evening shift appears to be the worst."</p> <p>The facility's follow up to the concerns, dated 7/17/18, documented "Discussed evening shift busy time after dinner and coordinating break and lunch times with co-workers."</p> <p>b. Resident Council minutes, dated 8/21/18, included past issues. The minutes documented "Call light[s] are beginning to become an issue; evening shift appears to be the worst. There has been no improvement in the timeliness of answering a call light." The Resident Council minutes identified current issues which included call lights. The minutes documented "Call light[s] are an issue on most shifts. Worst times are after meals, and the last half hour of the shifts."</p> <p>The facility's follow up to the concerns, dated 9/7/18, documented "Call light Audits completed." The call light audit tool, dated 9/7/18, documented three call lights were audited around 4:00 PM and were answered in less than 7 minutes. The call light audits were not completed during the time of day identified by the Resident Council Meeting on 8/21/18.</p> <p>c. Resident Council minutes, dated 9/18/18, included past issues. The minutes documented, "Call light[s] are an issue on most shifts. Worst times are after meals, and the last half hour of the shifts." The Resident Council minutes identified current issues which included call lights. The minutes documented "Call lights are getting better, not perfect but better."</p>	F 565	<p><b>MEASURES:</b> Administrator educated by Clinical Resource on the importance of insuring resident concerns expressed in the Resident Council meeting are communicated to management via the Grievance system in order to insure timely resolution. Any trending concerns will be identified and brought before the IDT. The Activity director shall process the concerns and issues expressed in Resident Council by entering them into the facility Grievance system including follow-up resolution. Resolutions will be reported to the Resident council the following resident council meeting.</p> <p><b>MONITORING OF CORRECTIVE ACTION:</b> A monthly audit on the grievance system to validate that resident grievances have been investigated and resolved will be completed by Administrator and/or designee. Documentation will be place on the QAPI audit tool starting the week of December 13, 2018. 1:1 remediation will be provided for any negative findings. QAPI committee will review results of findings to validate compliance with facility policy, as well as state, and federal regulations until deficiency is no longer a concern to the QAPI Committee.</p>		

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F 565	Continued From page 5  d. Resident Council minutes, dated 10/16/18, included current issues. The minutes documented "Call lights are not being answered in a timely manner. The worst times are from 7 pm to 6 am, after meals and at shift changes."  The facility's follow up to the concerns, dated 10/16/18, documented, "Communication made to all staff on items 1 & 2. Call light audit completed. Will be discussed further in CNA meeting."  On 11/6/18 at 10:45 AM, during the Resident Group interview, the residents stated the call lights were taking over 30 minutes to be answered after meals and during shift change. The residents stated the worst call light response time was from 7:00 PM to 6:00 AM.  On 11/9/18 at 12:15 PM, the Administrator stated he oversaw the grievances and the Activity Director attended the monthly Resident Council meetings. The Activity Director stated she notified the Administrator of the concerns brought up or identified at the Resident Council Meeting each month. The Administrator stated the DNS was notified of the concerns with the response times for the call lights. The DNS stated a call light audit was completed in August 2018 for the concerns with the call lights. The DNS did not provide a call light audit for the October 2018 concerns of call lights not being answered between 7:00 PM and 6:00 AM. The Administrator stated he was unaware the call lights were of concern for the past four months.	F 565			
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		12/13/18	

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F 578	<p>Continued From page 6</p> <p>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.</p> <p>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the</p>	F 578			

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F 578	<p>Continued From page 7 appropriate time. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a.) residents were provided information regarding advance directives upon admission and if necessary, assisted to formulate advance directives, and b.) resident records included documentation of this process, a copy of the residents' advance directives, or documentation of their decision not to formulate advance directives. This was true for 6 of 19 residents (#29, #63, #72, #74, #82 and #182) whose records were reviewed for advance directives. These failures increased the risk of residents not having their decisions documented, honored, and respected when they were unable to make or communicate health care preferences. Findings include:</p> <p>The facility's Advance Directives policy and procedure, dated 10/1/17, documented residents had the right to accept or refuse medical or surgical treatment and to formulate advance directives. During the admission process the facility determined if the resident had an advance directive. If the resident or the resident's legal representative had executed an advance directive, a copy was requested and maintained in the resident's record. If the resident did not have an advance directive, the facility provided assistance to the resident and their family to establish an advance directive. The facility documented in the resident's record the discussions regarding advance directives and any healthcare decisions the resident made. If the resident decided to change their advance</p>	F 578	<p><b>CORRECTIVE ACTION:</b> Resident #63 and #82 no longer reside at the facility. For residents #29, #72, #182 a copy of their advanced directives will be uploaded into their resident record. For resident #74 DNS or designee to provide information to the resident regarding their right to formulate an advance directive and if necessary, assist to formulate advance directives. Ensure that the resident records include documentation of this process.</p> <p><b>IDENTIFICATION OF OTHER RESIDENTS AFFECTED:</b> All residents have the potential to be affected. Director of Nursing or Designee to audit all resident records regarding advanced directives. Based upon the findings in the audit DNS / Designee to review advanced directives with resident, and or records to be updated to resident record.</p> <p><b>SYSTEMIC CHANGES/PREVENTION MEASURES:</b> IDT educated by Clinical Resource on providing resident information regarding advanced directives. Advanced directive should be provided upon admission and if necessary, assisted to formulate advance directives, and resident records included documentation of this process, a copy of the resident's advance directives, or documentation of their decision not to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/09/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</b>		
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F 578	<p>Continued From page 8</p> <p>directives it was documented in their record.</p> <p>The State Operations Manual defined an ""Advance directive" is "a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." "Physician Orders for Life-Sustaining Treatment (or POLST) paradigm form" is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an advance directive."</p> <p>Residents #29, #63, #72, #74, #82 and #182's records included documentation they had an Advance Directive. Their records did not include a copy of their Advance Directive.</p> <p>On 11/6/18 at 9:46 AM, RCM #1 presented a binder with residents' face sheets and Physician's Order for Scope of Treatment (POST). The RCM said the "Do Not Resuscitate (DNR)" order in the residents' record was the Advance Directive because it was a physician's order.</p> <p>On 11/9/18 at 8:48 AM, the DNS said it was the Licensed Nurse who discussed the POST with the residents upon admission, and reviewed quarterly, or when there was a significant change in the residents' health condition or as needed. The DNS said when the resident record</p>	F 578	<p>formulate advance directives. Social Services or Designee will assist and document information regarding advanced directives upon admission, quarterly, and if necessary, with significant changes.</p> <p><b>MONITORING OF CORRECTIVE ACTION:</b> A weekly audit on advanced directives will be completed by Director of Nursing and/or designee. Documentation will be placed on the QAPI audit tool starting the week of December 13, 2018. 1:1 remediation will be provided for any negative findings. QAPI committee will review results of findings to validate compliance with facility policy, as well as state, and federal regulations until deficiency is no longer a concern to the QAPI Committee.</p>		

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F 578	Continued From page 9 documented the Advance Directive was reviewed, it was the POST that was reviewed with the residents and/or their families.  On 11/9/18 at 9:18 AM, the LCSW said it was the admitting nurse who discussed the POST with the resident, and within three days the Social Services reviewed the POST with the residents and inquired about the Advance Directive. The LCSW said the facility recognized the POST as part of the Advance Directive and each quarter the multidisciplinary team reviewed the POST with the residents and their representatives or as needed.	F 578			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)  §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580		12/13/18	

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F 580	<p>Continued From page 10</p> <p>(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and record review, it was determined the facility failed to ensure a resident's family member was notified of changes in the resident's condition. This was true for 1 of 19 residents (Resident #42) whose records were reviewed. This failed practice had the potential for harm when the resident experienced a decline in condition requiring intervention or input from their family representative. Findings include:</p>	F 580	<p><b>CORRECTIVE ACTION:</b> Resident #42 medical record was reviewed for any significant changes, including physician order changes, and resident and resident's representative notify of any findings.</p> <p><b>IDENTIFICATION OF OTHER RESIDENTS AFFECTED:</b> All residents have the potential to be</p>		

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F 580	<p>Continued From page 11</p> <p>The facility's policy and procedure for Resident Changes of Condition, dated 11/28/17, documented the facility was to immediately inform the resident, consult with the resident's physician, and notify the resident's representative when there was a significant change in the resident's physical, mental, or psychosocial status in either life-threatening conditions or clinical complications.</p> <p>Resident #42 was admitted to the facility on 1/7/17, with multiple diagnoses including a stroke and chronic kidney disease.</p> <p>Resident #42's Admission Record identified a family member as their emergency contact.</p> <p>A Nurse's Progress Note, dated 8/11/18 at 4:08 AM, documented Resident #42 had increased swelling to his BLE (Bilateral Lower Extremities) and his legs were firm to the touch and painful.</p> <p>A Nurse's Progress Note, dated 8/11/18 at 7:46 AM, documented the physician was notified of Resident #42's increased swelling to his BLE and laboratory work was ordered.</p> <p>A Nurse's Progress Note, dated 8/11/18 at 7:03 PM, documented the physician was notified of Resident #42's laboratory results, the swelling had increased up to his knees, and he had swelling to his left hand.</p> <p>A physician order, dated 8/11/18, documented to start Lasix (a diuretic) 20 mg every day for 5 days. The order also included daily weights and repeat laboratory work after the Lasix was</p>	F 580	<p>affected. IDT reviewed other residents for the need for notification to resident and resident's representatives of any change's adjustments have been made as indicated.</p> <p><b>SYSTEMIC CHANGES/PREVENTION MEASURES:</b> Nursing staff educated by DNS or designee on the facility policy to notify resident and resident's representative when there is a change in condition. Director of Nursing or Designee will review all change in condition during clinical meeting to assure resident and family representative has been notified of changes in the resident's condition.</p> <p><b>MONITORING OF CORRECTIVE ACTION:</b> A weekly audit on notifying resident and resident's representative of change in residents' condition will be completed by Director of Nursing and/or designee. Documentation will be placed on the QAPI audit tool starting the week of December 13, 2018. 1:1 remediation will be provided for any negative findings. QAPI committee will review results of findings to validate compliance with facility policy, as well as state, and federal regulations until deficiency is no longer a concern to the QAPI Committee.</p>		

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F 580	Continued From page 12 completed.  Resident #42's clinical record did not include documentation the family representative was notified of his increased swelling to his BLE and the new physician orders on 8/11/18.  On 11/9/18 at 9:39 AM, the DNS was unable to provide documentation Resident #42's family representative was notified of his change of condition on 8/11/18. The DNS stated the nurse should have notified Resident #42's family representative for his change in condition and the new physician orders.	F 580			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		12/13/18	

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F 656	<p>Continued From page 13</p> <p>rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, resident interview, and staff interview, it was determined the facility failed to ensure person centered comprehensive care plans were developed and addressed resident dining needs. This was true for 1 of 19 residents (Resident #63) whose care plans were reviewed. This failure created the potential for harm if residents' received inappropriate or inadequate care. Findings include:</p> <p>Resident #63 was admitted to the facility on 10/4/18, with multiple diagnoses including diabetes mellitus and macular degeneration (loss of vision due to damage on the part of the eye).</p> <p>Resident #63's admission MDS assessment, dated 10/11/18, documented she was cognitively</p>	F 656	<p><b>CORRECTIVE ACTION:</b> Resident #63 no longer resides at the facility. Prior to resident discharge care plan was reviewed and updated by IDT to assure accommodations for visual impairment were met during meals.</p> <p><b>IDENTIFICATION OF OTHER RESIDENTS AFFECTED:</b> All other residents with impaired vision have the potential to be affected. The IDT review all MDS assessments for residents with highly impaired vision to ensure accommodations are met during meals and adjustments to their plan of care are made as needed.</p>		

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F 656	Continued From page 14 intact and required set-up for eating.  Resident #63's care plan, dated 10/4/18, documented the staff were to provide assistance with setting-up her meal. The care plan did not include describing or orienting Resident #63 to the location of the food on her plate.  On 11/6/18 at 1:39 PM, Resident #63 said she was blind and could only see the outline of people. Resident #63 said whenever the staff delivered her food and asked them what was on her plate, the staff told her it was breakfast or dinner and left the room.  On 11/8/18 at 3:50 PM, CNA #1 said if she served a food tray to Resident #63 she told her what was on her plate and opened the bottle of milk if Resident #63 asked her. CNA #1 did not say she told the orientation or location of the specific food on the plate to Resident #63.  On 11/8/18 at 3:51 PM, the DNS said she knew Resident #63 had Macular Degeneration, but she was not aware if the resident was assessed if she needed assistance with her meals.	F 656	<b>SYSTEMIC CHANGES/PREVENTION MEASURES:</b> IDT to review in clinical meeting all residents upon admission, and change in condition, with impaired vision to ensure accommodations are met during meals. The RCM to update the resident's person-centered care plan as indicated. Direct care staff are educated on accommodations for visual impairments during meal times and ensuring person center comprehensive care plans are developed and addressing resident dining needs. Re-education provided by DNS/Designee to include but not limited to, accommodations for visual impairments during meal times and the development of person-centered care plans.  <b>MONITORING OF CORRECTIVE ACTION:</b> A weekly audit on person centered comprehensive care plans to be completed by DNS and/or designee. Documentation will be place on the QAPI audit tool starting the week of December 13, 2018. 1:1 remediation will be provided for any negative findings. QAPI committee will review results of findings to validate compliance with facility policy, as well as state, and federal regulations until deficiency is no longer a concern to the QAPI Committee.		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)  §483.24(c) Activities.	F 679		12/13/18	

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F 679	<p>Continued From page 15</p> <p>§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and Activity Calendar review, it was determined the facility failed to ensure there was a variety of activities, an engaging program, and evening activities scheduled to meet the needs of residents with cognitive impairment who resided in the lock unit. This was true for 2 of 23 residents (#21 and #22) residing in the locked unit. This created the potential for residents to become bored and foster an increase in negative behaviors when not provided with meaningfully engaging activities throughout the day and evening. Findings include:</p> <p>The November 2018 Activity Calendar for the locked unit was posted on the back of the nurse's medication cart on an 11" x 17" piece of paper. The Activity Calendar was divided into Morning Activities and Afternoon Activities. There were no times posted for the activities except for every other Friday a Spiritual Activity was scheduled at 2:30 PM, Saturday The Lawrence Welk Show was scheduled at 7:00 PM, and on Sunday an Evening Movie without a specific time was scheduled.</p>	F 679	<p><b>CORRECTIVE ACTION:</b> Resident #21, and #22 provided with engaging activities of interest with supplies and assistance. The calendar was posted in a highly visible area. Activities calendar adjusted to implement evening activities for the residents on the secure unit.</p> <p><b>IDENTIFICATION OF OTHER RESIDENTS AFFECTED:</b> All residents that reside in the secure unit are potentially affected. Activity Assessment completed for all residents within the secure unit for activities of interest and assistance needed and adjustments to the activities program are made as needed.</p> <p><b>SYSTEMIC CHANGES/PREVENTION MEASURES:</b> Education provided by Staff Development Coordinator to the Activities Director, Assistants, Nurse Aides, and Friendship House Care Coordinator on the requirement to provide a variety of</p>		

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F 679	<p>Continued From page 16</p> <p>On 11/6/18 at 8:30 PM, four residents were sitting in recliners in the common area, two with their eyes closed, and the other two were watching a basketball game on TV. One resident was sitting at the dining room table going through magazines by herself. Two residents were sitting in their wheelchairs behind the recliners, one of them watching the basketball game on TV and the other with his back to the TV looking at the wall. The nurse was passing medications and was unable to conduct an activity. The three CNA's were assisting the other residents to bed and the fourth CNA was assigned as a 1:1 for one of the residents who was watching the basketball game on TV.</p> <p>On 11/6/18 at 8:40 PM, RN #1 stated after dinner was when they needed a structured activity for the residents because they have sundowners and that was when the behaviors started. (Sundowner is a person with dementia who becomes increasingly irritable or difficult as the day progresses). CNA #2 stated the residents needed a group activity after dinner until about 8:00 PM every evening to decrease the behaviors. CNA #3 stated the Activity Calendar did not schedule evening activities.</p> <p>The 11/7/18, Activity Calendar for locked unit documented Morning Activities were; Morning News, Relax and Color, and the Daily Chronicle (a newspaper).</p> <p>On 11/7/18 at 10:30 AM, Resident #21 and Resident #22 were observed sitting next to each other at the table, each had a picture in front of them to color. The crayons were on the opposite side of the table, and out of their to use to color.</p>	F 679	<p>activities, and engaging program, and evening activities to meet the needs of residents with cognitive impairment.</p> <p>Staffing schedule adjusted to ensure activities are being offered in the evening in the secure unit. Activities Calendar to offer a variety of activities with flexible scheduled times to meet the needs of residents with cognitive impairment. Staff are trained on engaging residents with activities throughout the day upon new hire, annually, and as needed.</p> <p><b>MONITORING OF CORRECTIVE ACTION:</b> A weekly audit of the activities program to ensure activities are meeting the interest/needs of each resident with cognitive impairment will be completed by DNS and/or designee. Documentation will be place on the QAPI audit tool starting the week of December 13, 2018. 1:1 remediation will be provided for any negative findings. QAPI committee will review results of findings to validate compliance with facility policy, as well as state, and federal regulations until deficiency is no longer a concern to the QAPI Committee.</p>		

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F 679	<p>Continued From page 17</p> <p>Resident #21 was sitting with her eyes open and slowly looked around with a dazed look on her face. Resident #22 sat staring straight ahead and then closed her eyes. There was not a staff member to assist them with the coloring.</p> <p>On 11/7/18 at 10:37 AM, RCM #2 was sitting in her office and was asked what the activity was at the time. RCM #2 stated the activity was low sensory with light music and coloring. The Surveyor asked RCM #2 to observe the coloring activity. RCM #2 stated Resident #21 was sitting at the table looking around and then she closed her eyes and Resident #22 had her eyes closed. RCM #2 stated they were set up for coloring, but the crayons were out of reach of the residents. RCM #2 stated the residents needed to have someone with them to keep them engaged in the activity. RCM #2 stated an activity assistant needed to stay and be engaged in the activity. RCM #2 stated the activity assistant was in another room participating in an exercise activity and the Coordinator for the locked unit needed to assist with the coloring activity. RCM #2 stated the residents on the locked unit required an activity assistant engaged during the entire activity. RCM #2 was aware there were no evening activities scheduled.</p> <p>On 11/8/18 at 9:30 AM, the DNS stated the residents in the locked unit were cognitively impaired and required an activity assistant to be engaged with them for the entire activity. The residents were not able to process a task without an activity assistant there to provide direction and assistance to complete the task. The DNS stated her expectations for the nursing staff were to provide small group activities in the evening. The</p>	F 679			

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

PRINTED: 01/11/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/09/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</b>		
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F 679	Continued From page 18 DNS was aware there were no evening activities.  On 11/9/18 at 10:00 AM, Activity Assistant #1 stated the activities in the locked unit were low sensory activities and lacked variety. She stated she suggested to the Activities Director the need for a variety of activities and the need for an activity assistant in the evening to provide small engaging activities after dinner when sundowning behaviors increased, but no changes were made.	F 679		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001790</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/09/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</b>
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(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) COMPLETE DATE
C 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the state licensing survey conducted November 5, 2018 to November 9, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Presie Billington, RN</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on review of Quality Assurance Performance Improvement meeting attendance records and staff interview, it was determined the facility failed to ensure a representative from each required department participated in the facility's Infection Control Meetings at least quarterly. This failure created the potential for negative outcomes for residents, visitors, and staff in the facility related to the prevention of infections and disease. Findings include:</p> <p>On 11/9/18 at 12:30 PM, the Administrator stated the facility held Quality Assurance Performance Improvement meetings monthly and Infection Control was a component of those meetings.</p> <p>The Administrator provided attendance records, dated 10/10/17, 11/14/17, 2/20/18, 2/27/18, 3/27/18, 4/30/18, and 6/8/18, that documented the environmental services representative did not</p>	C 664	<p><b>CORRECTIVE ACTION:</b> A QAPI/infection control meeting was held on 11/20/2018 and all required departments attended.</p> <p><b>IDENTIFICATION OF OTHER RESIDENTS AFFECTED:</b> All residents have the potential to be affected.</p> <p><b>SYSTEMIC CHANGES/PREVENTION MEASURES:</b> Administrator educated Medical Director, Pharmacist, Dietary Supervisor, Director of Nursing, Housekeeping service representative, and Maintenance Director on the requirement for each department to attend the QAPI/Infection Control Meeting at least quarterly. Administrator to ensure all required members of the QAPI/</p>	12/13/18

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
Electronically Signed

TITLE

(X6) DATE  
12/03/18

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001790</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/09/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</b>		
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C 664	Continued From page 1  attend the Infection Control Meetings. The Pharmacist did not attend the Infection Control meetings on 10/10/17, 11/14/17, 4/30/18, and 6/8/18. The Dietary Services representative did not attend the Infection Control meetings on 10/10/17, 11/14/17, and 9/18/18. The Administrator did not provide attendance records for December 2017, January 2018, May 2018, July 2018, and August 2018.	C 664	infection control committee are present and contributing at each quarterly meeting.  <b>MONITORING OF CORRECTIVE ACTION:</b> A monthly audit of the QAPI / Infection Control attendance record will be completed by Administrator and/or designee. Documentation will be place on the QAPI audit tool starting the week of December 13, 2018. 1:1 remediation will be provided for any negative findings. QAPI committee will review results of findings to validate compliance with facility policy, as well as state, and federal regulations until deficiency is no longer a concern to the QAPI Committee.	



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
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April 4, 2019

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

Provider #: 135090

Dear Mr. Roedel:

On November 5, 2018 through November 9, 2018, an unannounced onsite complaint survey was investigated at Shaw Mountain of Cascadia in conjunction with the annual recertification survey. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007945**

ALLEGATION #1:

Injuries of unknown origin are not investigated.

FINDINGS #1:

Eighteen resident records were reviewed, observations were conducted throughout the facility, interviews were conducted with residents, and facility policies were reviewed.

The facility's policy and procedure for Resident Changes of Condition, dated 11/28/17, documented the facility was to immediately inform the resident, consult with the resident's physician, and notify the resident's representative when there was a significant change in the resident's physical, mental, or psychosocial status in either life-threatening conditions or clinical complications.

One resident's family reported to staff he had bruising and swelling to his left eye. Staff and the Physician's Assistant checked the resident's left eye and face the day after the bruising and swelling were observed, and they found no visible bruising or swelling. The resident did not recall facial bruising or swelling.

Based on investigative findings the allegation was unsubstantiated with no deficient practice identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Resident records are not accurate.

FINDINGS #2:

Eighteen resident records were reviewed, interviews were conducted with residents, the Ombudsman, multiple staff members, and family members.

No concerns related to the allegation was identified.

Therefore, due to lack of sufficient evidence, the allegation was unsubstantiated with no deficient practice identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Responsible parties are not notified of changes in resident condition.

FINDINGS #3:

Eighteen resident records were reviewed, numerous observations were made throughout the facility, residents were interviewed, the Ombudsman and staff were interviewed, and family members were interviewed. Resident Council Minutes for the previous 6 months were also reviewed.

Benjamin Roedel, Administrator  
April 4, 2019  
Page 3 of 4

One resident had a significant change in medical condition without evidence of notifying the responsible party. The resident's record documented he had increased swelling to his bilateral lower extremities and his physician was notified and orders were received for laboratory testing and medication. There was no documentation a family representative was notified of the change in his condition and that the physician was notified and new orders were received.

The allegation was substantiated and deficient practice was cited at F580.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #4:

Residents are not assisted with activities of daily living.

#### FINDINGS #4:

During the onsite complaint investigation 18 resident records were reviewed, observations were made throughout the facility, residents were interviewed and staff were interviewed. Resident Council Minutes for the previous 6 months were also reviewed.

One resident's teeth were clean and intact on observation and he stated the staff assisted him with dental care, and he had no dental concerns. The resident's feet were well cared for with the physician-ordered boots in place, trim toenails, and skin without peeling or flaking.

Other residents whose records were reviewed and were interviewed had no concerns with receiving assistance with activities of daily living.

Based on investigative findings the allegation was unsubstantiated with no deficient practice identified.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #5:

Residents are overmedicated.

Benjamin Roedel, Administrator  
April 4, 2019  
Page 4 of 4

FINDINGS #5:

Eighteen resident records were reviewed, observations were made throughout the facility, and interviews were conducted with residents, the Ombudsman, multiple staff members, and family members.

One resident whose record was reviewed was previously receiving Melatonin for sleep and Baclofen four times per day for pain. The Melatonin was discontinued and the Baclofen had been reduced and eventually discontinued. Other current residents reviewed had no concerns with over-medication or unnecessary medications.

Based on investigative findings the allegation was unsubstantiated with no deficient practice identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor  
Long Term Care Program

LT/lj



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

April 10, 2019

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

Provider #: 135090

Dear Mr. Roedel:

On **November 5, 2018** through **November 9, 2018**, an unannounced on-site complaint survey was conducted at Shaw Mountain of Cascadia. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007880**

**ALLEGATION:**

There was earwigs and carpenter ants in the Friendship House Unit.

**FINDINGS:**

The facility was observed for pests and no concerns were identified.

The Maintenance Supervisor was interviewed and provided monthly pest control logs from May 2018 to October 2018 that documented earwigs and ants were a problem in the Friendship House Unit in June 2018. The pest control company provided additional spray and traps inside and outside of the facility due to findings of earwigs and ants. The Maintenance Supervisor stated there was a time in late June that the Friendship House did have earwigs and carpenter ants and he notified the pest control company and they came out the next day to spray and set up traps. He stated the pest control company resolved the pest control issue.

Benjamin Roedel, Administrator  
April 10, 2019  
Page 2 of 2

CNAs, nurses, and managers were interviewed and stated there was an issue with ants in the summer, but when the maintenance manager was notified, he took care of the problem with additional spraying and traps inside. The CNAs and nurses stated there was not ants or earwigs in residents rooms or the shower room, only in the dining room.

The allegation was substantiated. However, no deficiencies were cited related to the allegation because it was determined the facility identified the earwigs and carpenter ants and notified the pest control company to resolve the issue promptly.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

The allegation was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor  
Long Term Care Program

LT/lj



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June 20, 2019

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

Provider #: 135090

Dear Mr. Roedel:

On **November 5, 2018** through **November 9, 2018**, an unannounced on-site recertification and complaint survey was conducted at Shaw Mountain of Cascadia. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

**Complaint #ID00007870**

**ALLEGATION:**

A resident was potentially neglected which resulted in physical injury and hospitalization.

**FINDINGS:**

An unannounced recertification and complaint survey were conducted on November 5, 2018 through November 9, 2018. During the investigation resident records were reviewed, facility's Abuse Policy and Procedure was reviewed, Incident and Accident reports were reviewed, Skin Event reports were reviewed, and staff were interviewed.

One resident's record included A Fall/Post Fall Assessment report which documented the resident was last toileted at 10:00 PM and was last repositioned at 12:30 AM. At 1:25 AM a Certified Nursing Assistant (CNA) answered the resident's call light and saw the resident lying diagonally in her bed with her bottom halfway off her bed. The CNA attempted to reposition the resident back to her bed, but the resident became resistive and started to slide off her bed.

The report stated the CNA lowered the resident to the floor. The Fall/Post Fall Assessment report documented the resident had no injuries and she was assisted back to bed using a Hoyer lift (a mechanical lift).

A CNA statement report, documented at about 3:45 AM to 4:00 AM, the resident was heard yelling and when the CNA went to the resident's room she was hitting the wall. The CNA statement report did not state how or what part of the resident's body was hitting the wall. The CNA statement documented there were no noticeable marks on the resident's body.

A Nursing Note, at 7:27 AM, documented a 3.5 centimeter by 1.5-centimeter hematoma (a solid swollen area in the tissue) was noted on the resident's forehead during the medication administration at 5:00 AM. The resident reported to the nurse she hit the bookcase. The physician was informed and ordered to send the resident to the hospital for head imaging.

A Treatment Administration Record (TAR), included the physician's order to send the resident to the hospital for head imaging due to a hematoma on the forehead.

A Nursing Note, at 8:30 AM, documented an Injury Care non-emergent transport arrived and the resident was sent to the hospital.

A Licensed Practical Nurse (LPN) said the CNA reported to her the resident did not hit her head when she was assisted to the floor. The LPN said the CNA told her the resident was hitting the wall with her hand. When asked why it took 3.5 hours before the resident was sent to the hospital from the time the hematoma was discovered the LPN said the resident was "stable" according to her assessment. The LPN said the resident did not lose consciousness and the neurological examination she initiated was within normal limits. The LPN said she did not believe the resident needed an emergent transfer to the hospital at the time the hematoma was discovered.

A report from the hospital documented the resident reported to the Emergency Room's physician that a caregiver punched her on the head. The report also documented the resident said the caregiver got forceful with her because she was loud at night and had hit her in the past. A Computerized Tomography (CT) scan of the resident's head showed a soft tissue injury without fracture or bleeding in the brain.

The Director of Nursing (DNS) said an investigation on the resident's hematoma was initiated when she came back from the hospital. The DNS said a Skin Event Assessment was created, and staff who took care of the resident the night she had an assisted fall were interviewed and the resident's roommate was also interviewed. The DNS said the incident was not reported to the State because their investigation concluded the resident might have hit her head on the wall causing the hematoma and it was not due to staff mistreating the resident.

Benjamin Roedel, Administrator  
June 20, 2019  
Page 3 of 3

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson".

Laura Thompson, RN, Supervisor  
Long Term Care Program

LT/lj