



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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February 6, 2020

Trent Clegg, Administrator  
Creekside Transitional Care and Rehabilitation  
1351 West Pine Avenue  
Meridian, ID 83642-5031

Provider #: 135125

Dear Mr. Clegg:

On **January 24, 2020**, a survey was conducted at Creekside Transitional Care and Rehabilitation 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.

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 **February 18, 2020**. Failure to submit an acceptable PoC by **February 18, 2020**, may result in the imposition of penalties by **March 10, 2020**.

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 **February 28, 2020 (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 **April 24, 2020**. A change in the seriousness of the deficiencies on **March 9, 2020**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **April 24, 2020** includes the following:

Denial of payment for new admissions effective **April 24, 2020**. [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 **July 24, 2020**, 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 Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; 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 **April 24, 2020** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **February 18, 2020**. If your request for informal dispute resolution is received after **February 18, 2020**, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Laura Thompson, RN, Supervisor  
Long Term Care Program

lt/lj

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

PRINTED: 02/27/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/24/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>CREEKSIDE TRANSITIONAL CARE AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during a complaint survey conducted from January 23, 2020 through January 24, 2020.  The survey was conducted by:  Monica Meister, QIDP, MEd, Team Coordinator Juanita Stemen, RN  Survey Abbreviations:  CNA - Certified Nurse Assistant DON - Director of Nursing LPN - Licensed Practical Nurse LSW - Licensed Social Worker MAR - Medication Administration Record MDS - Minimum Data Set RN - Registered Nurse	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)  §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.  §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.  §483.10(a)(2) The facility must provide equal	F 550		3/6/20	

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

TITLE

(X6) DATE

Electronically Signed

02/16/2020

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 550	<p>Continued From page 1</p> <p>access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of personnel training, and staff interview, it was determined the facility failed to ensure each resident's right to be treated with respect and dignity was upheld for 1 of 2 residents (Resident #3) who required assistance with their meals. This resulted in a resident not being fed in a dignified manner during lunch. The findings include:</p> <p>Resident #3 was admitted to the facility on 4/3/19, with diagnoses which included dementia with Lewy Bodies (protein deposits in the brain).</p>	F 550	<p>Corrective actions taken for those residents who may have been affected by this deficiency:</p> <p>CNA #1 was in-serviced on sitting while feeding residents that require feeding assistance and the need to refer to the resident kardex prior to providing care.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice</p>		

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F 550	<p>Continued From page 2</p> <p>A quarterly Nutritional Evaluation, dated 12/20/19, stated Resident #3 was unable to state his food and fluid preferences, and he required total assistance (one-to-one) with eating and drinking. His care plan, initiated on 4/3/19 and revised 4/4/19, stated he required the physical assistance of one-person to eat.</p> <p>A lunch observation was conducted in the dining room on 1/23/20 from 12:23 PM to 1:15 PM. During that time, Resident #3 was sitting in a wheelchair and he was positioned parallel to the end of the table.</p> <p>At 12:57 PM, CNA #1 was standing at the end of Resident #3's wheelchair, next to his right foot. CNA #1 proceeded to cut Resident #3's lunch food items and then feed him, one bite at a time while standing. CNA #1 turned and asked a nearby CNA if Resident #3 used a straw to drink fluids. The nearby CNA mumbled an inaudible response and left the area. CNA #1 continued to stand and feed Resident #3.</p> <p>At 1:03 PM, CNA #1 left the table and obtained a straw from a container which was located in the front of the dining room. CNA #1 returned to the table, removed the paper from the straw, and put the straw into a bottle of chocolate milk. CNA #1 then held the bottle with the straw to Resident #3's mouth and Resident #3 then drank some milk. After drinking some milk, CNA #1 continued to feed Resident #3 his lunch while standing.</p> <p>When asked, CNA #1 stated at 1:11 PM, she did not know Resident #3's last name. CNA #1 stated it was her second day at the facility and "I was</p>	F 550	<p>and what corrective action will be taken:</p> <p>Dining room audit was conducted to ensure that those residents who require feeding assistance, were fed while the staff were seated.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>The facility in-serviced nursing staff regarding resident rights associated with feeding residents who require assistance, and the need to be seated while assisting.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>↳ DON or designee will audit the dining room service weekly X4, monthly X2, to ensure that staff are following facility policy when feeding residents who need assistance. These audits will be reviewed monthly by the QAPI committee until it is determined by the committee that the systems are effective.</p>		

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F 550	Continued From page 3 trained on his (Resident #3's) eating requirements today."  At 1:15 PM, CNA #1 moved an empty chair close to Resident #3. CNA #1 sat down and continued to feed Resident #3.  CNA #1's training record included a Comprehensive Clinical Competency Review - Skills Checklist which documented each of the skills listed were "Met" on 1/22/20. The document included Preservation of Resident Dignity and Eating Support tasks but did not include specific information of what skills were included in the tasks or how the competencies were verified. CNA #1's training record also included courses for the facility which were computer-based learning.  On 1/24/20 at 2:35 PM, the DON stated the Eating Support task consisted of "being shown and working with residents in the dining room." The DON stated CNA #1 was standing because her trainer had to do the same thing as she (the trainer) could not reach Resident #3 if she sat down.  The facility failed to ensure Resident #3's right to be treated with respect and dignity while dining was upheld.	F 550			
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4)  §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or	F 585		3/6/20	

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F 585	<p>Continued From page 4</p> <p>reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.</p> <p>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.</p> <p>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.</p> <p>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:</p> <p>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey</p>	F 585			

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F 585	Continued From page 5 Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility	F 585			

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F 585	<p>Continued From page 6</p> <p>or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, review of facility grievances, and resident and staff interview, it was determined the facility failed to ensure grievances were responded to and investigated, and prompt corrective action was taken to resolve the grievances. This was true for 7 of 14 residents (Residents #2, #3, #7, #12, #13, #15, and #18) reviewed for grievances. This failure created the potential for harm if verbal and written grievances were not acted upon and residents were not provided appropriate care to meet their needs. Findings include:</p> <p>The facility's Grievance Reports, dated 6/12/19 to 1/7/20, did not include evidence the incidents were thoroughly investigated, and that corrective action was taken to prevent reoccurrence.</p> <p>On 1/24/20 at 1:15 PM, when asked for documentation related to investigations and corrective action regarding the facility's grievances the Administrator provided a stack of folders and stated the documentation was in the folders, and if there was no folder, then there was no documentation of an investigation or corrective action taken.</p>	F 585	<p>Corrective actions taken for those residents who may have been affected by this deficiency:</p> <p>∩∩</p> <p>Resident #2 was checked to ensure bed sheet was in place and water was in cup &amp; provided in an appropriate location.</p> <p>Resident #12 is no longer in the facility</p> <p>Resident #7 is no longer in the facility</p> <p>Resident #13 shower schedule and task list was audited and had received showers as scheduled. The resident's room was audited for cleanliness and cleaned. No smell of BM was noted.</p> <p>Resident #3 CNA Task Sheets were audited and demonstrated frequent per care. Resident's wife was interviewed and is happy with care.</p> <p>Resident #15 is no longer in the facility</p> <p>Resident #18 is no longer in the facility</p>		

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F 585	<p>Continued From page 7</p> <p>The facility's Grievance Reports did not include documentation grievances were thoroughly investigated and corrective action was taken to prevent reoccurrence, as follows:</p> <p>a. A Grievance Report, dated 6/12/19, stated "[Resident #2's daughter] visited on 6/2/19 and 6/9/19 around 11:30 AM each day when she noticed [Resident #2] did not have any water in her cup. [The daughter] stayed for a while on each visit but nobody came by to refill it on either day. [The daughter] also noticed that [Resident #2] did not have a sheet on her bed on either day, even though [Resident #2] was in bed. [The daughter] checked with [a staff] on 6/2 and she said the sheet was in the wash. When [the daughter] returned on 6/9/19 there was still no sheet."</p> <p>The investigation section of the Grievance Report stated "Nurse UM [Unit Manager] called [Resident #2's daughter] to discuss plans to do better." Under the resolution section of the report it stated the nurse called Resident #2's daughter.</p> <p>The report did not include documentation of steps taken to investigate the grievance. There was no documentation corrective action was taken to prevent reoccurrence.</p> <p>There was no folder with additional investigation information or corrective action for the grievance dated 6/12/19 for Resident #2.</p> <p>b. A Grievance Report, dated 7/12/19 at 2:45 p.m., stated Resident #12 "...pushes call light - response time is 1 - 1 ½ hr [hours] which isn't acceptable...he pushes call light - no one comes</p>	F 585	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All resident are at risk. All residents will be interviewed to ensure that they feel safe and well cared for. Any negative result will be handled according to the facilities grievance and abuse policies.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Facility initiated an investigation checklist to ensure completion of a thorough investigation.</p> <p>Administrator and DON were in-serviced by clinical resource on the facility's abuse and grievance policy and procedures. The Administrator then in-serviced, Unit Managers and LSWs.</p> <p>Facility IDT will conduct a daily review of all grievances to ensure that investigations are performed and documented and corrective action was taken to prevent reoccurrence. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>Administrator will audit all grievances weekly X4 and monthly X2, to ensure that investigations are performed and</p>		

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F 585	<p>Continued From page 8</p> <p>so he wets himself...Needs pain med - Norco (not getting it)."</p> <p>The investigation section of the Grievance Report stated, "interview of clinical staff, rehab staff, and other residents." Under the resolution section of the report it stated informal education with staff regarding follow through, prioritization, communication, and job expectations."</p> <p>The report did not include documentation of steps taken to investigate the grievance. There was no other documentation that corrective action was taken to prevent reoccurrence.</p> <p>A folder was received for the Grievance Report, dated 7/12/19, which contained a handwritten note of an interview with Resident #12 which stated the facility could request the pain medication be scheduled, a toileting schedule may help, and a call light audit would be initiated to address the long wait times. The folder also contained a page from the resident's care plan which stated that as of 7/12/19, the resident was scheduled to be toileted every morning, before meals, before bed and as needed. The folder also contained a physician order, dated 7/12/19, that documented Norco was changed to a scheduled medication in addition to as needed. The folder also contained a call light audit, dated 7/17/19, which was handwritten that documented a call light audit was conducted from 1:00 to 1:30 PM for three rooms and three call lights. There was no documentation staff were interviewed, other residents were interviewed, or staff were educated.</p> <p>c. A Grievance Report, dated 7/31/19, stated</p>	F 585	<p>documented and corrective action was taken to prevent reoccurrence. These audits will be reviewed monthly by the QAPI committee until it is determined by the committee that the systems are effective.</p>		

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F 585	<p>Continued From page 9</p> <p>"[Resident #7] had a complaint about how [a staff] handled his bag last night (7/30/19). He said she pushed on one side of the bag which caused the other side to balloon. Then she 'smacked' the ballooned side to make it go down which was very uncomfortable. He also added that she typically turns her head away while handling the bag because the doesn't like it."</p> <p>The investigation section of the Grievance Report stated the LSW and DON interviewed Resident #7 and he felt staff do not know how to care for his colostomy bag (a bag which collects stool from the digestive tract through an opening in the abdomen). Under the resolution section the report stated staff education was to be done and staff who worked on the hall of Resident #7 regularly were to be signed off on a skills check on how to properly care for a colostomy bag.</p> <p>The report did not include documented evidence of staff and resident statements, and staff education related to care of the colostomy bag. There was no other documentation that corrective action was taken to prevent reoccurrence.</p> <p>A folder was received for the Grievance Report, dated 7/31/19, which contained a typed statement of the interview conducted with Resident #7. No other documentation was present in the folder.</p> <p>d. A Grievance Report, dated 8/5/19, by Resident #13's daughter stated "[Resident #13] has not been given her baths 2 x a week. It has been 2 weeks her [sic] last bath. Need more aids... [Resident #13's] floor [sic] room dirty. Everytime</p>	F 585			

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F 585	<p>Continued From page 10 [sic] I come it smells of BM [bowel movement]."</p> <p>The investigation section of the Grievance Report stated the LSW reviewed Resident #13's shower records and found she had received consistent showers. Under the resolution section of the report it stated, "Gave copy to Head of Housekeeping [sic] central supply researching a charcoal product for bathrooms."</p> <p>The report did not include documentation of steps taken to investigate the grievance. There was no other documentation that corrective action was taken to prevent reoccurrence. There was no folder for the grievance dated 8/5/19.</p> <p>e. A Grievance Report, dated 8/9/19, stated "[Resident #3's wife] requested [Resident #3] be moved back to 400 hall because she is not happy with his cares on 200. She said each time she has visited since the move she has found him wet. She added that 1 ½ - 2 hour waits for him to get changed are not uncommon on 200, either. She one had to get onto [a nurse] because she asked him to have the CNA's [sic] change [Resident #3] prior to the last care conference. After the care conference ended she found [Resident #3] had still not been changed. [Resident #3's] wife] brought it up to [the nurse] once again and he personally made sure [Resident #3] was changed. [Resident #3's wife] was also not happy with Resident #3's hygiene on 200. She said he is not clean and his face is not shaved often enough. [Resident #3] needs his mustache trimmed/shaped 2x weekly and the rest of his facial hair shaved."</p> <p>The investigation section of the Grievance Report</p>	F 585			

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F 585	<p>Continued From page 11</p> <p>stated the DON and Unit Manager were notified and the Unit Manager was going to observe Resident #3 more frequently to ensure he was clean, groomed, and changed. It also documented the hospice agency and facility shower aides were made aware facial grooming was part of showering and/or bathing. The resolution section of the report stated "Can't move patient back to 400 but now receiving more frequent checks for incontinence + facial hair."</p> <p>The report did not include documentation of steps taken to investigate the grievance. There was no other documentation that corrective action was taken to prevent reoccurrence.</p> <p>A folder was received for the Grievance Report, dated 8/9/19, which contained pages from Resident #3's care plan which documented that as of 8/15/19, he was to be toileted every 2 hours and every night. The folder also contained a Disciplinary Notice, dated 8/12/19, which documented a CNA was counseled on grooming residents during their showers. No other documentation was present in the folder.</p> <p>f. A Grievance Report, dated 8/12/19, stated "[Resident #15's daughter] called very angry about a few things...A couple weeks ago a 'little Mexican Boy' brought [Resident #15] his dinner tray. Family thinks he belonged to one of the staff members. [Resident #15's daughter] estimated his age to be about 10, maybe younger. Family very upset about infection control. Family upset about how 'no one cares to feed him.' [Resident #15's daughter] said [Resident #15's] wife has been coming in more often to feed him PM meals because staff doesn't help."</p>	F 585			

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F 585	Continued From page 12  The investigation section of the Grievance Report stated "Staff educated to make sure volunteers are not passing hall trays. Staff educated [Resident #15] will need to be fed @ [at] meal time." The resolution section of the report stated "Nursing educated staff on other matters."  The report did not include documentation of steps taken to investigate the grievance. There was no other documentation that corrective action was taken to prevent reoccurrence.  A folder was received for the Grievance Report, dated 8/12/19, which contained 2 handwritten notes, dated 8/12/19, which documented the DON interviewed 2 staff who reported Resident #15 was refusing to eat and the staff were re-approaching him to eat and drink. The folder also contained an In-service Attendance Record, dated 8/12/19, which stated volunteers and staffs' families were not to pass linens, meal trays, or water pitchers and it was signed by 13 staff.  g. A Grievance Report, dated 1/9/20, stated that Resident #18 reported "Evening of Jan. 7th [nurse] came in to give my me meds - She set them on my table & left - - then came in hurriedly and asked if I had take the pills yet ...I said no ...she said good, because they're the wrong ones. Then I rang for my pain meds at 1:00 am (Jan 8th) the CNA said she'd give [a nurse] the message...An hour had passed & it's now 2:00 am & I rang my call button again. The aide asked me what I wanted & I told her it's been a [sic] hour since I asked for my pain meds & I'm in pain. She was startled & brought her in her [sic] w/ [with] my meds - - I asked her what happened,	F 585			

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F 585	<p>Continued From page 13</p> <p>she said she had given them to someone else! I asked if her [other resident] name was 'Nancy' too? She said no, it was [proper name]. So I just said thank you &amp; she left."</p> <p>The investigation section of the Grievance Report stated, "Education &amp; counseling [sic] provided to nurse regarding 6 rights of medication administration." The resolution section stated "Education provided to nurse. Patient notified."</p> <p>The report did not include documentation of steps taken to investigate the grievance. There was no other documentation that corrective action was taken to prevent reoccurrence.</p> <p>A folder was received for the Grievance Report, dated 1/9/20, which contained a handwritten note, dated 1/9/20, which stated Resident #18 was interviewed and that "...she believed it took [the nurse] too long to deliver meds." The folder also contained a handwritten note from the nurse, dated 1/7/20, which stated "Patient asked for pain medication. This nurse went to retrieve pain medication. This nurse realized was in room 514 &amp; not in room 510. Room 510 medication in med cup on side table next to patient. Once pain medication retrieved for patient [sic]. Ask [sic] patient in room 514 'You didn't take medication in cup yet?' Patient stated, 'no.' Informed patient that the medication was for the patient next door."</p> <p>The folder also contained a Disciplinary Notice, dated 1/9/20, which documented the nurse was counseled on the 6 rights of medication administration and timeliness of medication administration. The folder also contained a copy</p>	F 585			

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F 585	Continued From page 14 of Resident #18's Narcotic Record for Tramadol 50 mg.  When asked about the grievance reports, the Administrator stated on 1/24/20 at 10:55 AM, he was the Abuse Coordinator and he reviewed all grievances.  On 1/24/20 at 1:15 PM, the Administrator provided the survey team with a folder which documented that on 12/19/19, past grievances, reporting procedures, the abuse policy, investigation protocols, and corrective action were reviewed during an in-service with the facility's social workers and DON.	F 585			
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1)  §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.  §483.12(a) The facility must-  §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		3/6/20	

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F 600	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, review of grievance reports, and staff interview, it was determined the facility failed to ensure residents were free from abuse and neglect for 2 of 14 residents (Residents #16 and #17) whose grievance reports were reviewed. This resulted in the potential for residents to be subjected to ongoing abuse and neglect. Findings include:</p> <p>The facility's Abuse policy, updated 4/2019, stated "It is the policy of this Facility [sic] that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The Facility [sic] will provide oversight and monitoring to ensure that its staff, who are agents of the Facility [sic], deliver care and services in a way that promotes and respects the rights of the residents to be free from abuse, neglect, misappropriation of resident property, and exploitation...All allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the Administrator or his/her designee...The investigation, and the results of the investigation, will be documented."</p> <p>The policy included the following definitions:</p> <p>- Abuse: "is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of</p>	F 600	<p>Corrective actions taken for those residents who may have been affected by this deficiency:</p> <p>Resident #16 is no longer in the facility.</p> <p>Resident #17 is no longer in the facility. 22</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All resident are at risk. All residents will be interviewed to ensure that they feel safe and well cared for. Any negative result will be handled according to the facilities grievance and abuse policies.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>All staff were in-serviced on the facilities abuse and grievance policies.</p> <p>Administrator, DON, Unit Managers and LSWs were in-serviced by clinical resource on the facilities abuse and grievance policies.</p> <p>Administrator and DON were in-serviced by clinical resource on the facility's abuse and grievance policy and procedures. The Administrator then in-serviced, Unit Managers and LSWs.</p>		

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F 600	<p>Continued From page 16</p> <p>any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse...Willful, as used in this definition of abuse, means the individual must have acted deliberately..."</p> <p>- Mistreatment: "means inappropriate treatment or exploitation of a resident."</p> <p>- Misappropriation of resident property: "means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of resident's belongings or money without the resident's consent."</p> <p>- Neglect: "is the failure of the Facility [sic], its employees or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress."</p> <p>- Verbal Abuse: "includes the use of oral written, or gestured language that willfully includes disparaging and derogatory terms to residents or their representatives, or within their hearing distance, regardless of their age, ability to comprehend, or disability."</p> <p>The policy also documented investigations would include the following "an interview with the person(s) reporting the incident; an interview with the resident(s); interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate; a review of the resident's medical records; an interview with staff members (on all shifts) who may have information regarding the alleged incident; interviews with other residents</p>	F 600	<p>Facility initiated an investigation checklist to ensure completion of a thorough investigation.</p> <p>Facility IDT will conduct a daily review of all grievances to ensure that investigations are performed and documented and corrective action was taken to prevent reoccurrence.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>• Administrator will audit all grievances weekly X4 and monthly X2, to ensure that investigations are performed and documented and corrective action was taken to prevent reoccurrence. These audits will be reviewed monthly by the QAPI committee until it is determined by the committee that the systems are effective.</p>		

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F 600	<p>Continued From page 17</p> <p>to whom the accused employee provides care or services or who may have information regarding the alleged incident; an interview with staff members (on all shifts) having contact with the accused employee; and a review of all circumstances surrounding the incident."</p> <p>The facility's Grievance Reports, dated 6/12/19 to 1/7/20, included allegations of abuse, neglect, and misappropriation of resident property, as follows:</p> <p>a. A Grievance Report, dated 10/18/19, stated Resident #16 reported that on the evenings of 10/16/19 and 10/17/19, he was " ...left dirty all evening...She [a CNA] said I talk down to her - got mad...She [a CNA] made me suffer...Didn't turn me at all...She [a CNA] made me feel bad - had a bad attitude."</p> <p>The investigation section of the Grievance Report stated, "staff [sic] education regarding caring for patients and how we speak to them. Staff member kept out of patient's room." Under the resolution section of the report it stated staff education was provided and Resident #16's "wishes" were honored and the CNA was not to enter his room.</p> <p>The report did not include documentation of steps taken to investigate the allegation further. There was no other documentation that corrective action was taken to prevent reoccurrence.</p> <p>A folder was received from the Administrator on 1/24/20 at 1:15 PM. The Administrator stated any documentation related to the allegation was in</p>	F 600			

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NAME OF PROVIDER OR SUPPLIER  <b>CREEKSIDE TRANSITIONAL CARE AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</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 600	<p>Continued From page 18</p> <p>the folder and if it was not in the folder he did not have it. For the Grievance Report, dated 10/18/19, which contained a handwritten note from the LSW, dated 10/17/19, which stated the LSW talked with Resident #16 and his wife, and Resident #16 stated the CNA "was impatient and rude" and did not want the CNA to care for him. The handwritten note also documented the LSW talked with the Nurse Manager who agreed to coordinate with staff so other CNAs would care for Resident #16. The folder contained a handwritten note from the CNA, dated 10/22/19, who stated the only thing she could think of was Resident #16 stated the air mattress on his bed was flat two times and she (the CNA) stated it had air in it and Resident #16 then yelled at her. The folder also contained a typed note from an RN, dated 10/17/19, which stated the RN talked with Resident #16 who stated, "she was mean and he didn't like her [the CNA]." The typed note stated "After speaking with the patient I came to the conclusion that it was a conflict of personalities. I counseled [the CNA] to continue helping the other patients on the hall and that I would assign the NOC [night shift] CNA to [Resident #16]."</p> <p>b. A Grievance Report, dated 12/13/19, stated Resident #17 reported "I had wet myself and gotten myself to the toilet, removed my clothes and hung them on the rod by the toilet. I rang for the nurse who came in, I told her I had hung my pants on the rail so she could see that they were soiled from the wound on my hip and butt cheeks [sic], and she looked frustrated and yelled 'I don't do laundry' and I said I didn't ask you to do laundry, I just want someone to help me clean myself up. I had regular clothes there to</p>	F 600			

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F 600	<p>Continued From page 19</p> <p>put on and she said you need regular briefs, I told her to look in the drawer and she got mad and I said let's just put on pajamas." Resident #17's daughter stated, "When I got here I found my mom on the toilet alone &amp; crying."</p> <p>The investigation section of the report stated staff and family statements were obtained and they were interviewed. It also stated the IDT was going to determine the steps for resolution. The resolution section of the Grievance Report, dated 12/16/19, stated staff education was going to be provided to assist the CNA in identifying when to involve a nurse for resident care and the CNA "misunderstood" Resident #17's "request."</p> <p>A typed statement from an RN, dated 12/13/19, was attached to the Grievance Report which stated "[Resident #17] stated that she had asked [the CNA] to look at her wet pants and tell her the amount of drainage from her wound was present. She stated that [the CNA] turned sharply and said that she did not do laundry. [Resident #17] then stated that attempted [sic] to explain what she meant to [the CNA] and [the CNA] ignored her and walked out...The family stated that when she called them and they had arrived; [sic] [Resident #17] was in tears in her room...They felt [the CNA] had been abrasive and short with their mother and they did not want her back in. Resident #17 also stated at this time that she did not want [the CNA] back in her room." The typed note from the RN stated the CNA "...explained that she hadn't been sharp with the patient and she hadn't snapped at her over the laundry and that she was answering multiple call lights and told [Resident #17] that she couldn't check over the garments at the time."</p>	F 600			

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F 600	Continued From page 20  There was also a handwritten statement from the CNA attached to the Grievance Report, dated 1/13/19 [sic], which stated there were 3 or 4 call lights on about 9:00 pm. I went into [Resident #17's] room [room number] to see what she needed. She told me she needed cleaned up, the floor cleaned & her garments cleaned...I told her I could clean her and the floor up but I would have to come in a little later to rinse her clothes better because of the call lights..."  The report did not include documentation of steps taken to investigate the allegation. There was no other documentation that corrective action was taken to prevent reoccurrence.  On 1/24/20 at 10:55 AM, the Administrator stated he was the Abuse Coordinator and he reviewed all grievances.  On 1/24/20 at 1:15 PM, the Administrator provided a folder which documented that on 12/19/19, past grievances, reporting procedures, the abuse policy, investigation protocols, and corrective action were reviewed during an in-service with the facility's social workers and DON. There was also documentation all staff were in-serviced on the abuse policy on 1/8/20.  The facility failed to ensure residents were free from abuse and neglect.	F 600			
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12  §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 602		3/6/20	

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F 602	<p>Continued From page 21</p> <p>and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of policies, review of facility grievances, and staff interview, it was determined the facility failed to ensure a resident was free from potential misappropriation of their wedding ring for 1 of 14 residents (Resident #10) whose grievances were reviewed. This failed practice had the potential to result in psychosocial distress due to the loss of a personal item with inherent value. Findings include:</p> <p>Resident #10 was admitted to the facility on 3/16/19, with diagnoses which included diabetes and anxiety.</p> <p>A Grievance Report, dated 6/26/19, stated "[Resident #10] is missing a ring since around mid-June. It is a gold wedding ring that is soldered together. Yellow gold, diamond on top, with two smaller diamonds." The Grievance Report stated the LSW searched Resident #10's room and nursing searched through 5 trash bags but did not find the wedding ring.</p> <p>The investigation section of the Grievance Report stated the social worker searched Resident #10's room and checked with the nurse's cart, reception and laundry. Under the resolution section of the report it stated the LSW searched Resident #10's room and nursing searched 5 trash bags but they were unable to find the wedding ring.</p>	F 602	<p>Corrective actions taken for those residents who may have been affected by this deficiency:</p> <p>Resident #10 is no longer in the facility.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All resident are at risk. All residents will be interviewed to ensure that they feel safe and well cared for. Any negative result will be handled according to the facilities grievance and abuse policies.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>All staff were in-serviced on the facilities abuse and grievance policies.</p> <p>Administrator and DON were in-serviced by clinical resource on the facility's abuse and grievance policy and procedures. The Administrator then in-serviced, Unit Managers and LSWs.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the</p>		

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F 602	Continued From page 22  The Grievance Report documented the grievance was not resolved as of 6/26/19, and Resident #10's granddaughter, who filed the grievance, was contacted by email on 7/18/19, 22 days later. There was no further documentation regarding the missing wedding ring.  A folder was received from the Administrator on 1/24/20 at 1:15 PM. The Administrator stated any documentation related to the allegation was in the folder and if it was not in the folder he did not have it. For the Grievance Report, dated 6/26/19, the folder contained an undated and unsigned Inventory of Personal Effects for Resident #10 which had "Reviewed for lost ring" handwritten at the top of the form. No other documentation was present in the folder.  On 1/24/20 at 10:55 AM, the Administrator stated he was the Abuse Coordinator and he reviewed all grievances.  On 1/24/20 at 1:15 PM, the Administrator provided a folder which documented that on 12/19/19, past grievances, reporting procedures, the abuse policy, investigation protocols, and corrective action were reviewed during an in-service with the facility's social workers and DON.  The facility failed to ensure residents were free from misappropriation of personal property.	F 602	corrective action taken to ensure that this deficiency has been corrected and will not recur:  ¿ Administrator will audit all grievances weekly X4 and monthly X2, to ensure that investigations are performed and documented and corrective action was taken to correct and prevent reoccurrence of lost or stolen resident property. These audits will be reviewed monthly by the QAPI committee until it is determined by the committee that the systems are effective.		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)  §483.12(b) The facility must develop and implement written policies and procedures that:	F 607		3/6/20	

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F 607	<p>Continued From page 23</p> <p>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>§483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on policy review, review of grievance reports, and staff interview, it was determined the facility failed to ensure its policies were implemented to protect residents from misappropriation and potential physical and/or psychosocial harm. This was true for 3 of 14 residents (Residents #10, #16, and #17) whose grievance reports were reviewed. This had the potential to place each of the 99 residents residing in the facility at increased risk for physical and/or psychosocial harm. Findings include:</p> <p>The facility's Abuse policy, updated 4/2019, stated "It is the policy of this Facility [sic] that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The Facility [sic] will provide oversight and monitoring to ensure that its staff, who are agents of the Facility [sic], deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, and exploitation...All allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and</p>	F 607	<p>Corrective actions taken for those residents who may have been affected by this deficiency:</p> <p>Resident #10 is no longer in the facility.</p> <p>Resident #16 is no longer in the facility.</p> <p>Resident #17 is no longer in the facility.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All resident are at risk. All residents will be interviewed to ensure that they feel safe and well cared for. Any negative result will be handled according to the facilities grievance and abuse policies.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Facility initiated an investigation checklist to ensure completion of a thorough</p>		

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F 607	<p>Continued From page 24</p> <p>thoroughly investigated by the Administrator or his/her designee...The investigation, and the results of the investigation, will be documented."</p> <p>The policy also documented investigations would include the following "an interview with the person(s) reporting the incident; an interview with the resident(s); interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate; a review of the resident's medical records; an interview with staff members (on all shifts) who may have information regarding the alleged incident; interviews with other residents to whom the accused employee provides care or services or who may have information regarding the alleged incident; an interview with staff members (on all shifts) having contact with the accused employee; and a review of all circumstances surrounding the incident."</p> <p>The facility's Grievance Reports, dated 6/12/19 to 1/7/20, included allegations of abuse, neglect, and misappropriation of resident property, as follows:</p> <p>a. A Grievance Report, dated 6/26/19, stated "[Resident #10] is missing a ring since around mid-June. It is a gold wedding ring that is soldered together. Yellow gold, diamond on top, with two smaller diamonds." The Grievance Report stated the LSW searched Resident #10's room and nursing searched through 5 trash bags but did not find the wedding ring.</p> <p>The Grievance Report documented the grievance was not resolved as of 6/26/19, and Resident #10's granddaughter, who filed the grievance, was contacted by email on 7/18/19, 22 days</p>	F 607	<p>investigation.</p> <p>All staff were in-serviced on the facilities abuse and grievance policies.</p> <p>Administrator and DON were in-serviced by clinical resource on the facility's abuse and grievance policy and procedures. The Administrator then in-serviced, Unit Managers and LSWs.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>¿ Administrator will audit all grievances weekly X4 and monthly X2, to ensure that investigations are performed and documented and corrective action was taken to correct and prevent reoccurrence. These audits will be reviewed monthly by the QAPI committee until it is determined by the committee that the systems are effective.</p>		

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F 607	<p>Continued From page 25</p> <p>later. There was no further documentation regarding the missing wedding ring.</p> <p>b. A Grievance Report, dated 10/18/19, stated Resident #16 reported that on the evenings of 10/16/19 and 10/17/19, he was "left dirty all evening...She [a CNA] said I talk down to her - got mad...She [a CNA] made me suffer...Didn't turn me at all...She [a CNA] made me feel bad - had a bad attitude."</p> <p>The investigation section of the Grievance Report documented staff were educated on caring for residents and how to speak to them. There was no documentation which staff were educated. The investigation section also documented the staff member was " ...kept out of patients [sic] room."</p> <p>c. A Grievance Report, dated 12/13/19, stated Resident #17 reported "I had wet myself and gotten myself to the toilet, removed my clothes and hung them on the rod by the toilet. I rang for the nurse who came in, I told her I had hung my pants on the rail so she could see that they were soiled from the wound on my hip and butt cheeks [sic], and she looked frustrated and yelled 'I don't do laundry' and I said I didn't ask you to do laundry, I just want someone to help me clean myself up. I had regular clothes there to put on and she said you need regular briefs, I told her to look in the drawer and she got mad and I said let's just put on pajamas." Resident #17's daughter stated, "When I got here I found my mom on the toilet alone &amp; crying."</p> <p>The investigation section of the report stated staff and family statements were obtained and they</p>	F 607			

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F 607	Continued From page 26 were interviewed. It also stated the IDT was going to determine the steps for resolution. The resolution section of the Grievance Report, dated 12/16/19, stated staff education was going to be provided to assist the CNA in identifying when to involve a nurse for resident care and the CNA "misunderstood" Resident #17's "request."  On 1/24/20 at 10:55 AM, the Administrator stated he was the Abuse Coordinator and he reviewed all grievances.  On 1/24/20 at 1:15 PM, the Administrator provided a folder which documented that on 12/19/19, past grievances, reporting procedures, the abuse policy, investigation protocols, and corrective action were reviewed during an in-service with the facility's social workers and DON. There was also documentation all staff were in-serviced on the abuse policy on 1/8/20.  The facility failed to implement their policy to thoroughly investigate and document all allegations of abuse, neglect, and misappropriation.	F 607			
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		3/6/20	

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F 609	<p>Continued From page 27</p> <p>that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on policy review, review of grievance reports, and interview, it was determined the facility failed to ensure allegations of abuse, neglect, and misappropriation of resident property, were reported to the State Survey Agency within 24 hours for 3 of 14 residents (Residents #10, #16, and #17) whose grievance reports were reviewed. This resulted in the potential for adverse outcomes to residents whose abuse, neglect, and misappropriation of resident property was not reported and investigated thoroughly. The findings include:</p> <p>The facility's Abuse policy, updated 4/2019, stated "It is the policy of this Facility [sic] that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The Facility [sic] will provide</p>	F 609	<p>Corrective actions taken for those residents who may have been affected by this deficiency:</p> <p>Resident #10 is no longer in the facility.</p> <p>Resident #16 is no longer in the facility.</p> <p>Resident #17 is no longer in the facility.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All resident are at risk. All residents will be interviewed to ensure that they feel safe and well cared for. Any negative</p>		

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F 609	<p>Continued From page 28</p> <p>oversight and monitoring to ensure that its staff, who are agents of the Facility [sic], deliver care and services in a way that promotes and respects the rights of the residents to be free from abuse, neglect, misappropriation of resident property, and exploitation...All allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the Administrator or his/her designee...The investigation, and the results of the investigation, will be documented."</p> <p>The policy included the following definitions:</p> <ul style="list-style-type: none"> <li>- Abuse: "is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse...Willful, as used in this definition of abuse, means the individual must have acted deliberately..."</li> <li>- Mistreatment: "means inappropriate treatment or exploitation of a resident."</li> <li>- Misappropriation of resident property: "means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of resident's belongings or money without the resident's consent."</li> </ul>	F 609	<p>result will be handled according to the facilities grievance and abuse policies.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>All staff were in-serviced on the facilities abuse, grievance and State reporting policies.</p> <p>Administrator and DON were in-serviced by clinical resource on the facility's abuse and grievance policy and procedures. The Administrator then in-serviced, Unit Managers and LSWs.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>↳ Administrator will audit all grievances weekly X4 and monthly X2, to ensure that investigations are performed and documented and corrective action was taken to correct and prevent reoccurrence and that timely State reporting has occurred. Any negative findings of not reporting will result in Administrator immediately reporting the incident in the State reporting portal. These audits will be reviewed monthly by the QAPI committee until it is determined by the committee that the systems are effective.</p>		

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F 609	<p>Continued From page 29</p> <p>- Neglect: "is the failure of the Facility [sic], its employees or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress."</p> <p>- Verbal Abuse: "includes the use of oral written, or gestured language that willfully includes disparaging and derogatory terms to residents or their representatives, or within their hearing distance, regardless of their age, ability to comprehend, or disability."</p> <p>The facility's Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment policy, revised 11/28/17, stated the facility would ensure all alleged violations were reported to the State Survey Agency.</p> <p>The facility's Grievance Reports, dated 6/12/19 to 1/7/20, which included allegation of abuse, neglect and misappropriation of resident property, did not include evidence the allegations were reported to the State Survey Agency, as follows:</p> <p>a. A Grievance Report, dated 6/26/19, stated "[Resident #10] is missing a ring since around mid-June. It is a gold wedding ring that is soldered together. Yellow gold, diamond on top, with two smaller diamonds." The Grievance Report stated the LSW searched Resident #10's room and nursing searched through 5 trash bags but did not find the wedding ring.</p> <p>The Grievance Report documented the grievance was not resolved as of 6/26/19, and Resident #10's granddaughter, who filed the grievance,</p>	F 609			

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F 609	<p>Continued From page 30</p> <p>was contacted by email on 7/18/19, 22 days later. There was no further documentation regarding the missing wedding ring.</p> <p>b. A Grievance Report, dated 10/18/19, stated Resident #16 reported that on the evenings of 10/16/19 and 10/17/19, he was "left dirty all evening...She [a CNA] said I talk down to her - got mad...She [a CNA] made me suffer...Didn't turn me at all...She [a CNA] made me feel bad - had a bad attitude."</p> <p>The investigation section of the Grievance Report documented staff were educated on caring for residents and how to speak to them. There was no documentation which staff were educated. The investigation section also documented the staff member was " ...kept out of patients [sic] room."</p> <p>c. A Grievance Report, dated 12/13/19, stated Resident #17 reported "I had wet myself and gotten myself to the toilet, removed my clothes and hung them on the rod by the toilet. I rang for the nurse who came in, I told her I had hung my pants on the rail so she could see that they were soiled from the wound on my hip and butt cheeks [sic], and she looked frustrated and yelled 'I don't do laundry' and I said I didn't ask you to do laundry, I just want someone to help me clean myself up. I had regular clothes there to put on and she said you need regular briefs, I told her to look in the drawer and she got mad and I said let's just put on pajamas." Resident #17's daughter stated, "When I got here I found my mom on the toilet alone &amp; crying."</p> <p>The investigation section of the report stated staff</p>	F 609			

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F 609	Continued From page 31 and family statements were obtained and they were interviewed. It also stated the IDT was going to determine the steps for resolution. The resolution section of the Grievance Report, dated 12/16/19, stated staff education was going to be provided to assist the CNA in identifying when to involve a nurse for resident care and the CNA "misunderstood" Resident #17's "request."  On 1/24/20 at 10:55 AM, the Administrator stated he was the Abuse Coordinator and he reviewed all grievances.  On 1/24/20 at 1:15 PM, the Administrator provided a folder which documented that on 12/19/19, past grievances, reporting procedures, the abuse policy, investigation protocols, and corrective action were reviewed during an in-service with the facility's social workers and DON. There was also documentation all staff were in-serviced on the abuse policy on 1/8/20.  The facility failed to ensure allegations of abuse, neglect, and misappropriation of resident property were reported to the State Survey Agency.	F 609			
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the	F 610		3/6/20	

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F 610	<p>Continued From page 32 investigation is in progress.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on policy review, review of grievance reports, and staff interview, it was determined the facility failed to ensure allegations of abuse, neglect, and misappropriation of resident property were thoroughly investigated, and corrective action was taken to prevent reoccurrence for 3 of 14 residents (Residents #10, #16, and #17) whose grievance reports alleged abuse, neglect, and misappropriation of personal property. This resulted in the potential for residents to be subjected to ongoing abuse, neglect, and misappropriation of resident property. Findings include:</p> <p>The facility's Abuse policy, updated 4/2019, stated "It is the policy of this Facility [sic] that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The Facility [sic] will provide oversight and monitoring to ensure that its staff, who are agents of the Facility [sic], deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, and exploitation...All allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and</p>	F 610	<p>Corrective actions taken for those residents who may have been affected by this deficiency:</p> <p>Resident #10 is no longer in the facility.</p> <p>Resident #16 is no longer in the facility.</p> <p>Resident #17 is no longer in the facility.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All resident are at risk. All residents will be interviewed to ensure that they feel safe and well cared for. Any negative result will be handled according to the facilities grievance and abuse policies.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Facility initiated an investigation checklist to ensure completion of a thorough investigation.</p>		

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F 610	<p>Continued From page 33</p> <p>thoroughly investigated by the Administrator or his/her designee...The investigation, and the results of the investigation, will be documented."</p> <p>The policy included the following definitions:</p> <ul style="list-style-type: none"> <li>- Abuse: "is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse...Willful, as used in this definition of abuse, means the individual must have acted deliberately..."</li> <li>- Mistreatment: "means inappropriate treatment or exploitation of a resident."</li> <li>- Misappropriation of resident property: "means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of resident's belongings or money without the resident's consent."</li> <li>- Neglect: "is the failure of the Facility [sic], its employees or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress."</li> <li>- Verbal Abuse: "includes the use of oral written, or gestured language that willfully includes</li> </ul>	F 610	<p>All staff were in-serviced on the facilities abuse and grievance policies.</p> <p>Administrator and DON were in-serviced by clinical resource on the facility's abuse and grievance policy and procedures. The Administrator then in-serviced, Unit Managers and LSWs.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>¿ Administrator will audit all grievances weekly X4 and monthly X2, to ensure that investigations are performed and documented and corrective action was taken to correct and prevent reoccurrence. These audits will be reviewed monthly by the QAPI committee until it is determined by the committee that the systems are effective.</p>		

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F 610	<p>Continued From page 34</p> <p>disparaging and derogatory terms to residents or their representatives, or within their hearing distance, regardless of their age, ability to comprehend, or disability."</p> <p>The policy also documented investigations would include the following "an interview with the person(s) reporting the incident; an interview with the resident(s); interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate; a review of the resident's medical records; an interview with staff members (on all shifts) who may have information regarding the alleged incident; interviews with other residents to whom the accused employee provides care or services or who may have information regarding the alleged incident; an interview with staff members (on all shifts) having contact with the accused employee; and a review of all circumstances surrounding the incident."</p> <p>The facility's Grievance Reports, dated 6/12/19 to 1/7/20, included allegations of abuse, neglect, and misappropriation of resident property. The facility's Grievance Reports did not include evidence that the incidents were thoroughly investigated, and that corrective action was taken to prevent reoccurrence.</p> <p>When asked for documentation related to investigations and corrective action being taken, the Administrator provided a stack of folders on 1/24/20 at 1:15 PM, and stated the documentation was in the folder, and if there was no folder, then there was no documentation of an investigation or corrective action being taken.</p> <p>The facility's Grievance Reports did not include</p>	F 610			

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F 610	<p>Continued From page 35</p> <p>documentation that the incidents were thoroughly investigated, and that corrective action was taken to prevent reoccurrence, as follows:</p> <p>a. A Grievance Report, dated 6/26/19, stated "[Resident #10] is missing a ring since around mid-June. It is a gold wedding ring that is soldered together. Yellow gold, diamond on top, with two smaller diamonds." The report stated the social worker searched Resident #10's room and checked with the nurse's cart, reception and laundry, and nursing searched 5 trash bags.</p> <p>The report did not include documented evidence of staff and resident statements and family interviews. There was no documentation that corrective action was taken to prevent reoccurrence.</p> <p>A folder was received for Resident #10's Grievance Report, dated 6/26/19, which included an undated and unsigned Inventory of Personal Effects which stated, "Reviewed for lost ring."</p> <p>No other documentation was present in the folder.</p> <p>b. A Grievance Report, dated 10/18/19, stated Resident #16 reported that on the evenings of 10/16/19 and 10/17/19, he was "left dirty all evening...She [a CNA] said I talk down to her - got mad...She [a CNA] made me suffer...Didn't turn me at all...She [a CNA] made me feel bad - had a bad attitude." The report stated, "staff education regarding caring for patients and how we speak to them."</p> <p>The report did not include documented staff and</p>	F 610			

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

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F 610	<p>Continued From page 36</p> <p>resident statements and a review of Resident #16's record. There was no other documentation that corrective action was taken to prevent reoccurrence.</p> <p>A folder was received for the Grievance Report, dated 10/18/19, which contained a handwritten note from the social worker, dated 10/17/19, which stated the social worker talked with Resident #16 and his wife, and Resident #16 stated the CNA "was impatient and rude" and did not want the CNA to care for him. The handwritten note also documented the social worker talked with the nurse manager who agreed to coordinate with staff so that other CNAs would care for Resident #16. The folder contained a handwritten note from the CNA, dated 10/22/19, who stated the only thing she could think of was she told Resident #16 that his bed was flat two times and the resident yelled at her. The folder also contained a typed note from an RN, dated 10/17/19, which stated the RN talked with Resident #16 who stated, "she was mean and he didn't like her." The typed note stated "After speaking with the patient I came to the conclusion that it was a conflict of personalities. I counseled [the CNA] to continue helping the other patients on the hall and that I would assign the NOC [night shift] CNA to [Resident #16]."</p> <p>No other documentation was present in the folder.</p> <p>c. A Grievance Report, dated 12/13/19, stated Resident #17 reported "I had wet myself and gotten myself to the toilet, removed my clothes and hung them on the rod by the toilet. I rang for</p>	F 610			

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F 610	<p>Continued From page 37</p> <p>the nurse who came in, I told her I had hung my pants on the rail so she could see that they were soiled from the wound on my hip and butt cheeks [sic], and she looked frustrated and yelled 'I don't do laundry' and I said I didn't ask you to do laundry, I just want someone to help me clean myself up. I had regular clothes there to put on and she said you need regular briefs, I told her to look in the drawer and she got mad and I said let's just put on pajamas." Resident #17's daughter stated, "When I got here I found my mom on the toilet alone &amp; crying." The Grievance report documented "the nurse" was a CNA.</p> <p>The report stated "Staff and family statements were obtained. Staff and family were interviewed after statements received. IDT review to determine steps of resolution. Staff education will be provided to assist CNA in identifying when to involve a nurse in patient's care. CNA misunderstanding patient's request and did not recognize it as a nursing concern. Patient/family education also provide [sic] to clarify role and skill set of CNA and nurse." A typed statement from an RN, dated 12/13/19, stated "[Resident #17] stated that she had asked [the CNA] to look at her wet pants and tell her the amount of drainage from her wound was present. She stated that [the CNA] turned sharply and said that she did not do laundry. [Resident #17] then stated that attempted [sic] to explain what she meant to [the CNA] and [the CNA] ignored her and walked out...The family stated that when she called them and they had arrived; [sic] [Resident #17] was in tears in her room...They felt [the CNA] had been abrasive and short with their mother and they did not want her back in. Resident #17 also stated at</p>	F 610			

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F 610	<p>Continued From page 38</p> <p>this time that she did not want [the CNA] back in her room." The typed note from the RN stated the CNA "...explained that she hadn't been sharp with the patient and she hadn't snapped at her over the laundry and that she was answering multiple call lights and told [Resident #17] that she couldn't check over the garments at the time." The folder also contained a handwritten statement from the CNA, dated 1/13/19 [sic], which stated there were 3 or 4 call lights on about 9:00 pm. I went into [Resident #17's] room [room number] to see what she needed. She told me she needed cleaned up, the floor cleaned &amp; her garments cleaned...I told her I could clean her and the floor up but I would have to come in a little later to rinse her clothes better because of the call lights..."</p> <p>The report did not include documented evidence of additional staff and resident statements and an assessment of staffing levels. There was no other documentation that corrective action was taken to prevent reoccurrence.</p> <p>No folder was received for the Grievance Report dated 12/13/19.</p> <p>When asked about the grievance reports, the Administrator stated on 1/24/20 at 10:55 AM, he was the Abuse Coordinator and he reviewed all grievances.</p> <p>On 1/24/20 at 1:15 PM, the Administrator provided a folder which documented that on 12/19/19, past grievances, reporting procedures, the abuse policy, investigation protocols, and corrective action were reviewed during an in-service with the facility's social workers and</p>	F 610			

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F 610	Continued From page 39 DON, and all staff were in-serviced on the abuse policy on 1/8/20.  The facility failed to ensure all allegations of abuse, neglect, and misappropriation of resident property were thoroughly investigated, and corrective action was taken to prevent reoccurrence.	F 610			
F 697 SS=D	Pain Management CFR(s): 483.25(k)  §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, it was determined the facility failed to ensure adequate pain management was provided to 1 of 9 residents (Resident #9) whose records were reviewed. This failure had the potential to cause the resident to suffer from elevated pain levels for an extended length of time. The findings include:  Resident #9 was admitted to the facility on 1/15/20, with diagnoses including aftercare following knee joint prosthesis (surgical revision of knee replacement) and arthritis of the left knee.  Resident #9's admission MDS assessment, dated 1/21/20, was not yet completed, but stated he had no cognitive impairment.	F 697	Corrective actions taken for those residents who may have been affected by this deficiency:  Resident #9 was assessed for pain and pain medication was immediately administered. The resident's pain medication schedule was reviewed by a medical provider and adjustments were made.  How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:  Facility will conduct pain assessments on all current residents to ensure that PRN	3/6/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/24/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>CREEKSIDE TRANSITIONAL CARE AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</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 697	<p>Continued From page 40</p> <p>Resident #9's baseline care plan, with a focus area for acute/chronic pain, dated 1/17/20, included interventions which stated "...Anticipate need for pain relief and respond immediately to any complaint of pain...Follow pain scale to medicate as ordered..."</p> <p>Resident #9's physician orders, dated 1/15/20, included "...Monitor level of pain using 0-10 scale (0=No pain, 1-3=Mild Pain, 4-5= Moderate Pain, 6-9= Severe Pain, 10=Excruciating Pain) every shift..." The physician orders also included oxycodone tablet (an opioid pain medication) 5 milligrams (mg), give two tablets by mouth every four hours as needed for severe pain scores of 6-9.</p> <p>On 1/23/20 at 12:35 PM, Resident #9 was observed in his room, upright in bed with a lunch tray of food. Resident #9 was observed not eating his lunch. When asked if he did not like the food, he said he could not eat his lunch because of pain. Resident #9 stated he had asked for pain medication approximately 35 minutes earlier. He said a staff person entered the room and turned his call light off. Resident #9 said the staff person said they would let the nurse know. According to Resident #9, no one came back to let him know if he could have his pain medication.</p> <p>On 1/23/20 at 12:36 PM, LPN #1 was observed exiting an empty resident room. She stated she was setting the room up for a new patient. When asked if she was aware Resident #9 had asked for pain medication approximately 35 minutes earlier, she said she was asked by a therapist</p>	F 697	<p>pain medication is managed appropriately. All negative results will be reviewed by DON and corrective action will be taken immediately.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>All licensed nursing staff were in-serviced on timely PRN pain medication administration.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>↳ DON or designee will conduct pain assessments on 20% of the residents from each hall weekly X4 and monthly X2, to ensure that PRN pain medication is managed appropriately. These audits will be reviewed monthly by the QAPI committee until it is determined by the committee that the systems are effective.</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/24/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>CREEKSIDE TRANSITIONAL CARE AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</b>		
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F 697	<p>Continued From page 41</p> <p>approximately one hour earlier if it was time for Resident #9's pain medication. LPN #1 said she told the therapist it would not be time for the medication for approximately one hour. LPN #1 said she was checking to see if it was time for the medication.</p> <p>On 1/23/20 at 2:10 PM, while interviewing LPN #1, Resident #9's MAR was reviewed. Resident #9's MAR documented he received oxycodone 5 mg at 7:19 AM. LPN #1 stated he received another dose of oxycodone at 12:44 PM, for a score of 5, which was almost 1.5 hours past the time he could have received it, according to his physician order.</p> <p>On 1/23/20 at 2:21 PM, LPN #2, the nursing manager for the rehabilitation unit, stated she was the person that entered Resident #9's room when he first activated his call light. She said Resident #9 asked if it was time for his pain medication. She said she visually assessed him for signs of pain, such as grimacing. When asked, LPN #2 confirmed she did not ask Resident #9 if he was in pain, nor did she assess the level of pain. LPN #2 said she went to the nurse's medication cart and wrote a note on the report sheet that Resident #9 wanted something for pain.</p> <p>On 1/23/20 at approximately 2:30 PM, Resident #9 said his surgeon told him not to wait too long to ask for his pain medication. He said the physician said he should "...keep ahead of the pain..." to keep the pain from getting worse.</p> <p>The facility failed to ensure adequate pain management was provided to Resident #9.</p>	F 697			

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F 726 SS=D	<p>Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)</p> <p>§483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).</p> <p>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.</p> <p>§483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure CNAs were able to demonstrate competency in skills and techniques necessary to</p>	F 726	<p>Corrective actions taken for those residents who may have been affected by this deficiency:</p>	3/6/20	

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F 726	<p>Continued From page 43</p> <p>care for residents' dining needs for 1 of 2 residents (Resident #3) who were observed eating lunch and whose records were reviewed. This resulted in the potential for a resident's needs to not be met. The findings include:</p> <p>Resident #3 was admitted to the facility on 4/3/19, with diagnoses which included dementia with Lewy Bodies (protein deposits in the brain).</p> <p>A quarterly Nutritional Evaluation, dated 12/20/19, stated Resident #3 was unable to state his food and fluid preferences, and he required total assistance (one-to-one) with eating and drinking.</p> <p>Resident #3's care plan, initiated on 4/3/19 and revised 4/4/19, stated he required one-person physical assistance to eat.</p> <p>A lunch observation was conducted in the dining room on 1/23/20 from 12:23 PM to 1:15 PM. During that time, Resident #3 was sitting in a wheelchair and he was positioned parallel to the end of the table.</p> <p>At 12:57 PM, CNA #1 was standing at the end of Resident #3's wheelchair, next to his right foot. CNA #1 proceeded to cut Resident #3's lunch food items and then feed him, one bite at a time while standing. CNA #1 was noted to turn and ask a nearby CNA if Resident #3 used a straw to drink fluids. The nearby CNA mumbled an inaudible response and left the area. CNA #1 continued to stand and feed Resident #3.</p> <p>At 1:03 PM, CNA #1 left the table and obtained a straw from a container which was located in the</p>	F 726	<p>CNA #1 was in-serviced on sitting while feeding residents that require feeding assistance and the need to refer to the resident kardex prior to providing care.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All residents are at risk. All nursing staff were trained on the facilities policy and procedure on proper training and staff competency.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Newly hired nursing staff will complete the CMS Staff Competency Assessment upon hire. Staff training will be tailored to the results of the assessment.</p> <p>All nursing staff will be trained on how to properly validate staff competency.</p> <p>SDC or Designee will conduct follow-up competency validation during and post orientation on all new hires.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>↳ DON or designee will observe care provided by newly hired nursing staff to</p>		

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F 726	<p>Continued From page 44</p> <p>front of the dining room. CNA #1 returned to the table, removed the paper from the straw, and put the straw into a bottle of chocolate milk. CNA #1 then held the bottle with the straw to Resident #3's mouth and Resident #3 drank some milk. After drinking some milk, CNA #1 continued to feed Resident #3 his lunch while standing.</p> <p>When asked, CNA #1 stated at 1:11 PM, she did not know the resident's last name. CNA #1 stated it was her second day at the facility and "I was trained on his (Resident #3's) eating requirements today."</p> <p>At 1:15 PM, CNA #1 moved an empty chair near Resident #3. CNA #1 then sat down and continued to feed Resident #3.</p> <p>CNA #1's training record included a Comprehensive Clinical Competency Review - Skills Checklist which documented each of the skills listed were "Met" on 1/22/20. The document included Preservation of Resident Dignity and Eating Support tasks but did not include specific information of what skills were included in the tasks or how the competencies were verified. CNA #1's training record also included courses for the facility which were computer-based learning. The training record documented CNA #1 had not completed a course titled "Protecting Resident Rights in Nursing Facilities" and it was not due by the facility until 3/14/20.</p> <p>On 1/24/20 at 2:35 PM, the DON stated the Eating Support task consisted of "being shown and working with residents in the dining room."</p> <p>The facility failed to ensure CNA #1 maintained</p>	F 726	<p>audit appropriate staff competency. Observations of new hired nursing staff will be conducted weekly X4 and Monthly X2. These audits will be reviewed monthly by the QAPI committee until it is determined by the committee that the systems are effective.</p>		

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

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F 726	Continued From page 45 Resident #3's dignity when assisting him with dining and was able to demonstrate competency in assisting with feeding Resident #3 per his needs.	F 726			



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – 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)

February 12, 2020

Trent Clegg, Administrator  
Creekside Transitional Care and Rehabilitation  
1351 West Pine Avenue  
Meridian, ID 83642-5031

Provider #: 135125

Dear Mr. Clegg:

On **January 24, 2020**, an unannounced on-site complaint survey was conducted at Creekside Transitional Care and Rehabilitation. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008199**

**ALLEGATION #1:**

Residents right to communicate with and have access to persons inside the facility are not upheld including the right to being treated in an environment that promotes maintenance or enhancement of quality of life, and the facility is not providing equal access to quality of care regardless of residents' diagnosis, severity of condition, or payment source.

**FINDINGS #1:**

An unannounced on-site complaint survey was conducted from 1/23/20 to 1/24/20. During the survey, grievances and resident records were reviewed, and observations and interviews were conducted.

During the observations, 7 residents were asked about their experiences in the facility. The residents were asked whether they had access to and communicated with persons inside the facility and whether they had access to quality care. All 7 residents reported they had access to and communicated with people inside the facility and they were pleased with their care and services.

Nine resident records were reviewed. All 9 records contained documented evidence of residents having access and receiving care with outside providers. No concerns were identified in the records.

The facility's Grievance Reports, dated 6/12/19 to 1/7/20, were reviewed. One Grievance Report, dated 7/24/19, stated "A resident's family member has attempted to call and talk to someone about their mother to get an update, but the phone never gets answered. The resident's family member called 3 times on Friday afternoon (7/19/19) between 1:30 - 4:30 pm, letting it ring 40 - 70 times each time, and phone was not answered. She has tried the nurse's station on several halls and her calls are not answered. She also tried called Saturday and Tuesday. " The report stated the social worker provided the daughter with direct phone numbers for various staff and locations. The report did not include documented evidence of staff and resident statements, family interviews, and an assessment of staffing levels. There was no other documentation that corrective action was taken to prevent reoccurrence. A folder was received for the 7/24/19 Grievance Report which contained a staff meeting agenda and staff attendance sheets, dated 7/31/19, which included the topic of answering phones. No other documentation was present in the folder.

The facility's receptionist was asked about the facility's telephone system on 1/24/20 at 1:02 PM. The receptionist stated incoming calls rang 4 times in the administrative office, then it went to human resources, medical records, the main nurse station, and the unit managers' offices. The receptionist stated that after 5:00 PM, the phone was on "nighttime" and then incoming calls rang at all the nurse stations and if not answered, the caller could identify the person they wanted to talk to, and the call would be redirected to the person's answering machine and the caller could leave a message.

When asked about the grievance reports, the Administrator stated on 1/24/20 at 10:55 AM, he was the Abuse Coordinator and he reviewed all grievances. On 1/24/20 at 1:15 PM, the Administrator provided the survey team with a folder which documented that on 12/19/19, past grievances, reporting procedures, the abuse policy, investigation protocols, and corrective action were reviewed during an in-service with the facility ' s social workers and Director of Nursing (DON), and all staff were in-serviced on the abuse policy on 1/8/20.

It could not be determined that residents' right to communicate with and have access to persons inside the facility were not upheld and the facility was not providing access to quality care. Therefore, 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 that pain management is provided to residents consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

**FINDINGS #2:**

During the survey, resident records were reviewed, and observations and interviews were conducted with the following results:

Observations were conducted in the facility on 1/23/20 and 1/24/20. During an observation on 1/23/20 at 12:35 PM., a resident was observed in his room, upright in bed with a lunch tray of food. The resident was observed to not be eating. When asked if he did not like the food, he said he could not eat his lunch because of pain. The resident further indicated he had asked for pain medication approximately 35 minutes earlier. He said a staff person entered the room and turned his call light off. The resident said the staff person said they would let the nurse know. According to the resident, no one came back to let him know if he could have his pain medication.

On 1/23/20 at 12:36 PM, a Licensed Practical Nurse (LPN) was observed exiting an empty resident room. She stated she was setting the room up for a new patient. When asked if she was aware that the resident had asked for pain medication approximately 35 minutes earlier, she said she was asked by a therapist approximately one hour earlier if it was time for the resident's pain medication. The LPN said she told the therapist it would not be time for the medication for approximately one hour. The LPN said she was now checking to see if the resident could have the medication.

On 1/23/20 at 2:10 PM, while interviewing LPN #1, Resident #9's MAR was reviewed. Resident #9's MAR documented he received oxycodone 5 mg at 7:19 AM. LPN #1 stated he received another dose of oxycodone at 12:44 PM, for a score of 5, which was almost 1.5 hours past the time he could have received it, according to his physician order.

On 1/23/20 at 2:21 PM, an interview was conducted with another LPN, who identified herself as the "...nursing manager for the rehabilitation unit." During the interview, it was determined that she was the person that entered the resident's room when he first activated his call light. She said the resident asked if it was time for his pain medication. She said she visually assessed the resident for signs of pain, such as grimacing or other indications of pain. When asked, the LPN confirmed she did not ask the resident if he was in pain, nor did she assess the level of pain. The LPN said she went to the nurse's medication cart and wrote a note on the report sheet that the resident wanted something for pain.

On 1/23/20 at approximately 2:30 PM, the resident was checked to see if his pain was relieved. He confirmed he was feeling better. He said the pain medication "...takes the edge off ... in about 20 to 25 minutes." The resident said his surgeon told him not to wait too long to ask for his pain medication. He said the physician said he should "...keep ahead of the pain..." to keep the pain from getting worse.

During the observations noted above, 6 other residents were asked about their experiences in the facility and whether they had pain and received pain medication. Five residents stated their pain was managed in a timely manner and one resident stated she did not have issues with pain.

Nine resident records were reviewed. Other than the resident observed and interviewed above, resident records contained documented evidence they received pain medications, both routinely and as needed.

The facility failed to ensure pain management was provided to a resident in a timely manner. Therefore, the allegation was substantiated, and deficient practice was identified and cited at F697 as it related to the facility's failure to ensure adequate pain management was provided.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,



Laura Thompson, RN, Supervisor  
Long Term Care Program

LT/lj



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
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FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

February 12, 2020

Trent Clegg, Administrator  
Creekside Transitional Care and Rehabilitation  
1351 West Pine Avenue  
Meridian, ID 83642-5031

Provider #: 135125

Dear Mr. Clegg:

On **January 24, 2020**, an unannounced on-site complaint survey was conducted at Creekside Transitional Care and Rehabilitation. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008205**

**ALLEGATION #1:**

Residents are subjected to abuse and the violations are not thoroughly investigated, and appropriate corrective action is not taken.

**FINDINGS #1:**

An unannounced on-site complaint survey was conducted from 1/23/20 to 1/24/20. During the survey, policies, grievances, and resident records were reviewed, and observations and interviews were conducted.

During the observations, 7 residents were asked about their experiences in the facility and whether they were subjected to abuse and neglect. All 7 residents reported they were not subjected to abuse and neglect and they were treated well by the staff.

The facility's Grievance Reports, dated 6/12/19 to 1/7/20, included 14 allegations of abuse, neglect, and misappropriation of resident property from various residents. The allegations were not reported to the State Survey Agency within 24 hours. Additionally, there was no documented evidence that the allegations were thoroughly investigated, and appropriate corrective action was taken to prevent reoccurrence.

When asked about the grievance reports, the Administrator stated on 1/24/20 at 10:55 AM, he was the Abuse Coordinator and he reviewed all grievances. On 1/24/20 at 1:15 PM, the Administrator provided a folder which documented that on 12/19/19, past grievances, reporting procedures, the abuse policy, investigation protocols, and corrective action were reviewed during an in-service with the facility's social workers and Director of Nursing (DON), and all staff were in-serviced on the abuse policy on 1/8/20.

The facility failed to follow their policies and ensure residents were free from potential abuse, neglect, and misappropriation of resident property, allegations were not reported to the State Survey Agency within 24 hours, and the allegations were not thoroughly investigated, and appropriate corrective action was not taken to prevent reoccurrence.

Therefore, the allegation was substantiated, and deficient practice was identified and cited at F600 as it related to the facility's failure to ensure residents were free from abuse and neglect, F602 as it related to the facility's failure to ensure a resident was free from potential misappropriation of personal property, F607 as it related to the facility's failure to ensure its policies were implemented to protect residents from misappropriation and potential physical and/or psychosocial harm, F609 as it related to the facility's failure to ensure allegations of abuse, neglect, and misappropriation of resident property, were reported to the State Survey Agency within 24 hours, and F610 as it related to the facility's failure to ensure allegations of abuse, neglect, and misappropriation of resident property were thoroughly investigated, and corrective action was taken to prevent reoccurrence.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #2:

The facility is not ensuring that licensed nurses and nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs.

## FINDINGS #2:

During the survey, employee training records and resident records were reviewed, and observations and interviews were conducted.

Observations were conducted in the facility on 1/23/20 and 1/24/20. During the observations, 7 residents were asked about their experiences in the facility and whether staff were able to demonstrate competency in skills and techniques necessary to care for them. All 7 residents reported they had no concerns with the staff and were pleased with their care and services.

During an observation in the dining room on 1/23/20 from 12:23 PM to 1:15 PM, a resident was noted to be sitting in a wheelchair and he was positioned parallel to the end of the table. At 12:57 PM, a Certified Nurse Aid (CNA) was standing at the end of the resident's wheelchair, next to his right foot. The CNA proceeded to cut the resident's lunch food items and then feed him, one bite at a time. The CNA was noted to turn and ask a nearby CNA if the resident used a straw to drink fluids. The nearby CNA mumbled an inaudible response and left the area. The CNA continued to stand and feed the resident. At 1:03 PM, the CNA left the table and obtained a straw from a container which was located in the front of the dining room. The CNA returned to the table, removed the paper from the straw, and put the straw into a bottle of chocolate milk. The CNA then held the bottle with the straw to the resident's mouth and the resident then drank some milk. After drinking some milk, the CNA continued to feed the resident his lunch.

When asked, the CNA stated at 1:11 PM, she did not know the resident's last name. The CNA stated it was her second day at the facility and "I was trained on his (the resident's) eating requirements today."

At 1:15 PM, the CNA was observed to move an empty chair near to the resident. The CNA sat down and continued to feed the resident.

CNA #1's training record included a Comprehensive Clinical Competency Review - Skills Checklist which documented each of the skills listed were "Met" on 1/22/20. The document included Preservation of Resident Dignity and Eating Support tasks but did not include specific information of what skills were included in the tasks or how the competencies were verified. CNA #1's training record also included courses for the facility which were computer-based learning.

When asked, the Director of Nursing (DON) stated during an interview on 1/24/20 at 2:35 PM, the Eating Support task consisted on being shown and working with residents in the dining room. The DON stated the CNA was standing because her trainer had to do the same thing as she (the trainer) could not reach the resident if she sat down.

The DON stated the Eating Support task consisted on being shown and working with residents in the dining room.

The facility failed to ensure the resident was treated with respect and dignity when eating his lunch and the CNA failed to demonstrate competency in skills and techniques necessary to care for the resident's eating and drinking needs.

The allegation was substantiated, and deficient practice was identified and cited at F550 as it related to the facility's failure to ensure each resident's right to be treated with respect and dignity was upheld and F726 as it related to the facility's failure to ensure CNAs were able to demonstrate competency in skills and techniques necessary to care for residents' dining needs.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #3:

Resident representatives' right to exercise the residents' rights to the extent those rights are delegated to representatives is not upheld including the right to be informed of, and participate in, his or her treatment.

#### FINDINGS #3:

During the survey, resident records were reviewed, and observations and interviews were conducted with the following results:

Observations were conducted in the facility on 1/23/20 and 1/24/20. During the observations, 7 residents were asked about their experiences in the facility and whether their rights were upheld. All 7 residents reported their rights were upheld and they were pleased with their care and services.

Nine residents' record were reviewed. All 9 records contained documented evidence of resident representative notifications and participation in the residents' treatment and care. No concerns with notification and participation were identified in the records.

It could not be determined that resident representatives' right to exercise the residents' rights was not upheld including the right to be informed of, and participate in, his or her treatment. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

Trent Clegg, Administrator  
February 12, 2020  
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**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,

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

**Laura Thompson, RN, Supervisor  
Long Term Care Program**

LT/lj