A complaint survey was conducted at the facility from 1/6/20 to 1/8/20. There were no deficiencies cited during the survey as a result of the complaint investigation.

Surveyors conducting the survey were:

Susan Gosney, RN - Team Coordinator
Monica Meister, M.Ed., QIDP

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.
January 23, 2020

Brantley Shattuck, Administrator
Cascadia of Nampa
900 N.Happy Valley Rd.
Nampa, ID 83687

Provider #: 135144

Dear Mr. Shattuck:

On January 6, 2020 through January 8, 2020, an unannounced on-site complaint survey was conducted at Cascadia of Nampa. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008291**

**ALLEGATION #1:**

The facility did not allow the resident's representative to exercise the rights of the resident on their behalf.

**FINDINGS #1:**

During the survey, facility grievances were reviewed, resident records were reviewed, observations were conducted, residents were interviewed, and staff were interviewed.

Observations were conducted in the facility on 1/6/20 and 1/7/20. During the observations, 9 residents were asked about their experiences in the facility and whether their rights and those of their representatives had been violated. Each of the 9 residents reported their rights and those of their representatives had not been violated. The residents stated they were treated well by the staff and were pleased with their care and services.
Additionally, during the observations, 7 Certified Nurse Assistants (CNAs), 1 Licensed Practical Nurse (LPN), and 2 Registered Nurses (RNs), who worked various shifts in the facility, were asked about resident rights. Each of the staff stated they had not witnessed or heard of residents' rights or their representatives' rights being violated. The staff reported if they witnessed or heard of such actions, they ensured the resident was safe and then immediately reported the allegation to the Administrator and/or Director of Nursing Services.

Six resident records were selected for review. Of those 6 records, 1 was a closed record (meaning the resident no longer resided in the facility). All 6 records included documentation residents' representatives were notified of changes in the status of the resident. The records also included documentation of resident representatives attending care conferences and medical appointments. No concerns related to violation of residents' rights or resident representatives' rights were identified.

The facility's grievances, dated 10/1/19 to 12/31/19, were reviewed. The grievances included documentation of being investigated with appropriate corrective action, and resident satisfaction. None of the grievances were related to resident rights' violations.

It could not be determined that resident representatives' rights were violated.

Based on the investigative findings, the allegation could not be substantiated, and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility is not ensuring allegations of abuse, neglect, or mistreatment are thoroughly investigated, and appropriate corrective action is taken to prevent recurrence.

FINDINGS #2:

During the survey, facility grievances were reviewed, incident reports were reviewed, resident records were reviewed, observations were conducted, residents were interviewed, and staff were interviewed.

Observations were conducted in the facility on 1/6/20 and 1/7/20. During the observations, 9 residents were asked about their experiences in the facility and whether they had been subjected to abuse, neglect, or mistreatment. Each of the 9 residents reported they had not been subjected to such actions. The residents stated they were treated well by the staff and were pleased with their care and services.
Additionally, during the observations, 7 CNAs, 1 LPN, and 2 RNs, who worked various shifts in the facility, were asked if they had witnessed or had knowledge of residents being abused, neglected, or mistreated. Each of the staff stated they had not witnessed or heard of residents being abused, neglected or mistreated. The staff who were interviewed reported if they witnessed or heard of such actions, they ensured the resident was safe and then immediately reported the allegation to the Administrator and/or Director of Nursing Services.

Six resident records were selected for review. Of those 6 records, 1 was a closed record. No concerns related to abuse, neglect, or mistreatment were identified.

Facility grievances, incident reports, and investigations, dated 10/1/19 to 12/31/19, were reviewed. The grievances contained documented evidence of being investigated with appropriate corrective action, and resident satisfaction. The incident reports and investigations included documentation they were thoroughly investigated and corrective action was taken to prevent reoccurrence.

One investigation, dated 10/14/19, stated a resident alleged a CNA told the resident to "shut up." The incident was investigated, and the allegation was unsubstantiated as there were 4 witnesses to the incident. The resident also alleged another CNA said to the resident "I'm not putting up with your shit." The incident was investigated, and that particular allegation was substantiated. The CNA's employment was terminated for indecent and inappropriate language.

Another investigation, dated 12/5/19, documented a resident alleged a CNA used offensive language while providing care to the resident. The incident was investigated, and the CNA denied using offensive language. The resident was adamant the CNA used offensive language while providing care to the resident. The investigation documented the CNA's employment was terminated based on the resident's statement.

It could not be determined that residents were subjected to abuse and the facility was not implementing their policy and appropriate corrective action was not being taken.

Based on the investigative findings, the allegation could not be substantiated, and no deficient practice was identified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.
ALLEGATION #3:

Residents are not receiving the necessary services to maintain good nutrition, grooming, and personal and oral hygiene and the facility is not ensuring that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents’ choices.

FINDINGS #3:

During the survey, resident records were reviewed, observations were conducted, residents were interviewed, and staff were interviewed.

Observations were conducted in the facility on 1/6/20 and 1/7/20. During the observations, 9 residents were asked about their experiences in the facility and whether they received services to maintain their nutrition, grooming, and personal and oral hygiene. Each of the residents stated they consistently received those services and were pleased with their care.

Additionally, during the observations, 7 CNAs, 1 LPN, and 2 RNs, who worked various shifts in the facility, were asked about residents' nutrition, grooming, and personal and oral hygiene services. Each of the staff stated they had not witnessed or heard of residents not being provided with care and/or services which were needed and stated if they had concerns, they would report the concerns to the Director of Nursing Services.

Six resident records were selected for review. Of those 6 records, 1 was a closed record. Each of the records documented the residents were consistently provided with nutrition, grooming, and personal and oral hygiene. The records documented that residents received or were receiving treatment and care in accordance with their physician orders, professional standards of practice, and their care plans. No concerns were identified.

It could not be determined that residents were not receiving the necessary services to maintain good nutrition, grooming, and personal and oral hygiene and that residents were not receiving treatment and care in accordance with professional standards of practice.

Based on the investigative findings, the allegation could not be substantiated, and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.
ALLEGATION #4:

The facility is not ensuring residents are receiving the care and services necessary to prevent and treat pressure ulcers.

FINDINGS #4:

During the survey, resident records were reviewed, observations were conducted, and staff were interviewed.

Observations were conducted in the facility on 1/6/20 and 1/7/20. During the observations, 9 residents were asked about their experiences in the facility and whether they received services to prevent pressure ulcers. Each of the 9 residents stated they consistently received services to prevent developing pressure ulcers and were pleased with their care.

Additionally, during the observations, 7 CNAs, 1 LPN, and 2 RNs, who worked various shifts in the facility, were asked about interventions to prevent pressure ulcers. Each of the staff stated they had not witnessed or heard of residents not being provided with interventions to prevent pressure ulcers and stated if they had concerns, they would report the concerns to the Director of Nursing Services.

Six residents' records were selected for review. Of those 6 records, 1 was a closed record. The records documented the residents received or were receiving appropriate interventions to prevent pressure ulcers.

One resident's record documented the resident was 99 years old and was discharged to a local hospital in May 2019. The resident had no pressure ulcers when he was discharged from the facility. When the resident returned to the facility, the resident was assessed to have a Stage 2 pressure ulcer on the coccyx which was acquired in the hospital. A Stage 2 pressure ulcer is defined by The National Pressure Ulcer Advisory Panel, 2016, as partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough (non-viable yellow, tan, gray, green, or brown tissue) and eschar (dead or weakened tissue that is hard or soft in texture - usually black, brown, or tan in color) are not present. The resident's record documented the resident was provided with interventions and by July 2019, the wound was healed. The resident's record documented the resident was re-admitted to the local hospital in October 2019 and passed away shortly thereafter. The resident's record documented the resident did not have any pressure ulcers or open sores prior to the re-admission.
It could not be determined that residents were not receiving care to prevent pressure ulcers or that residents with pressure ulcers were not receiving necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing.

Based on the investigative findings, the allegation could not be substantiated, and no deficient practice was identified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #5:**

The facility is not providing foot care and treatment for residents or assisting the resident in making appointments with a provider for evaluation and treatment, and arranging for transportation to and from such appointments.

**FINDINGS #5:**

During the survey, resident records were reviewed, observations were conducted, residents were interviewed, and staff were interviewed.

Observations were conducted in the facility on 1/6/20 and 1/7/20. During the observations, 9 residents were asked about their experiences in the facility and whether they received foot care and treatment, and if necessary, assistance in making appointments and arranging for transportation to and from those appointments. Each of the 9 residents stated they consistently received appropriate foot care and treatment. The residents stated they were assisted to make appointments with outside providers and the facility also assisted them with transportation if necessary.

Additionally, during the observations, 7 CNAs, 1 LPN, and 2 RNs, who worked various shifts in the facility, were asked about residents' foot care and treatment. All of the staff stated they had not witnessed or heard of residents not being provided with foot care and treatment and stated if they had concerns, they would report the concerns to the Director of Nursing Services. One RN stated the facility arranged for a podiatrist to come in the facility every three months for those residents who did not want to leave the facility to attend appointments.

Six resident records were selected for review. Of those 6 records, 1 was a closed record. Each of the records documented the residents were consistently provided with foot care and treatment. The records included documentation residents were assisted to make and arrange for transportation to and from appointments with outside providers.
One resident's record documented the resident was 99 years old and was offered podiatry services in February 2019 and the resident refused the services. Per a family member's request on 7/22/19, the facility made an appointment at a local podiatry clinic and the resident was transported to the appointment on 7/23/19. The podiatry note stated the resident arrived at the clinic and then refused services, and the resident was transported back to the facility.

It could not be determined that residents were not receiving foot care and treatment, and if necessary, assistance in making appointments and arranging for transportation to and from such appointments.

Based on the investigative findings, the allegation could not be substantiated, and no deficient practice was identified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #6:**

The facility is not ensuring that pain management is provided to residents.

**FINDINGS #6:**

During the survey, resident records were reviewed, observations were conducted, residents were interviewed, and staff were interviewed.

Observations were conducted in the facility on 1/6/20 and 1/7/20. During the observations, 9 residents were asked about their experiences in the facility and whether they received pain management services. All 9 residents stated they consistently received pain management services and were pleased with their care.

Additionally, during the observations, 7 CNAs, 1 LPN, and 2 RNs, who worked various shifts in the facility, were asked about residents' pain management services. Each of the staff stated they had not witnessed or heard of residents not being provided with pain management services and stated if they had concerns, they would report the concerns to the Director of Nursing Services.

Six residents' records were selected for review. Of those 6 records, 1 was a closed record. Each of the records documented the residents were consistently provided with pain management services in accordance with their physician orders and their care plans. The records included documentation residents were consistently assessed and monitored for pain as well as receiving medications as ordered by their physician.
It could not be determined that residents were not receiving pain management services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

Based on the investigative findings, the allegation could not be substantiated, and no deficient practice was identified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #7:**

The facility is not ensuring that each resident is offered sufficient food and fluid intake to maintain proper hydration and health.

**FINDINGS #7:**

During the survey, resident records were reviewed, observations were conducted, residents were interviewed, and staff were interviewed.

Observations were conducted in the facility on 1/6/20 and 1/7/20. During the observations, the breakfast and lunch meals were observed, and residents were provided with different kinds of fluids including water, milk, coffee, and various fruit juices. Resident rooms were all noted to contain plastic jugs of water and staff were noted to periodically obtain fresh water from the nourishment rooms as well as from large containers of water that were located in the dining rooms.

During the meals, residents were noted to be served their meals and were assisted, if necessary, to cut their food. No less than 5 residents were noted to require assistance to eat and 1 resident’s food was a pureed texture. One resident was also observed to ask for alternative food items at lunch and was served the requested items in a timely manner.

During the observations, 9 residents were asked about their experiences in the facility and whether they received sufficient amounts of food and fluid, based on their preferences and physician orders. All 9 residents stated they received sufficient amounts of food and fluid and their preferences were always taken into account.

Additionally, during the observations, 7 CNAs, 1 LPN, and 2 RNs, who worked various shifts in the facility, were asked about residents' food and hydration needs. All of the staff stated they had not witnessed or heard of residents not being provided with appropriate food and fluid and stated if they had concerns, they would report the concerns to the Director of Nursing Services.
Six resident records were selected for review. Of those 6 records, 1 was a closed record. All of the records documented the residents were consistently provided with food and fluid in accordance with their preferences, their physician orders, and their care plans. All 6 records documented ongoing monitoring, and interventions if necessary, of residents' nutritional status. Three of the 6 records documented the residents received fluid enhancement services 3 to 4 times a day per their physician orders and care plans. One of the records documented the resident's diet was pureed and required assistance to eat. One of the records documented the resident received thickened fluids due to the resident's medical condition and risk for aspiration. Both records were consistent with their physician orders and care plans.

It could not be determined that residents were not being offered therapeutic diets when there was a nutritional problem and that residents were not being offered sufficient fluids to maintain proper hydration and health.

Based on the investigative findings, the allegation could not be substantiated, and no deficient practice was identified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #8:**

The facility does not have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services.

**FINDINGS #8:**

During the survey, staff schedules were reviewed, resident records were reviewed, observations were conducted, residents were interviewed, and staff were interviewed.

Observations were conducted in the facility on 1/6/20 and 1/7/20. During the observations, residents were observed to be clean and well-groomed and call light response times were noted to be from 1 to 2 minutes. During the observations, 9 residents were asked about their experiences in the facility and about staffing. All 9 residents stated the facility had enough staff and 1 resident stated the longest wait time for answering a call light was 15 minutes due to an unforeseen emergency. All 9 residents stated they were treated well by the staff and were pleased with their care and services.
Additionally, during the observations, 7 CNAs, 1 LPN, and 2 RNs, who worked various shifts in the facility, were asked about staffing. All of the staff stated they did not work short-staffed and there were enough staff to meet resident needs. All staff stated if there was a call-in, then a nurse filled the position until another staff could be found. All of the staff expressed satisfaction with their jobs and with the facility.

Six residents’ records were selected for review. Of those 6 records, 1 was a closed record. All of the records documented the residents were consistently provided with care and services in accordance with their preferences, their physician orders, and their care plans. One of the 6 records documented the resident was receiving hospice care and had a one-to-one sitter, 24 hours a day.

The staff schedules, dated 10/1/19 to 1/6/20, were reviewed and documented that on any given day, the day shift was staffed with 1 RN, 3 LPNs, 11 CNAs, and 1.5 Restorative Nurse Aides (RNAs), and 3 residents had one-to-one sitters. The evening shift was staffed with 1 RN, 2 LPNs, and 11 CNAs, and 3 residents had one-to-one sitters. The night shift was staffed with 2 RNs, and 6 CNAs, and 2 residents had one-to-one sitters.

It could not be determined that the facility did not have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to residents.

Based on the investigative findings, the allegation could not be substantiated, and no deficient practice was identified.

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,

Laura Thompson, RN, Supervisor
Long Term Care Program