



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN- Director

TAMARA PRISOCK—ADMINISTRATOR
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March 1, 2019

Eric Miller, Administrator
Coeur d'Alene of Cascadia
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Miller:

On **February 15, 2019**, we conducted an on-site revisit and a complaint investigation to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **January 22, 2019**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- **F610 -- S/S: E -- 483.12(c)(2)-(4) -- Investigate/prevent/correct Alleged Violation**
- **F600 -- S/S: D -- 483.12(a)(1) -- Free From Abuse And Neglect**
- **F607 -- S/S: D -- 483.12(b)(1)-(3) -- Develop/implement Abuse/neglect Policies**
- **F609 -- S/S: D -- 483.12(c)(1)(4) -- Reporting Of Alleged Violations**
- **F755 -- S/S: D -- 483.45(a)(b)(1)-(3) -- Pharmacy Srvcs/procedures/pharmacist/records**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 11, 2019**.

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.
- 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*.

As noted in the Bureau of Facility Standards' letters of **October 4, 2018 and December 26, 2018**, following the survey of **October 30, 2018 and December 14, 2018**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **March 14, 2019**, if substantial compliance is not achieved by that time. The findings of non-compliance on **February 15, 2019**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **December 4, 2018**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **December 14, 2018**
- A 'per instance' civil money penalty

Eric Miller, Administrator
March 1, 2019
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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, it will provide you with a separate formal notification of that determination.

If you believe the deficiencies have been corrected, you may contact please contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

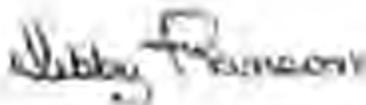
- BFS Letters (06/30/11)

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

This request must be received by **March 11, 2019**. If your request for informal dispute resolution is received after **March 11, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

DR/lj

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/15/2019
NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814		
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{F 000}	INITIAL COMMENTS The following deficiencies were cited during the revisit and complaint survey conducted February 12, 2019 to February 15, 2019. The surveyors conducting the survey were: Teresa Kobza, RDN, LD, Team Coordinator Geri Wolfe, RN Abbreviations: ADL = Activities of Daily Living CNA = Certified Nursing Assistant DNS = Director of Nursing Services IDNS = Interim Director of Nursing Services LPN = Licensed Practical Nurse MDS = Minimum Data Set mg = milligram PRN = As needed RN = Registered Nurse RSSM = Resident Support Services Manager F 600 Free from Abuse and Neglect SS=D 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	{F 000}			
		F 600		3/7/19	

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

TITLE

(X6) DATE

Electronically Signed

03/06/2019

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 600	<p>Continued From page 1</p> <p>physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, resident interview, staff interview, policy review, and review of grievances, it was determined the facility failed to ensure residents were free from verbal abuse for 1 or 13 residents (#147) whose records were reviewed. This deficient practice created the potential for harm if the facility failed to prevent and protect residents from potential incidents of abuse and/or neglect. Findings include:</p> <p>A facility abuse policy and procedure, dated 11/28/17, stated verbal, sexual, physical, and mental abuse, as well as neglect and mistreatment were strictly prohibited. The policy identified characteristics which may increase the risk for abuse to include poor or inadequate training for care giving responsibilities. The policy also documented residents who were at higher risk were those who had psychosocial, interactive, and/or behavioral dysfunction and those who were resistive to cares and services.</p> <p>A facility policy regarding the prevention of abuse, revised on 7/13/18, stated the facility had processes in place to prevent abuse and neglect which included assessment, care planning, and monitoring of residents' needs and behaviors which might lead to conflict or neglect.</p> <p>Resident #147 was admitted to the facility on 2/6/17, with diagnoses including anxiety disorder, chronic pain, and rheumatoid arthritis.</p>	F 600	<p>Resident Specific The ID team reviewed resident #147 grievance. The CNA was suspended pending investigation, the investigation was completed, and the summary reported on the LTC providers reporting portal.</p> <p>Other Residents The ID team and resource RN reviewed the grievance log and event log to validate abuse had been ruled out as indicated. In addition, residents and/or families were interviewed regarding potential concerns related to abuse. Other residents with potential abuse were reported and investigated as indicated.</p> <p>Facility Systems Staff are educated to abuse prevention, identification, and reporting, as well as the grievance process. Re-education was provided by Cascadia Healthcare's parent company Director of Clinical Operations to resource RN and management staff. Administrator, DNS, and/or designee completed training to the balance of staff. Education included but was not limited to implementation of care directives, abuse identification, removal of the alleged perpetrator, protection of the patient, timely reporting, timely and thorough investigation, medical record documentation, and implementation for</p>		

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F 600	<p>Continued From page 2</p> <p>A quarterly MDS assessment, dated 11/19/18, documented Resident #147 was cognitively intact, rejected care 4-6 days during the seven day assessment period, and required extensive assistance of two staff members for bed mobility.</p> <p>Resident #147's care plan, initiated on 5/15/18 and revised on 8/22/18, documented she had anxiety related to angry outbursts and fear of not getting her needs met. The care plan also documented Resident #147 was very particular about who she allowed to perform care, and to honor her choice of staff. Resident #147's care plan also directed staff to reassure her, leave and return in 5 to 10 minutes when she was resistive to care.</p> <p>A grievance form, dated 2/1/19, stated Resident #147 reported an incident to RN #1 that occurred on 1/31/19. The grievance documented Resident #147 was in pain when returning from an appointment the previous night and when CNA #4 was helping her to bed she was thrown around like a "rag doll." The grievance documented Resident #147 felt like she was going to fall when CNA #4 rolled her in the bed and CNA #4 pulled her sweater off causing pain to her hand. Resident #147 stated in the grievance CNA #4 "got in her face" and stated, "I need to get this done." Resident #147 stated she was then too scared to ask for food and was cold and hungry until the night shift came to work.</p> <p>The follow up to the grievance form, dated 2/1/19, included documentation RN #1 spoke to CNA #4 regarding the situation. CNA #4 stated Resident #147 was yelling at her and the other CNA. CNA #4 stated she did roll Resident #147</p>	F 600	<p>the prevention plan, as well as validation of concerns to be noted as a grievance vs an allegation of abuse, if in question, report and investigate as abuse. The system is amended to include team review of grievances in clinical meeting to determine abuse is ruled out and/or next steps. Routine interviews of sampled resident and/or family member to validate potential allegations of abuse have been appropriately addressed.</p> <p>Monitor The resource RN and/or designee will audit grievances for potentially unidentified abuse weekly for 12 week and sampled resident/family interviews monthly for 3 months. Starting the week of March 3, 2019, the review will be documented on the PI audit tool. In addition, Cascadia Healthcare's parent company Director of Clinical Operations and/or designee will review staff education validation, grievance logs, event logs, the reporting portal, and sample resident/family interviews monthly to validate appropriate management of potential allegations and/or allegations of abuse for 3 months. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 600	<p>Continued From page 3</p> <p>to remove the sling and then rolled her back to feel more secure, but Resident #147 kept yelling for her blanket and to get out of the room. CNA #4 stated she did pull Resident #147's sweater and it caught on her fingernail. The grievance form documented CNA #4 was educated on taking time and listening to residents and using two people for concerns of safety.</p> <p>On 2/13/19 at 10:15 AM, Resident #147 stated CNA #1 was training CNA #4 how to move her. When she came back from her doctor's appointment around 4:00 PM, she stated she was having pain from sitting in the wheelchair, so long. Resident #147 stated, "I was in so much pain I wanted to pass out." She stated CNA #1 and CNA #4 got her into the sling and "scrunched" her up in the mechanical lift until her knees were to her chest. Resident #147 said she yelled at the CNAs to let the sling out. She stated CNA #1 was called out of the room and CNA #4 was going to change her. Resident #147 stated she told CNA #4 to wait and CNA #4 just grabbed her and started to roll her over, and she kept telling her to pull her back over. Resident #147 said she was yelling because she was scared and CNA #4 was in her face, and told her she needed to stop yelling and told Resident #147 she was too demanding. Resident #147 said CNA #4 tried to take her sweater off and it got caught on her right ring finger and she thought CNA #4 had broken it. Resident #147 said CNA #4 continued to pull the sling out from under her, causing more pain. Resident #147 stated, "I was cold because the windows were open. She [CNA #4] threw a small blanket over me. I did not want to turn my call light back on." Resident #147 said LPN #2 told her she needed to report the incident</p>	F 600			

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F 600	<p>Continued From page 4</p> <p>with CNA #4. Resident #147 was tearful when she described what happened. Resident #147 stated the facility had not followed up with her about the incident. She stated the incident was scary because she could not defend herself due to her rheumatoid arthritis.</p> <p>On 2/13/19 at 2:10 PM, RN #1 stated she took the grievance on 2/1/19 and she did not consider it an allegation of abuse because CNA #4 told her another story. She stated she gave the grievance to the Executive Director.</p> <p>On 2/13/19 at 2:31 PM, Executive Director #1 said after review of nursing progress notes at the time of the incident, he considered it grounds for employee re-training with on how to care for Resident #147, and did not consider it a reportable incident.</p> <p>On 2/13/19 at 4 PM, CNA #2 stated there were two CNAs Resident #147 trusted to take care of her. CNA #2 stated she had a fear of getting hurt. CNA #2 stated she was in the room with Resident #147 and CNA #4 only once to show CNA #4 how to remove her clothes without causing pain. She stated Resident #147 yelled and screamed when she was in pain. CNA #2 stated, "If she gets upset when I am caring for her and she tells me to stop, I back away and let her regroup. I feel bad for her." CNA #2 stated it took a long time to get Resident #147 dressed and cleaned because of her joints. She stated the resident had a lot of pain.</p> <p>On 2/14/19 at 10:25 AM, CNA #3 stated there were days when Resident #147 refused care, and she would go back later and offer care again.</p>	F 600			

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F 600	<p>Continued From page 5</p> <p>CNA #3 said Resident #147 was pleasant most of the time, but had heard she was not pleasant with some caregivers. CNA #3 said Resident #147 gets nervous when she is rolled back and forth, and she may scream because she is afraid of falling.</p> <p>On 2/14/19 at 10:36 AM, LPN #1 stated "I take care of [Resident #147] occasionally, every other week. She is one of those people who everything you do needs to be orderly. She does refuse peri-care, but I always go in and try to talk to her and try to tell her why she needs care. The resident does not scream when I care for her. She is actually sweet. I have never known the resident to make up stories about staff. If she starts to get upset and escalates her behavior, I leave the room and she is okay."</p> <p>On 2/14/19 at 5:11 PM, LPN #2 stated on the day of the incident, 1/31/19, CNA #4 told her she yelled back at Resident #147 because she was yelling at CNA #4 and she had to get her care done. LPN #2 stated Resident #147 had a lot of pain that evening and explained to her what had happened. LPN #2 stated she did not report it to anyone because she thought it was settled. LPN #2 stated at the time of the incident she was in another hall giving medications and did not hear Resident #147 or CNA #4 yelling.</p> <p>On 2/15/19 at 8:46 AM, CNA #4 stated Resident #147 was very difficult. She stated on 1/31/19 CNA #1 did most of the care getting Resident #147 ready for her doctor's appointment. CNA #4 stated CNA #1 gave direction on what to do to help. CNA #4 stated this was the first day she had cared for Resident #147. She stated</p>	F 600			

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F 600	Continued From page 6 Resident #147 returned from her appointment around 5 or 5:30 PM when dinner was happening. She stated Resident #147 waited about 10-15 minutes to get placed back into bed, and stated Resident #147 kept yelling she wanted to get back in bed now. She stated they used the mechanical lift and transferred her to the bed. CNA #4 stated Resident #147 was yelling we were hurting her, the sling was hurting her, and CNA #1 was getting upset. She stated as soon as they laid her down and got her removed from the lift, CNA #1 left the room. CNA #4 stated, "I began to roll the resident toward the wall and then she was getting scared because there was no one on the other side of her. I then began rolling her toward me. She asked me to be gentle. I took off her shirt and her fingernail got caught in it. I got her pillow situated and a fuzzy blanket on her and gave her a drink and she dismissed me." CNA #4 stated when Resident #147 was in the mechanical lift both she and CNA #1 asked her to quit yelling and Resident #147 replied "I want this done." CNA #4 stated she did not remember if she told LPN #2 about it or not, but she was pretty sure she did. She stated a couple of days later the DNS came and asked her about the incident. CNA #4 stated "I did know she was a two person for the mechanical lift but did not know she was afraid of falling and to use two people for care." CNA #4 stated she had not seen the care plan for Resident #147 and at the time of the incident did not know how to access them.	F 600			
F 607 SS=D	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		3/7/19	

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F 607	Continued From page 7 §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy review, record review, and review of grievances, it was determined the facility failed to ensure abuse policies and procedures were implemented for 2 of 13 residents (#1 and #147) whose records were reviewed. This failure created the potential for harm when residents were not protected and potential abuse was not identified and investigated thoroughly. Findings include: The Facility's Detecting Abuse, Neglect, Misappropriation, and Injuries of Unknown Origin policy, dated 10/31/17, documented when a staff member was suspected of abuse or neglect, "regardless of discipline," they were removed from any resident contact and suspended pending the investigation results. The policy documented a thorough investigation included: * Documenting any observations and being specific in noting the time, location, and exact observation interviews with any person or persons involved who had seen the event or had knowledge of the event,	F 607	Resident Specific The ID team reviewed resident #147 grievance, see F600. The ID team reviewed the grievance for resident #1. The investigation was completed to support the summary already posted on the LTC providers reporting portal. Other Residents The ID team and resource RN reviewed the grievance log and event log to validate abuse had been ruled out as indicated. Other resident with potential abuse were reported and investigated as indicated. Facility Systems Staff are educated to abuse prevention, identification, and reporting, as well as the grievance process. Re-education was provided by Cascadia Healthcare's parent company Director of Clinical Operations to resource RN and management staff. Administrator, DNS, and/or designee		

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F 607	<p>Continued From page 8</p> <p>* Interview notes should be detailed,</p> <p>* The facility should report any allegation of abuse or neglect to the state survey agency within the designated time frame.</p> <p>1. Resident #147 was admitted to the facility on 2/6/17, with diagnoses including anxiety disorder, chronic pain, and rheumatoid arthritis.</p> <p>A grievance form, dated 2/1/19, included documentation Resident #147 reported to RN #1 about an incident that occurred on 1/31/19. The grievance documented Resident #147 was in pain when returning from an appointment the previous night and when CNA #4 was helping her to bed she was thrown around like a "rag doll." The grievance documented Resident #147 felt like she was going to fall when CNA #4 rolled her in the bed and CNA #4 pulled her sweater off causing pain to her hand. Resident #147 stated in the grievance CNA #4 "got in her face" and stated "I need to get this done." Resident #147 stated she was then too scared to ask for food, and was cold and hungry until the night shift came to work.</p> <p>The follow up to the grievance form, dated 2/1/19, included documentation RN #1 spoke to CNA #4 regarding the situation. CNA #4 stated Resident #147 was yelling at her and the other CNA. CNA #4 stated she did roll Resident #147 to remove the sling and then rolled her back to feel more secure but Resident #147 kept yelling for her blanket and to get out of the room. CNA #4 stated she did pull Resident #147's sweater and it caught on her fingernail. The grievance form documented CNA #4 was educated on</p>	F 607	<p>completed training to the balance of staff. Education included but was not limited to implementation of care directives, abuse identification, removal of the alleged perpetrator, protection of the patient, timely reporting, timely and thorough investigation, medical record documentation, and implementation for the prevention plan, as well as validation of concerns to be noted as a grievance vs an allegation of abuse, if in question, report and investigate as abuse. The system is amended to include validation of staff knowledge through post-test and/or surveillance. Re-education is provided as indicated.</p> <p>Monitor The resource RN and/or designee will review reportable events for recognition of potential abuse with implementation of removal of alleged perpetrator, protection of the resident, and timely reporting weekly for 12 weeks. Starting the week of March 3, 2019, the review will be documented on the PI audit tool. In addition, Cascadia Healthcare's parent company Director of Clinical Operations and/or designee will review staff education validation, grievance logs, event logs, the reporting portal, and sample resident/family interviews monthly to validate appropriate management of potential allegations and/or allegations of abuse for 3 months. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the</p>		

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F 607	<p>Continued From page 9</p> <p>taking time and listening to residents and using two people for concerns of safety.</p> <p>There was no documented evidence the facility completed an investigation into Resident #147's grievance of potential verbal and physical abuse. The grievance investigation did not include staff or resident interviews to determine if CNA #4 did abuse Resident #147, progress notes identifying the issues, and/or witness statements. Resident #147's record did not document implementation of preventative measures to protect her from potential abuse. the facility did not suspend CNA #4 after she was accused of verbal and physical abuse by Resident #147 on 2/1/19.</p> <p>The Facility's Daily Staffing sheets documented CNA #4 was working in the facility on 2/2/19, 2/6/19, 2/7/19, 2/8/19, 2/9/19, 2/12/19, and 2/13/19.</p> <p>On 2/13/19 at 2:10 PM, RN #1 said she wrote the grievance on 2/1/19 and she did not consider it an allegation of abuse because CNA #4 told her another story. RN #1 said she gave Resident #147's grievance to the Executive Director after writing it down.</p> <p>On 2/13/19 at 2:15 PM, the Clinical Resource RN said she was not aware of the grievance and she would have treated it "very different." The Clinical Resource RN said she would have investigated it as an allegation of abuse.</p> <p>On 2/13/19 at 2:31 PM, the Executive Director said after he reviewed the nursing progress notes at the time of the incident, "I considered it grounds for employee re-training on how to care</p>	F 607	<p>monitoring after 12 weeks, as it deems appropriate.</p>		

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F 607	<p>Continued From page 10 for [Resident #147]. I did not consider it a reportable incident."</p> <p>2. Resident #1 was admitted to the facility on 9/13/17, with multiple diagnoses including major depression, muscle weakness, and cerebral infarction (stroke).</p> <p>A quarterly MDS assessment, dated 11/9/18, documented Resident #1 was cognitively intact with no behavioral disturbances and required extensive assistance of one to two staff members with all ADL cares except eating.</p> <p>An investigation report, dated 1/22/19, documented Resident #1 requested the presence of the Clinical Resource RN and stated the Executive Director yelled at her in the hallway. The investigation report documented Resident #1 said the Executive Director yelled, "get out of here, you don't need to be part of this meeting." The investigation documented the Executive Director called a staff meeting in the hallway near the nurses' station to announce the current DNS was stepping down from her position. The summary documented Resident #1 was asked to continue to her room as the announcement was for staff.</p> <p>The investigation report, dated 1/22/19, documented social services conducted interviews with multiple residents regarding staff yelling at residents. The investigation report documented the Clinical Resource RN interviewed the Executive Director and the current DNS.</p> <p>The investigation report, dated 1/22/19, documented Resident #1 was headed down the</p>	F 607			

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F 607	<p>Continued From page 11</p> <p>hallway near the nurses' station towards her room. The report documented Resident #1 was a "gossip" and was moving her wheelchair slowly near the nurses' station. The report also documented the Executive Director told Resident #1 the meeting was for the staff and she would have to leave the area for a short period of time, and Resident #1 became angry and stated she was headed to her room anyway and did not want to be part of the meeting. The investigation report documented "Based off the staff interviews and multiple people witnessing the incident, abuse and neglect was ruled out."</p> <p>The Executive Director's statement dated, 1/22/19 at 2:48 PM, documented the Executive Director recalled saying something close to, "This is a meeting for employees, [Resident #1's name]." The statement documented Resident #1 stated she was headed to her room and did not want to listen.</p> <p>The DNS statement, dated 1/22/19, documented the Executive Director stated to Resident #1 in the hallway the meeting was "for staff only." The statement documented Resident #1 continued down the hallway towards her room and stated, "I don't wanna hang out anyway."</p> <p>The investigation report did not include documentation of the other staff members who were interviewed regarding the event, a witness statement from the resident, or other resident interviews. The investigation report documented four different versions of the incident (Clinical Nurse RN, Executive Director, the DNS, and Resident #1) of what the Executive Director said to Resident #1.</p>	F 607			

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F 607	Continued From page 12 Resident #1's record did not contain a progress note on 1/22/19 regarding the alleged abuse. A report, dated 1/24/19, documented training was provided by the Clinical Resource RN to the Executive Director The training consisted of speaking in a calm manner, being at eye level with the resident when talking, and not utilizing resident areas for staff meetings. The training was signed by the Executive Director on 2/12/19, 19 days later. On 2/13/19 at 10:18 AM, Resident #1 stated a couple of weeks ago the Executive Director yelled at her in front of at least 15 staff members to go to her room and the Executive Director stated the meeting was for "staff only" and it "did not include her." Resident #1 stated an unnamed staff member accused her of stopping her wheelchair in the hallway to eavesdrop. Resident #1 stated the number of people in the hallway hindered her from getting to her room, which was where she was headed. Resident #1 stated she had to slow down to keep from running over staff members. Resident #1 stated the facility had not followed up with her regarding the situation and the Executive Director had not left the building for the duration of the investigation. Resident #1 stated she was trying to avoid the Executive Director because he had not apologized for yelling at her. On 2/13/19 at 2:10 PM, the Clinical Resource RN stated she had investigated the abuse allegation and she was present when it occurred. The Clinical Resource RN stated the staff were gathering in the hallway near the nurses' station	F 607			

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F 607	Continued From page 13 to meet for an announcement. The Clinical Resource RN stated she could not tell if Resident #1 was slowing down because there were people in the hallway or if she wanted to listen to what was happening. The Clinical Resource RN stated she could not remember the exact words exchanged between the Executive Director and Resident #1 and stated what was said was in the investigation report. The Clinical Resource RN stated she did not realize her report did not reflect her presence at the incident and did not include other staff members' interviews, other than the Executive Director and the DNS. The Clinical Resource RN stated she did not suspend the Executive Director during the investigation because it was completed so fast. The Clinical Resource RN stated she educated the Executive Director on his conduct and how to approach residents in the hallway. On 2/13/19 at 2:45 PM, the Executive Director stated on 1/22/19 during shift change and staff members had gathered in the hallway for an announcement. The Executive Director stated Resident #1 had plenty of room to go around and did not need to slow down. The Executive Director stated what he said to Resident #1 was in his statement. The Executive Director stated he could tell Resident #1 was upset and not happy with what he said. The Executive Director stated he was still in the facility [not suspended] during the investigation. The Executive Director stated he received education on 1/24/19 regarding how to interact with residents to prevent this situation from occurring in the future.	F 607			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		3/7/19	

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F 609	<p>Continued From page 14</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</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 staff interview, record review, policy review, and review of grievances, it was determined the facility failed to ensure all allegations of potential abuse were reported to the State Survey Agency within 2 to 24 hours for 1 of 13 residents (#147) reviewed for abuse/neglect. The deficient practice created the potential for harm if abuse was not reported and</p>	F 609	<p>Resident Specific The ID team reviewed resident #147 grievance, see F600.</p> <p>Other Residents The ID team and resource RN reviewed the grievance log and event log to validate abuse had been ruled out or</p>		

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F 609	<p>Continued From page 15 investigated completely. Findings include:</p> <p>The Facility's Complaints and Grievances policy, dated 11/28/17, documented the facility reported any alleged violation involving neglect, abuse, and misappropriation of resident property as required.</p> <p>The Facility's Detecting Abuse, Neglect, Misappropriation, and Injuries of Unknown Origin Policy, dated 10/31/17, stated staff need to report any allegation of abuse or neglect to the state survey agency within the designated time frame.</p> <p>The Facility's Abuse Policy, dated 11/28/17: documented allegations of abuse should be reported to the Executive Director "immediately" and the state agency within 2 hours if there was alleged abuse or serious bodily injury as a result of an event or 24 hours if no serious bodily injury occurred.</p> <p>1. Resident #147 was admitted to the facility on 2/6/17, with diagnoses including anxiety disorder, chronic pain, and rheumatoid arthritis.</p> <p>On 2/13/19 at 10:15 AM, Resident #147 stated CNA #1 was training CNA #4 how to move her. When she came back from her doctor's appointment around 4:00 PM, she stated she was having pain from sitting in the wheelchair, so long. Resident #147 stated, "I was in so much pain I wanted to pass out." She stated CNA #1 and CNA #4 got her into the sling and "scrunched" her up in the mechanical lift until her knees were to her chest. Resident #147 said she yelled at the CNAs to let the sling out. She stated CNA #1 was called out of the room and CNA #4</p>	F 609	<p>reported as indicated. Other resident with potential abuse were reported and investigated as indicated.</p> <p>Facility Systems Staff are educated to abuse prevention, identification, and reporting, as well as the grievance process. Re-education was provided by Cascadia Healthcare's parent company Director of Clinical Operations to resource RN and management staff. Administrator, DNS, and/or designee completed training to the balance of staff. Education included but was not limited to implementation of care directives, abuse identification, removal of the alleged perpetrator, protection of the patient, timely reporting, timely and thorough investigation, medical record documentation, and implementation for the prevention plan, as well as validation of concerns to be noted as a grievance vs an allegation of abuse, if in question, report and investigate as abuse. The system is amended to include team review of grievance and event log in clinical meeting to determine timeliness of reporting. Grievance and reportable events with will be trended and presented to the QAPI team for directives.</p> <p>Monitor The resource RN and/or designee will audit grievance and event log for timeliness of reporting weekly for 12 weeks. Starting the week of March 3, 2019, the review will be documented on the PI audit tool. In addition, Cascadia</p>		

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F 609	<p>Continued From page 16</p> <p>was going to change her. Resident #147 stated she told CNA #4 to wait and CNA #4 just grabbed her and started to roll her over, and she kept telling her to pull her back over. Resident #147 said she was yelling because she was scared and CNA #4 was in her face, and told her she needed to stop yelling and told Resident #147 she was too demanding. Resident #147 said CNA #4 tried to take her sweater off and it got caught in her right ring finger and she thought CNA #4 had broken it. Resident #147 said CNA #4 continued to pull the sling out from under her, causing more pain. Resident #147 stated, "I was cold because the windows were open. She [CNA #4] threw a small blanket over me. I did not want to turn my call light back on." Resident #147 said LPN #2 told her she needed to report the incident with CNA #4. Resident #147 was tearful when she described what happened. Resident #147 stated the facility had not followed up with her about the incident. She stated the incident was scary because she could not defend herself due to her rheumatoid arthritis.</p> <p>A grievance form, dated 2/1/19, stated Resident #147 reported an incident to RN #1 that occurred on 1/31/19. The grievance documented Resident #147 was in pain when returning from an appointment the previous night and when CNA #4 was helping her to bed she was thrown around like a "rag doll." The grievance documented Resident #147 felt like she was going to fall when CNA #4 rolled her in the bed and CNA #4 pulled her sweater off causing pain to her hand. Resident #147 stated in the grievance CNA #4 "got in her face" and stated, "I need to get this done." Resident #147 stated she was then too scared to ask for food and was cold</p>	F 609	Healthcare's parent company Director of Clinical Operations and/or designee will review staff education validation, grievance logs, event logs, the reporting portal, and sample resident/family interviews monthly to validate appropriate management of potential allegations and/or allegations of abuse for 3 months. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		

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F 609	<p>Continued From page 17 and hungry until the night shift came to work.</p> <p>The follow up to the grievance form, dated 2/1/19, documented RN #1 spoke to CNA #4 regarding the situation. CNA #4 stated Resident #147 was yelling at her and the other CNA. CNA #4 stated she did roll Resident #147 to remove the sling and then rolled her back to feel more secure, but Resident #147 kept yelling for her blanket and to get out of the room. CNA #4 stated she did pull Resident #147's sweater and it caught on her fingernail. The grievance form documented CNA #4 was educated on taking time and listening to residents and using two people for concerns of safety.</p> <p>On 2/13/19 at 2:10 PM, RN #1 stated she took the grievance on 2/1/19 and she did not consider it an allegation of abuse because CNA #4 told her another story. She stated she gave the grievance to the Executive Director after she wrote it down.</p> <p>On 2/13/19 at 2:31 PM, the Executive Director said he reviewed the nursing progress notes at the time of the incident and considered it grounds for employee re-training on how to care for Resident #147. The Executive Director stated he did not consider it a reportable incident. The Executive Director confirmed the alleged abuse was not thoroughly investigated.</p> <p>On 2/13/19 at 2:15 PM, the Clinical Resource RN said she was not aware of the grievance and she would have treated it very different. The Clinical Resource RN said she would have investigated it as an allegation of abuse and reported the incident.</p>	F 609			

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{F 610} SS=E	<p>Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the 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: Based on resident interview, staff interview, record review, grievance review, and facility policy review, it was determined the facility failed to ensure verbal and physical abuse was thoroughly investigated and potential abuse was recognized for 2 of 13 residents (#1, and #147) who were reviewed for abuse/neglect. The deficient practice placed residents residing in the facility at risk of harm due to undetected physical and/or verbal abuse and lack of a thorough investigation. Findings include:</p> <p>The facility's Complaints and Grievances policy, dated 11/28/17, documented residents had the right to voice grievances to the facility and the facility would make prompt efforts to resolve the</p>	{F 610}	<p>Resident Specific The ID team reviewed resident #147 grievance, see F600.</p> <p>The ID team reviewed resident #1 grievance, see F607.</p> <p>Other Residents The ID team and resource RN reviewed the grievance log and event log to validate abuse had been reported as indicated. Reportable events were reviewed for complete and thorough investigation, additional investigative steps were completed and documented as indicated.</p>	3/7/19	

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{F 610}	<p>Continued From page 19</p> <p>grievances. The policy documented the facility would ensure all grievances included the date it was received, a summary of the grievance, steps the facility had taken to investigate the grievance, a conclusion, and any corrective actions taken by the facility. The policy documented the facility would report any alleged violation involving neglect, abuse, and misappropriation of resident property as required.</p> <p>The facility's Detecting Abuse, Neglect, Misappropriation, and Injuries of Unknown Origin policy, dated 10/31/17, documented when a staff member was suspected of abuse or neglect, "regardless of discipline," they were removed from any resident contact and suspended pending the investigation results. The policy documented a thorough investigation included:</p> <ul style="list-style-type: none"> * Documenting any observations and being specific in noting the time, location, and exact observation interviews with any person or persons involved who had seen the event or had knowledge of the event, * Interview notes should be detailed, * The facility should report any allegation of abuse or neglect to the state survey agency within the designated time frame. <p>The facility failed to implement and follow its policies and did not investigate, prevent or correct alleged abuse as follows:</p> <ol style="list-style-type: none"> 1. Resident #147 was admitted to the facility on 2/6/17, with diagnoses including anxiety disorder, unspecified, chronic pain, and rheumatoid 	{F 610}	<p>Facility Systems</p> <p>Staff are educated to investigate abuse, protect the resident during the investigation, and report. Re-education was provided by Cascadia Healthcare's parent company Director of Clinical Operations to resource RN and management staff. Administrator, DNS, and/or designee completed training to the balance of staff. Education included but was not limited to suspending the abuser, protecting the resident, resident assessment, victim interviews, other resident and witness interviews, resolution of apparent conflict in data collected, documentation summary of findings, timely implementation of plan to prevent recurrence. The system is amended to include team review of events in clinical meeting to monitor investigation process and validate timely completion. Reportable events will be reviewed, trended, and presented to the QAPI team for directives.</p> <p>Monitor</p> <p>The resource RN and/or designee will audit events for complete and thorough investigation weekly for 12 weeks. Starting the week of March 3, 2019, the review will be documented on the PI audit tool. In addition, Cascadia Healthcare's parent company Director of Clinical Operations and/or designee will review staff education validation, grievance logs, event logs, the reporting portal, and sample resident/family interviews monthly</p>		

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{F 610}	Continued From page 20 arthritis. A quarterly MDS assessment, dated 11/19/18, documented Resident #147 was cognitively intact and required extensive assistance of two or more staff members with all ADL cares except eating. On 2/13/19 at 10:15 AM, Resident #147 stated CNA #1 was training CNA #4 how to move her. When she came back from her doctor's appointment around 4:00 PM, she stated she was having pain from sitting in the wheelchair, so long. Resident #147 stated, "I was in so much pain I wanted to pass out." She stated CNA #1 and CNA #4 got her into the sling and "scrunched" her up in the mechanical lift until her knees were to her chest. Resident #147 said she yelled at the CNAs to let the sling out. She stated CNA #1 was called out of the room and CNA #4 was going to change her. Resident #147 stated she told CNA #4 to wait and CNA #4 just grabbed her and started to roll her over, and she kept telling her to pull her back over. Resident #147 said she was yelling because she was scared and CNA #4 was in her face, and told her she needed to stop yelling and told Resident #147 she was too demanding. Resident #147 said CNA #4 tried to take her sweater off and it got caught in her right ring finger and she thought CNA #4 had broken it. Resident #147 said CNA #4 continued to pull the sling out from under her, causing more pain. Resident #147 stated, "I was cold because the windows were open. She [CNA #4] threw a small blanket over me. I did not want to turn my call light back on." Resident #147 said LPN #2 told her she needed to report the incident with CNA #4. Resident #147 was tearful when she described what happened. Resident #147	{F 610}	to validate appropriate management of potential allegations and/or allegations of abuse for 3 months. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		

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{F 610}	<p>Continued From page 21</p> <p>stated the facility had not followed up with her about the incident. She stated the incident was scary because she could not defend herself due to her rheumatoid arthritis.</p> <p>A grievance form, dated 2/1/19, stated Resident #147 reported an incident to RN #1 that occurred on 1/31/19. The grievance documented Resident #147 was in pain when returning from an appointment the previous night and when CNA #4 was helping her to bed she was thrown around like a "rag doll." The grievance documented Resident #147 felt like she was going to fall when CNA #4 rolled her in the bed and CNA #4 pulled her sweater off causing pain to her hand. Resident #147 stated in the grievance CNA #4 "got in her face" and stated, "I need to get this done." Resident #147 stated she was then too scared to ask for food and was cold and hungry until the night shift came to work.</p> <p>The follow up to the grievance form, dated 2/1/19, documented RN #1 spoke to CNA #4 regarding the situation. CNA #4 stated Resident #147 was yelling at her and the other CNA. CNA #4 stated she did roll Resident #147 to remove the sling and then rolled her back to feel more secure, but Resident #147 kept yelling for her blanket and to get out of the room. CNA #4 stated she did pull Resident #147's sweater and it caught on her fingernail. The grievance form documented CNA #4 was educated on taking time and listening to residents and using two people for concerns of safety.</p> <p>There was no documentation the facility completed an investigation for Resident #147's grievance of potential verbal and physical abuse.</p>	{F 610}			

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{F 610}	<p>Continued From page 22</p> <p>The grievance investigation did not include staff or resident interviews to determine if CNA #4 did abuse Resident #147, progress notes identifying the issues, and/or witness statements. Resident #147's record did not document implementation of preventative measures to protect her from potential abuse. The facility did not suspend CNA #4 after she was accused of verbal and physical abuse by Resident #147 on 2/1/19.</p> <p>The Facility's Daily Staffing sheets documented CNA #4 was working in the facility on 2/2/19, 2/6/19, 2/7/19, 2/8/19, 2/9/19, 2/12/19, and 2/13/19.</p> <p>On 2/13/19 at 2:10 PM, RN #1 stated she took the grievance on 2/1/19 and she did not consider it an allegation of abuse because CNA #4 told her another story. She stated she gave the grievance to the Executive Director.</p> <p>On 2/14/19 at 5:11 PM, LPN #2 stated on the day of the incident, 1/31/19, CNA #4 told her she yelled back at Resident #147 because she was yelling at CNA #4 and she had to get her care done. LPN #2 stated Resident #147 had a lot of pain that evening and explained to her what had happened. LPN #2 stated she did not report it to anyone because she thought it was settled. LPN #2 stated at the time of the incident she was in another hall giving medications and did not hear Resident #147 or CNA #4 yelling.</p> <p>On 2/15/19 at 8:46 AM, CNA #4 stated Resident #147 was very difficult. She stated on 1/31/19 CNA #1 did most of the care getting Resident #147 ready for her doctor's appointment. CNA #4 stated CNA #1 gave direction on what to do to</p>	{F 610}			

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{F 610}	<p>Continued From page 23</p> <p>help. CNA# 4 stated this was the first day she had cared for Resident #147. She stated Resident #147 returned from her appointment around 5 or 5:30 PM when dinner was happening. She stated Resident #147 waited about 10-15 minutes to get placed back into bed. CNA #4 stated Resident #147 kept yelling that she wanted to get back in bed now. She stated they used the mechanical lift and transferred her to the bed. CNA #4 stated Resident #147 was yelling we were hurting her, the sling was hurting her, and CNA #1 was getting upset. She stated as soon as they laid her down and got her removed from the lift, CNA #1 left the room. CNA #4 stated, "I began to roll the resident toward the wall and then she was getting scared because there was no one on the other side of her. I then began rolling her toward me. She asked me to be gentle. I took off her shirt and her fingernail got caught in it. I got her pillow situated and a fuzzy blanket on her and gave her a drink and she dismissed me." CNA #4 stated when Resident #147 was in the mechanical lift both she and CNA #1 asked her to quit yelling and Resident #147 replied "I want this done." CNA #4 stated she did not remember if she told LPN #2 about it or not, but she was pretty sure she did. She stated a couple of days later the DNS came and asked her about the incident. CNA #4 stated "I did know she was a two person for the mechanical lift but did not know she was afraid of falling and to use two people for care." CNA #4 stated she had not seen the care plan for Resident #147 and at that time did not know how to access them.</p> <p>On 2/13/19 at 2:31 PM, the Executive Director said he reviewed the nursing progress notes at</p>	{F 610}			

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{F 610}	<p>Continued From page 24</p> <p>the time of the incident and considered it grounds for employee re-training with on how to care for Resident #147. The Executive Director said he did not consider it a reportable incident. The Executive Director confirmed the alleged abuse was not thoroughly investigated.</p> <p>On 2/13/19 at 2:15 PM, the Clinical Resource RN said she was not aware of the grievance and she would have treated it "very different." The Clinical Resource RN said she would have investigated it as an allegation of abuse.</p> <p>2. Resident #1 was admitted to the facility on 9/13/17, with multiple diagnoses including major depression, muscle weakness, and cerebral infarction (stroke).</p> <p>A quarterly MDS assessment, dated 11/9/18, documented Resident #1 was cognitively intact with no behavioral disturbances and required extensive assistance of one to two staff members with all ADL cares except eating.</p> <p>Resident #1 had an allegation of verbal abuse against a staff member and the facility did not follow their policies to suspend the potential abuser and complete a thorough investigation as follows:</p> <p>An investigation report, dated 1/22/19, documented Resident #1 requested the presence of the Clinical Resource RN and stated the Executive Director yelled at her in the hallway. The investigation report documented Resident #1 said the Executive Director yelled, "get out of here, you don't need to be part of this meeting." The investigation documented the Executive</p>	{F 610}			

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{F 610}	<p>Continued From page 25</p> <p>Director called a staff meeting in the hallway near the nurses' station to announce the current DNS was stepping down from her position. The summary documented Resident #1 was asked to continue to her room as the announcement was for staff.</p> <p>The investigation report, dated 1/22/19, documented social services conducted interviews with multiple residents regarding staff yelling at residents. The investigation report documented the Clinical Resource RN interviewed the Executive Director and the current DNS.</p> <p>The investigation report, dated 1/22/19, documented Resident #1 was headed down the hallway near the nurses' station towards her room. The report documented Resident #1 was a "gossip" and was moving her wheelchair slowly near the nurses' station. The report also documented the Executive Director told Resident #1 the meeting was for the staff and she would have to leave the area for a short period of time, and Resident #1 became angry and stated she was headed to her room anyway and did not want to be part of the meeting. The investigation report documented "Based off the staff interviews and multiple people witnessing the incident, abuse and neglect was ruled out."</p> <p>The Executive Director's statement dated, 1/22/19 at 2:48 PM, documented the Executive Director recalled saying something close to, "This is a meeting for employees, [Resident #1's name]." The statement documented Resident #1 stated she was headed to her room and did not want to listen.</p>	{F 610}			

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{F 610}	<p>Continued From page 26</p> <p>The DNS statement, dated 1/22/19, documented the Executive Director stated to Resident #1 in the hallway the meeting was "for staff only." The statement documented Resident #1 continued down the hallway towards her room and stated, "I don't wanna hang out anyway."</p> <p>The investigation report did not include documentation of the other staff members who were interviewed regarding the event, a witness statement from the resident, or other resident interviews. The investigation report documented four different versions of the incident (Clinical Nurse RN, Executive Director, the DNS, and Resident #1) of what the Executive Director said to Resident #1.</p> <p>Resident #1's record did not contain a progress note on 1/22/19 regarding the alleged abuse.</p> <p>A Progress Note, dated 1/23/19 at 3:14 PM, documented Resident #1 denied any staff member yelling at her today.</p> <p>A Progress Note, dated 1/23/19 at 6:23 PM, documented Resident #1 felt safe in the facility but she did not want "him" [Executive Director] in her room.</p> <p>A report, dated 1/24/19, documented training was provided by the Clinical Resource RN to the Executive Director. The training consisted of speaking in a calm manner, being at eye level with the resident when talking, and not utilizing resident areas for staff meetings. The training was signed by the Executive Director on 2/12/19, 19 days later.</p>	{F 610}			

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{F 610}	<p>Continued From page 27</p> <p>On 2/13/19 at 10:18 AM, Resident #1 stated a couple of weeks ago the Executive Director yelled at her in front of at least 15 staff members to go to her room and the Executive Director stated the meeting was for "staff only" and it "did not include her." Resident #1 stated an unnamed staff member accused her of stopping her wheelchair in the hallway to eavesdrop. Resident #1 stated the number of people in the hallway hindered her from getting to her room, which was where she was headed. Resident #1 stated she had to slow down to keep from running over staff members. Resident #1 stated the facility had not followed up with her regarding the situation and the Executive Director had not left the building for the duration of the investigation. Resident #1 stated she was trying to avoid the Executive Director because he had not apologized for yelling at her.</p> <p>On 2/13/19 at 12:22 PM, the RSSM stated she had completed other resident interviews regarding staff yelling at residents. The RSSM reviewed the current abuse investigation and stated the interviews she conducted with residents were not included in the abuse investigation and they should be. The RSSM provided a copy of the interviews for review.</p> <p>The Resident Interviews, dated 1/22/19, documented the RSSM conducted interviews with seven residents out of 41 in the facility. The RSSM asked the residents if a staff member had yelled at them recently. The interviews documented all resident said "no" they had not been yelled at. The interviews were not specific and did not provide the residents with a time frame</p>	{F 610}			

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{F 610}	<p>Continued From page 28 regarding the incident.</p> <p>On 2/13/19 at 2:10 PM, the Clinical Resource RN stated she had investigated the abuse allegation and she was present when it occurred. The Clinical Resource RN stated the staff were gathering in the hallway near the nurses' station to meet for an announcement. The Clinical Resource RN stated she could not tell if Resident #1 was slowing down because there were people in the hallway or if she wanted to listen to what was happening. The Clinical Resource RN stated she could not remember the exact words exchanged between the Executive Director and Resident #1 and stated what was said was in the Allegation Investigation. The Clinical Resource RN stated she did not realize her report did not reflect her presence at the incident and did not include other staff members' interviews other than the Executive Director and the DNS. The Clinical Resource RN stated she followed up with Resident #1 and to check Resident #1's Progress Notes. (Resident #1's Progress Notes did not contain follow up notes from the Clinical Resource RN.) The Clinical Resource RN stated she did not suspend the Executive Director during the investigation because it was completed so fast. The Clinical Resource RN stated she educated the Executive Director on his conduct and how to approach residents in the hallway.</p> <p>On 2/13/19 at 2:45 PM, The Executive Director stated on 1/22/19 it was change of shift and staff members had gathered in the hallway for an announcement. The Executive Director stated Resident #1 had plenty of room to go around and did not need to slow down. The Executive</p>	{F 610}			

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{F 610}	Continued From page 29 Director stated what he said to Resident #1 was in his statement. The Executive Director stated he could tell Resident #1 was upset and not happy with what he said. The Executive Director stated he was still in the facility during the investigation. The Executive Director stated he received education on 1/24/19 regarding how to interact with residents to prevent this situation from occurring in the future. The facility failed to suspend alleged abuser and complete a thorough investigation to include all the staff interviews or witness statements and Resident #1's interview.	{F 610}			
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all	F 755		3/7/19	

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F 755	<p>Continued From page 30</p> <p>aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident interview, staff interview, record review, and review of grievances, it was determined the facility failed to ensure residents medications were refilled by the pharmacy as ordered to meet the needs of each resident. This was true for 1 of 13 residents (Resident #147) whose medications were reviewed. This had the potential for residents to experience physical and mental harm from uncontrolled pain. Findings include:</p> <p>Resident #147 was admitted to the facility on 2/6/17, with diagnoses including anxiety disorder, chronic pain, and rheumatoid arthritis.</p> <p>A Physician's Progress Note, dated 1/31/19, documented Resident #147 reported doing well and did not have any immediate concerns. The note documented Resident #147 complained of increased joint pain during the winter months and pain to her right hip joint with touch. The Past Medical/Surgical History section documented Resident #147 had joint surgeries including, knee replacement, and back surgery.</p>	F 755	<p>Resident Specific</p> <p>The ID team reviewed resident #1 to validate sufficient supply of narcotic medications. In addition, resident was offered provider pharmacy use which would reduce the time required to refill a prescription. Resident declined and prefers use of non-provider pharmacy. Current supply is adequate, trigger established to promote timely reorder with personal pharmacy.</p> <p>Other Residents</p> <p>The ID team reviewed other residents who have non-provider pharmacies. No additional current residents use non-provider pharmacies.</p> <p>Facility Systems</p> <p>Licensed Nurses are educated to use of non-provider pharmacies. The DNS, and/or designee provided re-education to include, but not limited to, process to re-order from non-provider pharmacies, evaluation for routine and PRN narcotic</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 755	<p>Continued From page 31</p> <p>The care plan area addressing Resident #147's pain, initiated on 11/28/18, documented she had pain related to immobility and contractures (immovable joints) related to rheumatoid arthritis and directed staff to administer scheduled pain mediation as ordered, as well as Dilaudid (pain medication) PRN.</p> <p>Resident #147's record included progress notes which documented the Dilaudid was not available PRN to control her pain. Examples include:</p> <ul style="list-style-type: none"> - A Progress Note, dated 2/1/19 at 7:08 PM, documented Resident #147's PRN Dilaudid was not in the narcotic drawer and the nurse was unable to administer the medication. The note documented the previous nurse accessing the narcotic drawer notified the facility's managers. - A Progress Note, dated 2/2/19 at 1:00 AM, documented Resident #147 did not have any PRN Dilaudid available for administration. The note documented Resident #147 was offered PRN Tylenol but refused and Resident #147 verbalized concerns. - A Progress Note, dated 2/2/19 at 10:44 AM, documented the nurse called the pharmacy regarding filling Resident 147's PRN Dilaudid. The note documented the pharmacist stated the doctor had to be faxed to obtain the refill because the medication was a controlled narcotic. The note documented the nurse stated the PRN Dilaudid was out and Resident #147 "needed it." The note documented the pharmacist stated she would contact the doctor and send out a refill on the same day. 	F 755	<p>supply availability, PCC applicable reports, and how to obtain medication if non-provider pharmacy does not supply timely. The system is amended to include prompts in the electronic medical record for residents who receive medications from non-provider pharmacies.</p> <p>Monitor The DNS and/or designee will audit resident medications for re-order who utilize non-provider pharmacy weekly for 4 weeks, then monthly for 2 months. Starting the week of March 3, 2019, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 755	<p>Continued From page 32</p> <p>- A Progress Note, dated 2/4/19 at 10:49 AM, documented the nurse contacted the pharmacy again to request Resident #147's PRN Dilaudid refills of 2 mg and 8 mg tablets. The note documented the pharmacy technician stated the refills were in process. The note documented the pharmacy technician stated they would send an urgent/emergent fax again to the physician's office for the medication refills. The note documented Resident #147 was notified.</p> <p>- A Progress Note, dated 2/4/19 at 12:30 PM, documented the nurse called the physician's office to let her know the facility was waiting for an emergent refill on Resident #147's PRN Dilaudid and the request for a refill was faxed over from the pharmacy. The note documented the employee at the physician's office stated she had not received any faxes. The note documented the nurse left a message Resident #147 had been out of the medication "since Friday" and she needed the medication "urgently." The note documented the employee at the physician's office stated she would pass on the message to the physician.</p> <p>- A Progress Note, dated 2/4/19, documented the nurse called the pharmacy asked about the status of Resident #147's PRN Dilaudid refill. The note documented the pharmacy technician stated they received the order, however the driver went out already and the pharmacy technician was not sure if the refill would process today because of Medicaid. The note documented the nurse asked if the pharmacy technician could process the order "right now" and the nurse would come pick it up. The pharmacy technician said the refill would not process today because the pharmacy</p>	F 755			

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F 755	<p>Continued From page 33</p> <p>needed more information from the physician. The note documented the nurse asked the pharmacy to call her as soon as it was available.</p> <p>A facility grievance, dated 2/4/19, documented Resident #147 reported to RN #2 and the RSSM on 1/31/19 she was out of her Dilaudid. The grievance documented Resident #147 was concerned the medication did not get reordered. The response to the grievance, documented the medications arrived on 2/4/19 and nursing staff were re-educated on proper ordering procedures.</p> <p>On 2/13/19 at 10:15 AM, Resident #147 said her PRN Dilaudid had not been available for days. Resident #147 said it seemed like every time RN #3 worked there were problems receiving her medications. She said when RN #3 brought pain medications into the room, RN #3 would tell her, "I'll take it if you don't want it."</p> <p>On 2/13/19 at 3:10 PM, RN #2 said she was working the medication cart on the 100 hall on 1/31/19. RN #2 said when she went to get the Dilaudid 2 mg for Resident #147 there were none left. RN #2 said she called the nurse who administered the last dose and she confirmed she had given the last Dilaudid dose available. RN #2 said she called the pharmacy to reorder the Dilaudid.</p> <p>The Medication Administration Record (MAR), documented Resident #147 was administered Tylenol 650 mg on 2/1/19 at 2:23 AM for pain and again on 2/2/19 at 5:51 PM for pain and both were documented to be effective. The MAR documented Resident #147 was administered Tylenol 650 mg on 2/3/19 at 5:03 PM, and it was</p>	F 755			

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F 755	Continued From page 34 documented as ineffective. On 2/14/19 at 9:06 AM, the Interim Director of Nursing Services (IDNS) said the Dilaudid was delivered on 1/7/19 and ran out on 2/1/19. The IDNS stated the pharmacy delivered 100 tablets on 2/4/19. The IDNS said she was going to call the pharmacy to see why there was such a delay in getting the medications refilled.	F 755			

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F 000	INITIAL COMMENTS On February 12, 2019 through February 15, 2019, a revisit and complaint investigation survey was conducted at the facility. Refer to the revisit survey report Event ID J7O613 F600, F607, F609, and F610. The surveyors conducting the survey were: Teresa Kobza, RDN, LD, Team Coordinator Geri Wolfe, RN	F 000			
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-	F 600			
F 607 SS=D	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			

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

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/15/2019
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F 607	Continued From page 1 §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Refer to Survey Event J7O613.	F 607			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609			

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F 609	Continued From page 2 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: Refer to Survey Event J7O613.	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 investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Refer to Survey Event J7O613.	F 610			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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June 20, 2019

Eric Miller, Administrator
Coeur D'Alene Of Cascadia
2514 North Seventh Street,
Coeur D'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Miller:

On **February 15, 2019**, an unannounced on-site complaint survey was conducted at Coeur D'Alene Of Cascadia. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00008019

ALLEGATION #1:

Facility failed to ensure infection control standards were enforced.

FINDINGS #1:

Two surveyors conducted an unannounced onsite complaint investigation in conjunction with the revisit survey at the facility from 02/12/19 through 02/15/19. Observations were conducted throughout the facility. Interviews were conducted with residents, family members, and staff members. There were 13 residents reviewed during the investigation.

Review of facility records included documentation the facility was tracking and trending infections in the facility. They currently had no active infections in the facility and no one was on isolation precautions. Employees received bloodborne pathogen training, how to manage resident altercations, work place violence, and employee incidents upon hire. Infection control was an annual requirement.

Eric Miller, Administrator
June 20, 2019
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The facility does annual training for dementia and workplace violence, and they are growing their education about workplace violence.

There were no unusual smells detected in the facility. One shower room had some black build-up on the caulking and baseboards with a slight odor. The other parts of the facility had in the past had a leaky roof which has been resolved. The facility appeared clean and there was only one resident complaint of the shower being dirty. The resident council minutes did not document any issues with cleanliness of the facility.

CONCLUSIONS:

Based on investigative findings, the allegation could not be substantiated and no citation was issued.

ALLEGATION #2:

Facility failed to ensure resident's inappropriate behaviors were managed.

FINDINGS #2:

Once resident reviewed had diagnoses including dementia with behavioral disturbance. The resident was observed during the day. She was supervised in the activity room most of the day. The resident had a care plan that included interventions for physical aggression (pinching, hitting, scratching, biting) related to diagnosis of dementia. These behaviors were monitored each shift and did not occur every day or every shift. The resident was on Seroquel (a medication used to treat mental conditions). They were also monitoring her pain level to establish if it was a trigger for physical aggression.

A second resident reviewed had diagnoses including dementia. She had been assessed for physical and verbal aggression and was prescribed Depakote (a medication sometimes used for manic symptoms) and Seroquel. There were no observations of staff not managing the resident's behaviors.

A third resident's record was reviewed for behavioral management and the record documented staff monitored him for repetitive calling out, aggressive behaviors, hallucinations, delusions, and verbal aggression. Staff documented interventions of redirections, offering pain medications, and toileting when his behaviors manifested. The resident's record documented he was on medication for his behavior management. The resident was seen by a psychiatrist to assist with behavioral management.

The facility recently upgraded their training to include Teepa Snow's training on dementia and

Eric Miller, Administrator
June 20, 2019
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challenging behaviors. Teepa Snow is a recognized leader in dementia care.

CONCLUSIONS:

Based on investigative findings, the allegation could not be substantiated and no citations were issued.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,



BELINDA DAY, RN, Supervisor
Long Term Care Program

BD/slj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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July 25, 2019

Eric Miller, Administrator
Coeur d'Alene Of Cascadia
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Miller:

On **February 12, 2019** through **February 15, 2019**, an unannounced on-site complaint survey was conducted at Coeur d'Alene of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008006

ALLEGATION #1

The facility did not thoroughly investigate allegations of abuse.

FINDINGS #1:

During the investigation 10 residents were observed and 13 resident's records, which included three closed records, were reviewed for quality of care and abuse and neglect. Interviews were conducted with residents and family members. Staff members were interviewed and observed regarding abuse and neglect. Facility abuse allegations, grievances, and Resident Council minutes were reviewed.

Eric Miller, Administrator
July 25, 2019
Page 2 of 6

A facility abuse investigation and a grievance documented concerns with resident to staff allegations of abuse.

All 13 residents' records were reviewed for potential abuse and neglect concerns, including two residents, one admitted in September 2017 and one admitted in February 2017.

During the review of the records for one resident, admitted September 2017, an abuse investigation was initiated on 1/22/19, when a resident stated the Executive Director yelled at her in the hallway. The investigation report documented the resident said the Executive Director yelled, "get out of here, you don't need to be part of this meeting." The report documented social services conducted interviews with residents regarding staff yelling at residents, and the Clinical Resource Registered Nurse (RN) interviewed the Executive Director and the current Director of Nursing Services (DNS).

The investigation report did not include documentation of the other staff members who were interviewed regarding the event, a witness statement from the resident, or other resident interviews. The investigation report documented four different versions of the incident (Clinical Nurse RN, Executive Director, the DNS, and the resident) of what the Executive Director said to the resident.

Review of another resident's record, admitted February 2017, did not include an abuse investigation was initiated when the resident filled out a grievance which accused a CNA of verbal and physical abuse. A grievance form, dated 2/1/19, stated the resident reported an incident regarding potential physical and verbal abuse to a nurse that occurred on 1/31/19.

The follow up to the grievance form, dated 2/1/19, documented the nurse spoke to the CNA regarding the incident and the CNA was educated on taking time and listening to residents and using two people for concerns of safety.

There was no documentation the facility completed an investigation for the resident's grievance of potential verbal and physical abuse. The grievance investigation did not include staff or resident interviews to determine if the CNA did abuse the resident, progress notes identifying the issues, and/or witness statements. The record did not document implementation of preventative measures to protect the resident from potential abuse. The facility did not suspend the CNA after she was accused of verbal and physical abuse by the resident on 2/1/19.

In an interview, a nurse stated she took the grievance on 2/1/19 and she did not consider it an allegation of abuse because the CNA told her another story. She stated she gave the grievance to the Executive Director.

Eric Miller, Administrator
July 25, 2019
Page 3 of 6

Based on investigative findings, the allegation was substantiated. A deficiency was cited at F600, F607, F609, and F610 as it relates to the failure of the facility to thoroughly investigate allegations of abuse.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2

A resident fell and sustained injuries.

FINDINGS #2:

During the investigation three residents were observed and four resident's records, which included one closed record, were reviewed for accidents and incidents, specifically falls. Interviews were conducted with residents and family members. Staff members were interviewed regarding accidents and incidents and the investigation process. Facility grievances and Resident Council minutes were reviewed.

Three of four residents' records reviewed documented the facility followed the steps outlined by the DNS for falls. However, the fourth resident's record reviewed documented the resident was admitted on 1/8/18, and experienced seven falls between 11/11/18 and 12/4/18. The record did not identify causalities of the falls. The record did not include documentation of completed post fall assessments or the assessments were not completed timely for four of the falls. The record did not include documentation the care plan was updated for four of the falls. Six of the falls did not include documentation the resident's neurological status was assessed consistently.

In an interview, the DNS stated when a resident fell staff should follow the policy and the fall protocol for all the steps they should complete. The DNS defined a fall as any unplanned change in elevation. The DNS stated she would look into why care planned interventions were not followed.

Based on investigative findings, the allegation was substantiated. However, a deficiency was not cited at the time of this survey because the allegation was investigated during a previous survey, dated 12/14/18. During the 12/14/18 survey, deficient practice was identified and cited at F580, F684, F689, and F758 as they related to the failure of the facility to ensure falls were investigated and appropriate interventions were added after the falls.

ALLEGATION #3

A resident did not receive regular showers.

FINDINGS #3:

During the investigation all residents were observed for cleanliness and odors. Resident Council meeting minutes were reviewed, facility grievances were reviewed, and residents and family members were interviewed regarding showers. Five residents' records were reviewed for showers, including one closed record.

During observations of residents and their scheduled showers, no concerns were identified. The bath aide was observed providing showers to residents daily and efficiently. The bath aide was observed asking other aides to assist when required and the staff complied.

The record for one resident, admitted in January 2018, documented she did not receive two showers a week as scheduled for November and December 2018. Additionally, Resident Council Meeting minutes and Grievances from November 2018 to December 2018 documented showers were a concern. The Resident Council Meeting minutes and Grievances from January to February 2019, documented showers were no longer a concern and the facility corrected the concern.

Several residents and two family members said showers were currently being provided in the last few months. Residents stated a few months ago showers were infrequent. The residents stated the facility hired new staff members to provide showers and it was helping to meet the needs of the residents. CNAs and nurses said showers were provided and they met residents' needs.

The DNS and the Executive Director stated they hired new staff to provide the showers, and residents did not voice more concerns.

Based on the investigative findings, the allegation was substantiated. However, the facility corrected the concerns prior to the survey and no current deficient practice was identified.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #4

The facility was understaffed to meet the needs of the residents.

FINDINGS #4:

During the investigation all residents were observed for quality of care and staffing concerns. Resident Council meeting minutes were reviewed, facility grievances were reviewed, and multiple residents and family members were interviewed regarding staffing.

During observations of residents and staff members interacting, no concerns were identified. The residents' call lights were answered timely, assistance with activities of daily living (ADL) was provided, hydration was offered, activities were offered, and other care was offered and provided by staff.

Resident Council Meeting minutes and Grievances from November 2018 to December 2018 documented staffing was an issue. The Resident Council Meeting minutes and Grievances from January to February 2019, documented staffing was not an issue and the facility had corrected the concern.

Several residents and two family members said staffing numbers were better and the number of staff currently in the building met their needs. Residents stated a few months ago there was not enough staff to meet their needs and things like showers were infrequent, call light response times were long, and ADL assistance was not always provided. The residents stated the facility hired new staff members to provide cares and it was helping to meet the needs of the residents. CNAs and nurses said the staff numbers were better and they had more time to spend with the residents to ensure their needs were met.

The Director of Nursing and the Executive Director said the facility hired more staff and had plans to hire more. The DNS stated the staff were currently meeting residents' needs.

Based on the investigative findings, the allegation was substantiated. However, the facility corrected the concerns prior to the survey and no current deficient practice was identified.

ALLEGATION #5

Meals were late.

FINDINGS #5:

Residents' records were reviewed for nutrition needs, Resident Council meeting minutes were reviewed, observations were conducted, and family members and residents were interviewed.

Eric Miller, Administrator
July 25, 2019
Page 6 of 6

Review of 6 residents' records did not include documentation about concerns regarding meals being late. Nursing progress notes for one resident admitted to the facility in January 2018, did not include documentation of concerns with meals provided late.

Resident Council minutes from December 2018 to February 2019 did not document concerns with meals being provided late.

During the survey, seven residents were observed at four different meal times, and no concerns were identified. Three residents were observed asking to be taken down to the dining room an hour to an hour and a half before the start of the meal. These residents did sit in the dining room before the start of the meal, however it was their choice.

The seven residents interviewed had no concerns regarding meal times, and/or they liked to wait in the dining room before meals started. CNAs and nurses said they assisted residents to the dining room when the resident requested and sometimes it could be a while before the scheduled meal service time.

Based on the investigating findings, the allegation could not be substantiated.

CONCLUSIONS:

Substantiated. No 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,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj