



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE- Governor  
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TAMARA PRISOCK—ADMINISTRATOR  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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March 8, 2019

Thomas Welker, Administrator  
Clearwater of Cascadia  
1204 Shriver Road  
Orofino, ID 83544-9033

Provider #: 135048

Dear Mr. Welker:

On **February 15, 2019**, a survey was conducted at Clearwater of Cascadia by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Thomas Welker, Administrator  
March 8, 2019  
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Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 18, 2019**. Failure to submit an acceptable PoC by **March 18, 2019**, may result in the imposition of civil monetary penalties by **April 10, 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; and
- Include dates when corrective action will be completed in column (X5).

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

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

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

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

- **Denial of payment for new admissions effective May 15, 2019**
- **A civil money penalty**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 15, 2019**, if substantial compliance is not achieved by that time.

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

Thomas Welker, Administrator  
March 8, 2019  
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If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/ta/bid/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 18, 2019**. If your request for informal dispute resolution is received after **March 18, 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

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

PRINTED: 03/22/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/15/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1204 SHRIVER ROAD OROFINO, ID 83544</b>		
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F 000	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification and complaint investigation survey conducted from February 10, 2019 through February 15, 2019.  The surveyors conducting the survey were:  Edith Cecil, RN, Team Coordinator Jenny Walker, RN Kate Johnsrud, RN Carmen Blake, RN  Abbreviations:  ADL = Activities of Daily Living BG = Blood Glucose cm = centimeter CNA = Certified Nursing Assistant DON = Director of Nursing ER = Emergency Room PNA = Pneumonia MAR = Medication Administration Record MDS = Minimum Data Set mg/dl = milligrams per deciliter OT = Occupational Therapy PT = Physical Therapy RCM = Resident Care Manager RNC = Regional Nurse Consultant RN = Registered Nurse ST = Speech Therapy TAR = Treatment Administration Record	F 000			
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8)  §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination	F 561			4/2/19

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

TITLE

(X6) DATE

Electronically Signed

03/18/2019

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 561	<p>Continued From page 1 through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section.</p> <p>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.</p> <p>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.</p> <p>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, and record review, it was determined the facility failed to ensure residents received diet textures ordered by the physician and per resident choice. This was true for 1 of 3 residents (Resident #16) whose diets were reviewed. This failure had the potential for psychological harm when resident preferences were not recognized. Findings include:  Resident #16 was admitted to the facility on</p>	F 561	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Clearwater Health and Rehabilitation of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal</p>		

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F 561	<p>Continued From page 2</p> <p>11/27/18, with the diagnosis of corticobasilar degeneration (a progressive neurological disorder characterized by nerve cell loss and shrinkage of multiple areas of the brain). According to the National Institute of Neurological Disorders and Stroke, website accessed on 3/6/19, a common complication with corticobasilar degeneration is difficulty swallowing which can cause a person to choke or inhale food or liquid into the airway, which can develop into pneumonia.</p> <p>A physician order, dated 12/24/18, directed staff to provide a mechanical soft diet in small portions per Resident #16's request.</p> <p>An MDS assessment, dated 12/25/18, documented Resident #16 was cognitively intact, had clear speech, understood others and was understood by others, had received a mechanically altered diet and exhibited coughing or choking during meals or when swallowing medications.</p> <p>A physician order, dated 1/11/19, documented the initiation of enteral feeding (feeding through a tube) 12 hours a day from 7:00 PM to 7:00 AM.</p> <p>A Registered Dietitian Progress Note, dated 2/8/19, documented Resident #16 continued to snack between meals and eat meals with an average oral intake of 45%. The note documented Resident #16's significant other stated she was having more difficult with her swallowing and felt it was related to the Botox injections in her neck (which were prescribed for her diagnosis).</p>	F 561	<p>proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p><b>Resident Specific</b> The ID team reviewed resident #16 diet texture order. Residents <input type="checkbox"/> diet texture is mechanical soft as ordered by the physician and per residents <input type="checkbox"/> preference. Care plan updated to reflect residents <input type="checkbox"/> diet preference and physician order.</p> <p><b>Other Residents</b> The ID team reviewed other residents for diet orders to validate correct orders are in place. Residents <input type="checkbox"/> will be interviewed to ensure diet order is their preference. Adjustments have been made as indicated.</p> <p><b>Facility Systems</b> Social Services and/or designee will educate nursing staff on Residents <input type="checkbox"/> Rights. The Clinical Resource RN and/or designee will educate nurses on following Physician orders and advocating for resident rights. The system is amended to include oversight by the clinical management team with new admissions and new orders being reviewed in the Clinical review meeting to validate correct diet orders in place. If a new diet downgrade order is received the Director of Nursing and/or designee will validate</p>		

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F 561	<p>Continued From page 3</p> <p>Resident #16's nutritional decline care plan, dated 2/11/19, and revised on 2/12/19, documented Resident #16 requested the placement of the enteral feeding tube due to a decline in her oral food intake and the length of time it took her to complete her meals because of difficulty chewing her food. Resident #16's goal, dated 1/10/19, was to tolerate the highest, safest diet texture, avoiding significant changes or concerns.</p> <p>A Nurse's Progress Note, dated 2/11/19 at 11:25 AM, documented Resident #16's physician was notified by Resident #16's friend of her dissatisfaction with the change in her diet from mechanical soft to puree by the DON and the Medical Director, who was in the facility and consulted by the DON. The physician gave a phone order to keep the resident at a mechanical soft diet. The Nurse's Progress Note documented the therapy evaluation determined Resident #16 was cognitively safe to follow a mechanical soft diet. "Her diet was initiated per her physician's order."</p> <p>A Nurse's Progress Note, dated 2/11/19 at 1:35 PM, signed by the DON documented Resident #16 was observed not being able to chew her mechanical soft diet. The DON documented there was grave concern for the risk of choking and it was clinically decided by nurse management and the Medical Director Resident #16's diet was going to be downgraded to a puree diet until ST could evaluate. The progress note documented the DON, RCM #1, and one additional RN discussed the concerns with Resident #16 and her significant other. The DON documented Resident #16 became visibly upset</p>	F 561	<p>order is residents <input type="checkbox"/> and/or responsible parties <input type="checkbox"/> preference.</p> <p>Monitor The Director of Nursing and/or designee will audit new diet orders five times weekly 12 weeks. Starting the week of March 31st 2019, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 561	<p>Continued From page 4</p> <p>and began to cry. "She was not able to be understood at this point. We explained that she could choke and that the DON had to protect her and all the residents in the facility." The note documented, Resident #16's friend was not accepting of this. She stated if the facility brought in a puree meal tray, they were going to throw it out. The DON documented until the ST assessment was completed, the facility had to serve Resident #16 the safest diet for her observed deficits. The progress note documented a written grievance was received related to Resident #16's unhappiness over the diet change.</p> <p>An ST evaluation and plan of treatment, dated 2/11/19, documented Resident #16 had an incident where she stated to her nurse she could not chew, and she was only using her tongue on the roof of her mouth. "Nursing precipitously downgraded her diet to puree foods in the interest of eliminating any safety risk." The ST documented Resident #16 " ...did not appear to have had a precipitous decline in her swallowing ability at this time, she is cognitively able to prevent getting into a difficult situation, and remove food that is not going well. She is managing mechanical soft foods with slow and accurate movements. She is safest with someone with her. She is cognitively capable to make her own choices about what to eat."</p> <p>A facility diet order and communication form, dated 2/12/19, documented Resident #16's diet changed to a mechanical altered.</p> <p>On 2/12/19 at 9:18 AM, Resident #16 and her significant other stated the DON had decided to</p>	F 561			

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F 561	<p>Continued From page 5</p> <p>downgrade Resident 16's diet to a puree texture without discussing it with her. The significant other stated the nurse that helped Resident #16 with her meal on 2/10/19, did not know Resident #16, "It was the first time she had ever helped [Resident #16] eat." Resident #16 stated she received a puree diet this morning for breakfast and refused to eat it. The significant other stated Resident #16's physician ordered a mechanical soft texture, but the DON and the Medical Director overrode Resident #16's physician. The significant other stated the Speech Therapist evaluated Resident #16 on 2/11/19 between 5:00-5:15 PM. Resident #16 stated because her neck was bent, she had received Botox injections in her neck in the attempt to relax the muscles but it had not worked. Resident #16 stated she was not able to get her teeth together to chew but with a soft diet, she can use her tongue to separate the food and mix it around in her mouth until she was able to swallow it. Resident #16 stated with her progressive disease, she knew her meal intake was going to be more difficult which was why she requested the enteral tube feeding to supplement her oral intake. Resident #16 stated when she could no longer eat, she will no longer use the tube feeding. Resident #16 stated her significant other was in the facility for most meals to assist her.</p> <p>On 2/13/19 at 4:36 PM, the DON stated RCM #1 reported she had fed Resident #16 on 2/10/19. Resident #16 told RCM #1 she could not chew because her teeth did not line up. The DON stated she discussed this with RCM #1 and stated they could not risk Resident #16 choking. The DON stated she used her nursing judgement to downgrade Resident #16's diet until ST could</p>	F 561			

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F 561	<p>Continued From page 6</p> <p>evaluate her. The DON stated when they told Resident #16 and her significant other, the significant other said they were not happy with the change and if you bring in a puree diet, we will just throw it away. The DON stated the significant other called Resident #16's primary physician. The DON stated she consulted the Medical Director who was familiar with Resident #16. The Medical Director told the DON, Resident #16 had multiple failed swallow evaluations in the past. The DON stated she did not contact Resident #16's physician.</p> <p>The DON also stated she did not talk to Resident #16 about the decision to downgrade her diet, she stated she was not going to provide a diet the resident could "choke to death on." The DON stated she had the liability and was held accountable for Resident 16's safety. The DON stated she was aware Resident #16 had not choked but her not being able to chew was a change. "Am I supposed to wait until they choke before I make a change?" The DON stated she made a nursing judgement.</p> <p>On 2/13/19 at 5:04 PM, RCM #1 stated she had assisted Resident #16 with her evening meal for the first time on 2/10/19. She stated she was concerned Resident #16 was not chewing her food. Resident #16 told RCM #1 the Botox treatments did not help, and if she had something in her mouth she could not swallow, she would spit it out. RCM #1 stated she never saw Resident #16 choke and stated it was a chewing issue. RCM #1 stated she did not feel Resident #16 was at risk of choking when she left for the night.</p>	F 561			

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F 561	Continued From page 7 RCM #1 further stated she reported her concern during the morning meeting. RCM #1 stated the DON said they needed to downgrade Resident #16's diet until the Speech Therapist assessed her. RCM #1 stated the DON directed her to notify Resident #16 of the diet texture change to puree. RCM #1 stated Resident #16 appeared to be okay with the puree diet until she addressed the need to remove the snacks Resident #16 had at her bedside. RCM #1 stated Resident #16 started crying, she was very upset the snacks were going to be removed.	F 561			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)  §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580		4/2/19	

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F 580	<p>Continued From page 8</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and record review, it was determined the facility failed</p>	F 580	<p>This Plan of Correction is prepared and submitted as required by law. By</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1204 SHRIVER ROAD OROFINO, ID 83544</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 580	<p>Continued From page 9</p> <p>to ensure the physician was notified of high blood glucose levels. This was true for 1 of 1 resident (Resident #7) reviewed for diabetic management. This failed practice had the potential for harm if Resident #7 experienced signs and symptoms of hyperglycemia. Findings include:</p> <p>The facility's Hyperglycemia and Diabetic Coma policy and procedure, dated 10/31/17, documented, "It is important to treat hyperglycemia as soon as it is detected. If not treated, a condition called ketoacidosis (diabetic coma) could occur...If the resident's blood glucose is over 240 mg/dl and is not on sliding scale insulin, call the physician for directives."</p> <p>Resident #7 was readmitted to the facility on 8/9/18, with multiple diagnoses including diabetes.</p> <p>Resident #7's MAR included physician's orders for blood glucose checks four times a day. The orders included an injection of 10 units of Lantus insulin every day at bedtime. Resident #7's orders did not include parameters for notifying the physician related to elevated blood glucose levels.</p> <p>Resident #7's MAR, from 1/1/19 to 1/31/19, documented 54 out of 123 blood glucose checks were greater than 240 mg/dl. Resident #7's blood glucose levels ranged from 242 mg/dl to 587 mg/dl and one reading dated 1/3/19 was documented as 2891 mg/dl. There was no documentation Resident #7's physician was notified of the elevated blood sugar levels.</p> <p>On 2/14/19 at 3:00 PM, the RNC stated Resident</p>	F 580	<p>submitting this Plan of Correction, Clearwater Health and Rehabilitation of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p><b>Resident Specific</b> The ID team reviewed resident #7 insulin orders. Physician order was received for blood sugar parameters, MD was notified of blood glucose trending results outside of parameters.</p> <p><b>Other Residents</b> The ID team reviewed other non-sliding scale diabetic residents to validate parameter orders are in place. MD was notified of blood glucose trending results outside of parameters. Adjustments have been made as indicated.</p> <p><b>Facility Systems</b> Director of Nursing and/or designee will educate nurses on Physician Notification of blood glucose parameters per facility hyperglycemia protocol. The system is</p>		

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F 580	Continued From page 10 #7 was not on sliding scale insulin and there were no resident specific orders to report the elevated blood glucose levels. The RNC agreed the facility did not follow their hyperglycemia policy.	F 580	amended to include oversight by the Director of Nursing with review in the clinical meeting of new admissions, new orders, to validate residents receiving insulin, accu-checks and SSI have parameter orders in place, as well as that physician has been notified when outside of parameters.  Monitor The Director of Nursing and/or designee will audit insulin dependent residents and resident with accu-check orders, Blood Glucose results and physician notification of results outside of parameters 5x□s weekly for 4 weeks, then minimum 3x□s weekly. Starting the week of March 31st 2019, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)  §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate	F 622		4/2/19	

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F 622	<p>Continued From page 11</p> <p>because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;</p> <p>(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;</p> <p>(D) The health of individuals in the facility would otherwise be endangered;</p> <p>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or</p> <p>(F) The facility ceases to operate.</p> <p>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's</p>	F 622			

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F 622	Continued From page 12 medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c) (1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c) (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and	F 622	This Plan of Correction is prepared and		

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F 622	<p>Continued From page 13</p> <p>record review, it was determined the facility failed to ensure information was provided to the receiving hospital for emergent situations for 2 of 2 residents (#17 and #30) reviewed for transfers. This deficient practice had the potential to cause harm if the resident was not treated in a timely manner due to lack of information. Findings include:</p> <p>The facility's Transfer and Discharge policy, dated 11/28/17, directed information conveyed to the receiving provider include the following:</p> <ul style="list-style-type: none"> <li>* Resident representative information, including contact information</li> <li>* Advance directive information</li> <li>* Special instructions and/or precautions for ongoing care</li> <li>* The resident's comprehensive care plan goals</li> <li>* All information necessary to meet the resident's needs, which included, but may not be limited to resident status baseline and current mental, behavioral, and functional status, reason for transfer, vital signs, diagnoses and allergies, medications, recent relevant labs, diagnostic tests, and recent immunizations.</li> </ul> <p>1. Resident #30 was readmitted to the facility on 1/14/19, with multiple diagnoses including coronary artery disease and atrial fibrillation.</p> <p>A discharge MDS assessment, dated 1/11/19, documented Resident #30 was discharged to a hospital.</p> <p>A Nursing Progress Note, dated 1/11/19 at 12:24 AM, documented Resident #30 had an increase in confusion, shortness of breath, and oxygen</p>	F 622	<p>submitted as required by law. By submitting this Plan of Correction, Clearwater Health and Rehabilitation of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p><b>Resident Specific</b> The clinical management team reviewed resident #17, resident has since returned to the facility after receiving safe treatment during the transition of care..</p> <p>The clinical team reviewed resident #30, resident has since returned to the facility after receiving safe treatment during the transition of care.</p> <p><b>Other Residents</b> The clinical management team reviewed other residents discharged in the last 30 days for documentation of information provided to the receiving hospital or facility. Medical record reflects information was documented as provided to the paramedics, emergency room, and hospital to ensure a safe and effective transition of care. Re-education was provided for situations where information</p>		

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F 622	<p>Continued From page 14</p> <p> saturations in the low 70's. The facility called the hospital and notified Resident #30's physician of his change in status. Physician orders were received to transport Resident #30 to the hospital. Resident #30 was transported to the hospital via emergency transport.</p> <p>Resident #30's medical record did not document information was provided to the paramedics, emergency room, or the hospital to ensure a safe and effective transition of care.</p> <p>On 2/13/19 at 10:25 AM, the RNC stated the facility sent the face sheet, orders, and transfer sheet to the emergency room with the resident. The RNC stated the facility did not retain a copy of the medical records sent and did not document what was sent.</p> <p>2. Resident #15 was readmitted to the facility on 12/5/18, with multiple diagnoses including cellulitis (a common bacterial skin infection).</p> <p>A discharge MDS assessment, dated 12/2/18, documented Resident #15 was discharged to a hospital.</p> <p>A Nurse's Progress Note, dated 12/2/18 at 2:32 AM, documented Resident #15 had chest tightness. Resident #15's physician was notified and the ambulance transported him to the hospital via emergency transport.</p> <p>Resident #15's record did not document information was provided to the paramedics, the emergency room, and the hospital to ensure a safe and effective transition of care.</p>	F 622	<p>was lacking.</p> <p>Facility Systems Licensed nurses are educated regarding transfer and discharge documentation requirements. Re-education was provided by Resident Care Manager and/or designee to include but not limited to, emergent transfer's documentation of information given to the paramedics, emergency room, or the hospital when a resident is being transferred, completion of the facility's transfer/discharge form, facility's transfer/discharge policy and procedure, and process of documentation regarding the communication and information provided to the receiving facility/agency. The system is amended to include review in the clinical meeting of discharges to validate documentation of information packet sent is reflected in the medical record.</p> <p>Monitor The Director of Nursing and/or designee will audit discharged resident records for documentation of information sent to receiving facility/agency with each discharge for 12 weeks. Starting the week of 3/31/19 the review will be documented</p>		

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F 622	Continued From page 15 On 2/13/19 at 12:18 PM, RCM #1 stated Resident #15's record did not include documentation the Transfer/Discharge Form and paperwork were provided to the paramedics, a physician's order to transport him, and the reason for admission to the hospital.	F 622	on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)  §483.15(d) Notice of bed-hold policy and return-  §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.  §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625		4/2/19	

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F 625	<p>Continued From page 16</p> <p>by:</p> <p>Based on staff interview, policy review, and record review, it was determined the facility failed to ensure a second bed-hold notice was provided to a resident or their representative upon transfer to the hospital. This was true for 2 of 2 residents (#17 and #30) who were reviewed for transfers. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time and may cause psychosocial distress if not informed they may be charged to reserve their bed/room. Findings include:</p> <p>The facility's Bed-Hold Readmission Policy, dated 11/28/17, documented the facility issued two notices related to bed-holds, as follows:</p> <ul style="list-style-type: none"> <li>* The first notice was provided in the admission packet.</li> <li>* The second notice was provided to the resident at the time of transfer, or in cases of emergency transfer, within 24 hours of the transfer.</li> <li>* The notices provided information to the resident that explained the duration of the bed-hold.</li> </ul> <p>1. Resident #30 was readmitted to the facility on 1/14/19, with diagnoses of coronary artery disease and atrial fibrillation (irregular heartbeat).</p> <p>Resident #30 was transferred to the hospital on 1/11/19 and readmitted to the facility on 1/14/19. Resident #30's medical record did not include documentation he received a second bed-hold notification when he was transferred to the</p>	F 625	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Clearwater Health and Rehabilitation of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p><b>Resident Specific</b> The ID team reviewed resident #17s record. Resident no longer requires written notification of Bed Hold Policy, as they have returned to their bed at the facility.</p> <p>The ID team reviewed resident #30s record. Resident no longer requires written notification of Bed Hold Policy, as they have returned to their bed at the facility.</p> <p><b>Other Residents</b> The ID team reviewed other residents, no other resident are currently in an acute setting. No adjustments indicated.</p>		

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F 625	Continued From page 17 hospital.  On 2/13/19 at 12:35 PM, RCM #1 provided a copy of a signed Bed-Hold policy, dated 4/20/18. RCM #1 stated Resident #30 did not receive a second bed-hold notification.  2. Resident #15 was readmitted to the facility on 12/5/18, with multiple diagnoses including cellulitis (a common bacterial skin infection).  Resident #15 was transferred to the hospital on 12/2/18 and readmitted to the facility on 12/5/18. Resident #15's record did not include documentation he received a second bed-hold notification when he was transferred to the hospital.  On 2/13/19 at 12:18 PM, RCM #1 stated Resident #15 did not receive a second bed-hold notification.	F 625	Facility Systems Admissions Coordinator, Social Services, and nursing staff were educated to the Bed Hold Policy. The Executive Director and/or designee re-educated to include but not limited to, providing the bed hold policy at time of discharges and/or transfers to acute care setting within 24 hours of the resident leaving the facility. The system is amended to include review in the clinical meeting for residents who transfer to the acute care setting to validate communication of the Bed Hold Policy is in the record.  Monitor The Executive Director and/or designee will audit Bed Hold Policy provided to the resident and/or representative at time of discharge or within 24 hours to validate that it is present in the medical record. Monitoring will occur with each discharge for 12 weeks. Starting the week of 3/31/19 the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		4/2/19	

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F 657	Continued From page 18  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure resident care plans were updated to maintain consistent and accurate information. This was true for 1 of 12 residents (Resident #15) whose care plans were reviewed. This failure created the potential for harm if cares and/or services were not provided due to inaccurate information	F 657	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Clearwater Health and Rehabilitation of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or		

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F 657	<p>Continued From page 19 on the care plan. Findings include:</p> <p>Resident #15 was readmitted to the facility on 12/5/18, with multiple diagnoses including cellulitis (a common bacterial skin infection) and weakness.</p> <p>A Nurse's Progress Note, dated 1/29/19, documented Resident #15 had increased pain to his right hip and was sent to the emergency room for an evaluation. Resident #15 returned from the emergency room with orders for PT to evaluate and treat, and for pain medication.</p> <p>On 2/12/19 at 10:20 AM, Resident #15 stated he had pain to his right knee and it radiated up to his right hip. Resident #15 stated he went to the emergency room and was sent back to the facility a few hours later.</p> <p>Resident #15's care plan was not updated to include pain medications or pain management.</p> <p>On 2/13/19 at 2:09 PM, the RNC stated Resident #15's care plan did not address pain management.</p>	F 657	<p>conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p><b>Resident Specific</b> The ID team reviewed resident #15 Care plan. Care plan was updated to reflect residents plan of care for pain.</p> <p><b>Other Residents</b> The ID team reviewed other residents clinical record to validate individualized care plan for pain are in place. Adjustments have been made as indicated.</p> <p><b>Facility Systems</b> Director of nursing and/or designee will educate nurses on Care Planning and revisions. The system is amended to include a review in clinical meeting new admission(s), residents returning from ER/physician appointments, residents with a change in condition or receiving new orders to validate individualized and revision of the residents <input type="checkbox"/> care plan, including pain management are in place.</p> <p><b>Monitor</b></p>		

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F 657	Continued From page 20	F 657	The Director of Nursing and/or designee will audit care plans for revisions 5x□s weekly for 4 weeks, then 3x□s weekly for 8 weeks. Starting the week of March 31st 2019, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and record review, it was determined the facility failed to ensure professional standards of practice were followed for 1 of 15 residents (#7) reviewed for standards of practice. Resident #7's physician was not notified of elevated blood glucose levels. This failed practice had the potential to adversely affect or harm residents whose care and services were not delivered according to accepted standards of clinical practices. Findings include:  1. The facility's Hyperglycemia and Diabetic Coma policy and procedure, dated 10/31/17,	F 684	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Clearwater Health and Rehabilitation of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form	4/2/19	

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F 684	<p>Continued From page 21 documented, "It is important to treat hyperglycemia as soon as it is detected. If not treated, a condition called ketoacidosis (diabetic coma) could occur... If the resident's blood glucose is over 240 mg/dl and is not on sliding scale insulin, call the physician for directives."</p> <p>Resident #7 was readmitted to the facility on 8/9/18, with multiple diagnoses including diabetes.</p> <p>Resident #7's MAR included physician's orders for blood glucose checks four times a day. The orders included an injection of 10 units of Lantus insulin every day at bedtime. Resident #7's orders did not include parameters for notifying the physician related to elevated blood glucose levels.</p> <p>Resident #7's MAR, from 1/1/19 to 1/31/19, documented 54 out of 123 blood glucose checks were greater than 240 mg/dl. Resident #7's blood glucose levels ranged from 242 mg/dl to 587 mg/dl and one reading dated 1/3/19 was documented as 2891 mg/dl. The American Diabetes Association, website accessed on 3/6/19, suggested the following targets for most adults with diabetes: Before a meal 80-130 mg/dl, 1-2 hours after beginning of the meal less than 180 mg/dl. Michigan Medicine at the University of Michigan, accessed 3/6/19, stated a blood sugar reading of 300 mg/dl or more can be dangerous and over time can greatly increase the risk for long-term complications of diabetes.</p> <p>There was no documentation Resident #7's physician was notified of the elevated blood sugar levels.</p>	F 684	<p>the basis for the deficiency.</p> <p><b>Resident Specific</b> The clinical management team reviewed resident #7 for Hyperglycemia/Hypoglycemia parameters and notified physicians to get resident specific parameters. Resident specific parameters have been received. See F580.</p> <p><b>Other Residents</b> The clinical management team reviewed other residents for Hyperglycemia/Hypoglycemia parameters and notified physicians to receive resident specific parameters. Resident specific parameters have been entered on the medication administration review and care plans have been update to reflect physician orders. Adjustments have been made as indicated.</p> <p><b>Facility Systems</b></p> <p>LN□s are educated on management of diabetes. The Director of Nursing and/or designee re-educated to the updated</p>		

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F 684	Continued From page 22  On 2/14/19 at 3:00 PM, the RNC stated Resident #7 was not on sliding scale insulin and there were no resident specific orders to report the elevated blood glucose levels. The RNC agreed the facility did not follow their hyperglycemia policy.	F 684	policy for Hyperglycemia and Diabetic Coma policy, to include but not limited to, validation of parameters on hyperglycemia for non-sliding scale, residents notification and documentation on blood sugars that are out of stated parameters. The system is amended to include notification of MD upon admission for residents with a diabetic diagnosis or insulin dependent, to determine physician preference on parameters and notification for hypoglycemia and hyperglycemia. Medical record will be reviewed in clinical meeting to validate documentation of blood sugar parameters.  Monitor The Director of Nursing and/or designee will audit insulin dependent residents Blood Glucose results and physician notification of results outside of parameters 2 times weekly for 4 weeks, then 1 time weekly for 8 weeks starting the week of 3/31/19. The review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		4/2/19	



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F 686	<p>Continued From page 24</p> <p>condition demonstrates they were unavoidable." An Avoidable pressure ulcer means the resident developed a pressure ulcer and the facility did not do not evaluate the resident's clinical condition, implement interventions or revise the interventions as appropriate. Interventions included, "Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.)."</p> <p>The National Pressure Ulcer Advisory Panel website (<a href="http://www.npuap.org">www.npuap.org</a>), accessed on 3/6/19, stated a pressure injury is damage to an area of skin and underlying soft tissue, usually located over a bony prominence, and may be associated with a medical or other device. The pressure injury can appear as intact skin or an open ulcer. A pressure injury results from severe and/or prolonged pressure or pressure with shearing. The website stated a Stage 2 pressure injury is "partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister."</p> <p>The Lippincott Manual of Nursing Practice, tenth edition, stated measures to prevent pressure ulcer development included repositioning every two hours, using special devices to cushion the specific area, and use an alternating pressure mattress or air fluidized bed for patients who are at high risk.</p> <p>1. Resident #38 was admitted to the facility on 7/7/05 and readmitted on 10/1/17, with multiple diagnoses including a stroke with hemiplegia and hemiparesis (paralysis and weakness to one side of the body) affecting his right side.</p>	F 686	<p><b>Other Residents</b> The ID team reviewed other residents by assessing residents' skin and documented assessments on the Weekly Skin Evaluation Tool. The residents' Braden Scale Score will be reviewed and prevention plans updated as indicated. Residents identified with skin injuries will have plans of care addressed to meet healing needs. Resident's with new skin injuries will be tracked in Risk Management to include, but not limited to, wound location, description, possible cause, care plan, and monitoring of care interventions. Adjustments have been made as indicated.</p> <p><b>Facility Systems</b> Licensed Nurses will be educated on Pressure Ulcer Prevention and Interventions, Wound Assessment and Documentation, Care planning, Weekly Skin Assessment documentation and completion, Risk Management Documentation of new skin injuries, Resident Change of Condition skin needs, timely implementation of new interventions as indicated, and required documentation of healing interventions. Certified Nurse Assistance will be educated on the task button for resident turn and repositioning in POC to validate care is being received. Education will be</p>		

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F 686	<p>Continued From page 25</p> <p>Resident #38's quarterly MDS assessment, dated 2/2/18, documented he was moderately cognitively impaired and required extensive assistance of one staff with bed mobility and transfers. The MDS documented Resident #38 was at risk for pressure ulcers and had a history of pressure ulcers but did not have pressure ulcers at the time of the assessment.</p> <p>Resident #38's at risk for skin breakdown care plan, dated 3/11/18, included interventions for a pressure reducing mattress to the bed and a cushion to his wheelchair, a padded foot rest to the right wheelchair foot pedal, weekly skin checks by the licensed nurse, and use of a draw sheet for turning and repositioning while in bed. The care plan did not include how often Resident #38 should have been repositioned in bed or to float his heels with pillows while in bed.</p> <p>Resident #38's record included documentation of visits at a clinic on 4/5/18 and 4/10/18. The documentation from the 4/5/18 clinic visit, signed by a physician on 4/10/18, stated Resident #38 had a bruise to his right lower humerus (arm bone). There was no documentation of a blister or wound. The clinic visit dated 4/10/18, signed by a physician assistant on 4/12/18, stated Resident #38 had no skin lesions or wounds.</p> <p>An Incident and Accident Report, dated 4/13/18 at 2:00 AM, documented Resident #38 had a flat blister with discoloration beneath. The blister was 4.2 cm x 4.0 cm to the right inner part of his heel.</p> <p>A Nurse's Progress Note, dated 4/13/18 at 4:30 AM, documented Resident #38 had a discolored</p>	F 686	<p>provided by Medline representative, Director of Nursing and/or designee. The Medline representative will be auditing the residents' mattress to assist in prevention of skin injury. The system is amended to include a review in the Clinical review meeting of new admissions clinical record, weekly skin assessments, timely referral to wound specialist with lack of healing, resident's at risk and residents with new skin injuries. Residents with skin injuries will be discussed in the weekly wound meeting with plan of care adjusted as indicated. Residents identified as at risk will have a task implemented to document frequency of turning and repositioning, floating of heels, and/or other interventions as indicated. This will assist with validation of wound healing interventions and effectiveness of wound care prevention.</p> <p>Monitor The Director of Nursing and/or designee will audit weekly skin assessments on 3 resident's five times weekly for 4 weeks, then 5 residents three times weekly for 8 weeks. Starting the week of March 31st 2019, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 686	<p>Continued From page 26</p> <p>area to the bottom of his right heel. The area was a flat blister which measured 4.2 cm x 4.0 cm with discoloration beneath the blister. The note stated "Area Stage 2 pressure area as determined by site and wound. Resident with recent decline in ADL status and subsequent diagnosis of PNA [pneumonia] with antibiotic treatment." The note documented a heel boot was placed to relieve pressure to Resident #38's right heel.</p> <p>Resident #38's TAR documented weekly skin assessments were to be completed on Wednesdays. A Skin Integrity Review form, dated 3/28/18, documented Resident #38's skin was intact. A subsequent Skin Integrity Review form, dated 4/22/18, documented Resident #38 had blisters and an "old" open area. The body diagram on the form did not illustrate where the blisters and or open area were located. Skin assessments were not documented as completed on 4/4/18 and 4/11/18.</p> <p>Resident #38's skin breakdown care plan, revised on 4/26/18, documented a Potus boot (heel lift boot) was to be worn to relieve pressure to his right foot.</p> <p>The ADL's for bathing for April 2018 documented Resident #38 received a shower on 4/2/18, 4/4/18, 4/8/18, and 4/12/18. On 4/11/18 it was documented Resident #38 refused.</p> <p>On 2/11/19 at 11:50 AM, Resident #38 was observed with a wrap to his right foot and ankle, TED (stockings worn to prevent blood clots) hose over the wrapped dressing, and a heel lift boot. CNA #1 stated Resident #38 had an open area to</p>	F 686			

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F 686	<p>Continued From page 27</p> <p>his right heel for a long time and he was going to the wound clinic for the first time on 2/12/19.</p> <p>A Wound Clinic Consult Report, dated 2/12/19, documented Resident #38 had a Stage II pressure ulcer and this was his first visit to the clinic. The report stated debridement to the right heel was " ...performed to remove devitalized tissue: biofilm and slough. Post debridement measurements: 2.5 cm x 2.3.cm x 0.3 cm noted as Stage 2 Pressure Injury." The report stated dressing changes were to be completed every two days.</p> <p>On 2/14/19 at 3:28 PM, the Dietitian stated the facility completed weekly skin checks on the residents scheduled shower days. The Dietitian stated Resident #38 refused to have a shower on 4/11/18.</p> <p>On 2/14/19 at 3:30 PM, a request was made to observe the dressing change for Resident #38. The DON stated the dressing was not due to be changed until 2/15/19, on the night shift. The DON stated she was not employed at the facility when Resident #38 acquired the pressure ulcer on 4/13/18. The DON stated Resident #38 had a Stage II pressure ulcer to his inner right heel. She stated they should have floated his heels when he was in bed and when he had a change of condition on 4/10/18. The DON was unable to provide documentation Resident #38's heels were floated prior to 4/13/18. The DON stated Resident #38's right leg was contracted which may have caused difficulty when trying to float his heels while in bed.</p> <p>On 2/14/19 at 3:40 PM, the RNC was unable to</p>	F 686			

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F 686	<p>Continued From page 28</p> <p>provide documentation in Resident #38's record the staff floated his heels while he was in bed from 4/4/18 through 4/13/18. She stated after the heel boot was in place on 4/13/18, the boot reduced pressure to his right heel. The RNC stated it was later changed to the heel lift boot on 4/26/18, to prevent further breakdown to his right heel.</p> <p>2. Resident #3 was admitted to the facility on 10/24/18, with multiple diagnoses including diabetes mellitus, restless legs syndrome, and muscle weakness.</p> <p>A quarterly MDS assessment, dated 1/31/19, documented Resident #3 was severely cognitively impaired and required extensive assistance of two staff with bed mobility and total assistance with transfers.</p> <p>An admission Braden Scale (a tool used to assess a resident's risk for developing pressure ulcers) assessment, dated 10/24/18, documented Resident #3 was at moderate risk for developing a pressure ulcer.</p> <p>Resident #3's record included a care plan initiated on 10/25/18 and 10/26/18, which identified her code status, her risk for falls, risk for an ADL deficit, and nutritional risk. Her care plan was revised to include risk for impaired skin integrity on 11/6/18. The skin integrity care plan included interventions for a pressure reducing cushion to her wheelchair and staff were to remind Resident #3 and assist her with repositioning at least every 2 hours.</p> <p>Resident #3's record included documentation she</p>	F 686			

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F 686	<p>Continued From page 29</p> <p>was assisted by staff with bed mobility and required total assistance with 2 or more staff on 11/2/18, 11/3/18, 11/4/18, 11/5/18, 11/6/18, and 11/7/18. There was no documentation in the record Resident #3 was assisted with repositioning, turning, or floating her heels.</p> <p>A Weekly Skin Check Report, dated 11/6/18 at 4:20 PM, documented Resident #3 had no skin conditions or changes, pressure ulcers, or injuries.</p> <p>A Weekly Pressure Ulcer Report, dated 11/7/18 at 8:32 PM, documented Resident #3 developed a new Stage II pressure ulcer to her left heel which measured 5.0 cm x 4.0 cm, and was described as a fluid filled blister. The report documented the pressure ulcer had a scant amount of thin, watery, pale red/pink fluid. The report also stated Resident #3 had limited activity for the past few days.</p> <p>A pressure ulcer care plan, initiated 11/8/18, documented staff were to float Resident #3's heels while in bed as she allowed, follow facility's policies/protocols for the prevention and treatment of skin breakdown, assess/record/monitor wound healing weekly and as needed, and to notify the physician for any changes.</p> <p>Resident #3's November 2018 TAR, dated 11/8/18 at 3:30 PM, documented licensed nurses were to assess the heel lift boot to her left foot two times a day, until the blister was resolved.</p> <p>Resident #3's November 2018 TAR, dated 11/12/18 at 3:30 PM, documented licensed</p>	F 686			

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F 686	<p>Continued From page 30</p> <p>nurses were to apply skin prep to her bilateral heels two times a day for skin protection.</p> <p>A Physical Restraint Consent, dated 11/13/18, documented Resident #3 and spouse consented to have an air mattress with perimeter sides for her "impaired skin (pressure injury)."</p> <p>On 2/11/19 at 11:23 AM, Resident #3 was observed laying on her back in bed wearing her heel lift boot. Her left heel was turned sideways with her left heel touching her bed. CNA #2 stated the heel lift boot was not positioned correctly and repositioned the heel lift boot to have Resident #3's left heel not touching the bed. CNA #2 stated the heel lift boot was to allow the heel to float and alleviate any type of pressure to her heel. CNA #1 and CNA #2 stated the heel lift boot was initiated after Resident #3 developed a pressure ulcer to her left heel in November.</p> <p>On 2/11/19 at 12:22 PM, the DON was observed providing a dressing change to Resident #3's left heel. The left heel wound was black in color (eschar) with the wound bed edges lifted. The DON measured the wound and it measured 3.3 cm x 2.0 cm and the depth was undetermined, because the wound bed was covered with eschar. The DON cleansed the left heel wound, applied Santyl ointment (debridement ointment to remove the eschar), and covered the wound with an adhesive dressing. The DON stated the Santyl ointment was initiated a week ago and the wound bed edges were now lifting with the current treatment. The DON stated the staff should be checking and repositioning Resident #3's heel lift boot every two hours to ensure her heel was not touching anything to cause</p>	F 686			

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

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F 686	Continued From page 31 pressure.  A Pressure Ulcer Investigation, signed by the DON on 2/13/19, stated Resident #3 had a left heel pressure ulcer discovered on 11/7/18. The investigation documented the pressure ulcer was 5 cm by 4 cm. The DON documented the facility consistently implemented interventions which included preventive skin care, consistently turn and position, utilization of appropriate pressure reduction support surfaces, incontinence management program, a registered dietician consult, and prevention was addressed on care plan to manage identified risk factors. Resident #3's care plan did not identify skin integrity as a risk until 11/6/18, and the consent for a pressure relieving mattress was not signed until 11/13/18. There was no documentation in Resident #3's record she was turned and repositioned consistently.  On 2/14/19 at 3:54 PM, the RNC, with the DON, stated due to Resident #3's co-morbidities and refusal of care the facility did not cause the wound to Resident #3's left heel. The DON and the RNC stated the staff should check and reposition the heel lift boot at least every two hours and should have been documented as an intervention on Resident #3's care plan. The RNC was unable to provide documentation in Resident #3's record her heels were floated by pillows prior to the development of the pressure ulcer to her left heel.	F 686			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)  §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that	F 690		4/2/19	

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F 690	<p>Continued From page 32</p> <p>resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, policy review, and record review, it was determined the facility failed to ensure the bowel protocol was followed and implemented for 1 of 2 residents (#30) reviewed</p>	F 690	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Clearwater Health and Rehabilitation of</p>		

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F 690	<p>Continued From page 33 for bowel and bladder care. This had the potential to place residents at risk for fecal impaction. Findings include:</p> <p>Resident #30 was readmitted to the facility on 1/14/19 with diagnoses of coronary artery disease and atrial fibrillation.</p> <p>Resident #30's admission physician orders, dated 1/14/19, directed staff to provide:</p> <p>* Bisacodyl delayed release 10 mg by mouth after 3 days with no bowel movement, as needed.</p> <p>* Bisacodyl suppository 10 mg rectally after 4 days with no bowel movement, as needed.</p> <p>The facility's Bowel Function Monitoring for January 2019, documented Resident #30 did not have a bowel movement on 1/28/19, 1/29/19, 1/30/19, and 1/31/19.</p> <p>Resident #30's January 2019 MAR did not include documentation the Bisacodyl was administered as ordered for no bowel movement.</p> <p>On 2/13/19 at 11:54 AM, RCM #1 stated when Resident #30 did not have a bowel movement for 3 or 4 days, it was expected medication was provided per physician's orders.</p>	F 690	<p>Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>Resident Specific The clinical team has reviewed resident #30 for implementation of facility bowel protocol and MD notification. Regular bowel movements are occurring.</p> <p>Other Residents The clinical management team has reviewed other residents for proper bowel protocol interventions in the last 7 days. Adjustments have been made as indicated.</p> <p>Facility Systems Nursing staff are educated to the facility bowel protocol. Re-education was provided by Director of Nursing and/or designee to include but no limited to; documentation and monitoring of bowel movements, the facility bowel protocol and physician specific directives, timely implementation of bowel care plans, MD notification and monitoring. The system is</p>		

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F 690	Continued From page 34	F 690	amended to include oversight by the Director of Nursing with review of bowel monitors and plan implementation in the clinical meeting.  Monitor The Director of Nursing and/or designee will audit residents for timely use of facility bowel protocol/physician specific directives implementation three times weekly twelve weeks. Starting the week of 3/31/2019. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)  §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-  §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;  §483.25(g)(2) Is offered sufficient fluid intake to	F 692		4/2/19	

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F 692	<p>Continued From page 35 maintain proper hydration and health;</p> <p>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, policy review, resident and staff interview, and record review, it was determined the facility failed to ensure residents received diet textures ordered by their physician. This was true for 1 of 3 residents (Resident #23) whose diets were reviewed. This failure resulted in harm when Resident #23 experienced a choking episode which required emergency measures and transport to the hospital. Findings include:</p> <p>The facility's Meal Distribution policy, dated 3/2014, documented, "1. The Food Service Director will ensure that all meals are assembled in accordance with the individualized diet order, plan of care and preferences ...3. The nursing staff shall be responsible for verifying the accuracy and delivery of meals to the residents/patients ...4. ...the dietary department staff, under the supervision of the licensed nurse, will assemble the meal in accordance with the indicated meal card and present it to the resident/patient or care staff for delivery to the resident/patient."</p> <p>Resident #23 was admitted to the facility on 9/25/18, with multiple diagnoses including a stroke with hemiplegia (weakness on one side) and dysphagia (difficulty swallowing).</p> <p>A physician's admission order, dated 9/25/18,</p>	F 692	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Clearwater Health and Rehabilitation of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>Resident Specific The clinical team has reviewed resident #23 for implementation of physician ordered diet textures and is currently eating all meals in the supervised dining room.</p> <p>Other Residents The clinical management team reviewed other residents for proper implementation of physician ordered diet textures, SLP recommendations for safe eating as indicated, and staff supervision while eating. Adjustment have been made as</p>		

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F 692	<p>Continued From page 36 included a mechanical soft texture diet.</p> <p>An admission MDS assessment, dated 10/2/18, documented Resident #23 was cognitively intact, had coughing or choking during meals, had difficulty or pain with swallowing, and required a mechanically altered diet.</p> <p>An ST evaluation documented dates of service were from 9/26/18 to 1/28/19. The short-term goal for Resident #23 was to safely consume mechanical soft/chopped textured foods.</p> <p>An Incident and Accident Report, dated 12/16/18 at 1:15 PM, documented Resident #23 was sitting straight up in bed and visibly choking. Resident #23 could not breathe or make a sound, her face was severely red, lips were blue, and she was flailing her right arm and leg. The licensed nurse performed the Heimlich maneuver countless times before the object finally expelled. The object was a large piece of meat. Resident #23 began gasping for air, sobbing, and was sent to the ER for evaluation.</p> <p>On 2/13/19 at 10:00 AM, the consulting Registered Dietician stated she was aware Resident #23 had a choking episode. She stated dietary staff were retrained on meal service and tray preparation.</p> <p>On 2/13/2019 at 4:45 PM, RN #2 stated she was the RN on duty on 12/16/18, when Resident #23 choked on the food she was eating. RN #2 stated Resident #23 was not served the correct meal tray she was served a regular diet when mechanical soft was ordered. She said Resident #23 was eating while in the bed, and not in a</p>	F 692	<p>indicated.</p> <p>Facility Systems Food Service Director, dietary staff, licensed nurses and Certified Nursing Assistants, are educated to the facility Meal Distribution policy and following physician orders. Re-education was provided by Director of Nursing and/or designee to include but no limited to; the facility's Meal distribution policy, Diet orders and Nutrition Prescriptions Policy, Therapeutic Diets, SLP directives, and Meal Plans, as well as following physician order, and supervision as indicated on the resident care plan/Kardex. The system is amended to include oversight and meal observation by the Executive Director, validating that two dietary staff are verifying the correct physician diet orders are being served and staff delivering trays validate the diet served reflects the tray card directives.</p> <p>Monitor The Executive Director and/or designee will audit 5 residents physician diet texture orders for accuracy and implementation weekly for 4 weeks and then 2 residents weekly for 8 weeks. Starting the week of 3/31/2019. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may</p>		

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F 692	Continued From page 37 chair as recommended. RN #2 stated staff was not present in the room as Resident #23 initially started choking. RN #2 stated staff heard noises coming from the Resident #23's room and found her banging the call light on the overbed table to get staff's attention. RN #2 described the emergent care provided which included the Heimlich Maneuver (a life-saving technique to clear the airway when an object becomes lodged) was administered to dislodge the meat and clear Resident #23's airway to allow her to breathe. RN #2 stated Resident #23 was transferred to the hospital for examination following the incident and then returned to the facility the same night. RN #2 stated Resident #23 complained of being sore, due to the Heimlich Maneuver when she returned to the facility.  On 2/13/19 at 5:00 PM, the Director of Rehabilitation stated Resident #23 was assessed for safe eating and it was determined Resident #23 required a mechanical soft/chopped diet, should be seated in a chair or wheelchair to eat, and required supervision with meals.  On 2/13/19 at 7:15 PM, Resident #23 stated she remembered the choking episode, and stated the food she swallowed was a piece of meat about the size of a golf ball. Resident #23 stated the choking episode was "terrifying."	F 692	adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2)  §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language	F 825		4/2/19	

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F 825	<p>Continued From page 38</p> <p>pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must-</p> <p>§483.65(a)(1) Provide the required services; or</p> <p>§483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure residents received rehabilitative services as ordered by the physician. This was true for 2 of 3 residents (#3 and #139) who were reviewed for therapy services. This failure created the potential for harm if residents experienced a decline in their physical functioning when rehabilitative services were not provided. Findings include:</p> <p>1. Resident #3 was readmitted to the facility on 11/20/18, with multiple diagnoses including osteoporosis with pathological fractures (a weakness in the bone caused by disease).</p> <p>A Nurse's Progress Note, dated 2/5/19 at 1:18 PM, documented Resident #3 had returned from a physician appointment and there was a new order for PT. The nurse documented Resident #3</p>	F 825	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Clearwater Health and Rehabilitation of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>Resident Specific The ID team reviewed resident #3 and #139</p> <p>Resident #3 is receiving physical therapy.</p>		

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F 825	<p>Continued From page 39 was aware of this order.</p> <p>An orthopedic surgeon ordered Resident #3 to receive PT for progression to weight bearing as tolerated on 2/5/19. The physician's order documented, "Has severe osteoporosis so begin WB [weight bearing] cautiously 5x/wk."</p> <p>On 2/11/19 at 11:20 AM, Resident #3 stated she was not receiving any type of therapy.</p> <p>On 2/11/19 at 2:50 PM, the DON stated Resident #3 had three pathological fractures and will not have Resident #3 receive therapy because she was morbidly obese and this may cause another pathological fracture.</p> <p>On 2/14/19 at 5:21 PM, the Director of Rehabilitation stated the Physical Therapist had concerns for providing therapy services to Resident #3. The Director of Rehabilitation stated Resident #3's record did not include documentation of the concerns the Physical Therapist had or that the orthopedic surgeon was not notified of the Physical Therapist's concerns. The Director of Rehabilitation stated Resident #3 will receive physical therapy beginning on 2/15/19, as ordered by the physician.</p> <p>2. Resident #139 was admitted to the facility on 2/7/19, with multiple diagnoses including history of falls and weakness.</p> <p>Resident #139's admission orders, dated 2/7/19, documented Resident #139 was to receive PT, OT, and ST.</p> <p>On 2/12/19 at 2:04 PM, Resident #139 stated</p>	F 825	<p>Physical therapy department is following weight bearing status orders as ordered by orthopedic surgeon's order.</p> <p>Resident #139 is currently receiving occupational therapy as ordered by the physician.</p> <p>Other Residents The ID team reviewed other residents' clinical records to validate therapy orders are being followed as ordered by the physician. Adjustments have been made as indicated.</p> <p>Facility Systems DON and/or designee will educate Therapy department and nurses on Following Physician Orders and Physician Notification. Education was provided by the DON and/or designee to include but not limited to follow through of residents' plan of care and notifying the physician of concerns and or clarification of resident order(s) specifically related to therapy. The system is amended to include oversight by the Director of Nursing with review of new admission and new orders in the Clinical review meeting to validate therapy orders are being implemented timely and followed as ordered.</p>		

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F 825	Continued From page 40 she did not receive therapy services.  On 2/13/19 at 10:56 AM, the Director of Rehabilitation stated Resident #139 was receiving PT and ST. The Occupational Therapist stated she had not worked with Resident #139. The Director of Rehabilitation stated the physician's order for Resident #139 to receive OT was missed.	F 825	Monitor The Department Head Therapist and/or designee will audit new therapy orders 5x□s weekly until 4 consecutive weeks of compliance is achieved. Once achieved, the audit will then be monitored 3x□s weekly for 8 weeks. Starting the week of March 31st 2019, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)  §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza	F 883		4/2/19	

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NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1204 SHRIVER ROAD OROFINO, ID 83544</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 883	<p>Continued From page 41 immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and record review, it was determined the facility failed to ensure residents received the pneumococcal vaccine per the Centers for Disease Control and Prevention (CDC) recommendations. This was</p>	F 883	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Clearwater Health and Rehabilitation of Cascadia does not admit that the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/15/2019</b>
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F 883	<p>Continued From page 42</p> <p>true for 1 of 5 residents (Resident #23) reviewed for pneumococcal immunizations. This failure created the potential for harm should residents contract pneumonia. Findings include:</p> <p>The facility's Pneumococcal Program Policy and Procedure, dated 10/31/17, documented residents are offered and given the pneumococcal vaccine in accordance with physician's orders unless medically contraindicated, the resident had already received the immunization, or the resident refuses. The procedure documented staff provided education about the pneumococcal vaccination, screen the resident to determine where they are in the pneumococcal vaccination series, administer the pneumococcal vaccine, and update the resident's immunization record.</p> <p>The CDC website, accessed on 3/6/19, stated for those who have not received any pneumococcal vaccines, or those with unknown vaccination history the recommendations were as follows:</p> <ul style="list-style-type: none"> <li>* Administer 1 dose of PPSV23 [pneumococcal polysaccharide vaccine] at 19 through 64 years.</li> <li>* Administer 1 dose of PCV13 [pneumococcal conjugate vaccine] at 65 years or older. This dose should be given at least 1 year after PPSV23.</li> <li>* Administer 1 final dose of PPSV23 at 65 years or older. This dose should be given at least 1 year after PCV13 and at least 5 years after the most recent dose of PPSV23.</li> </ul> <p>Resident #23 was admitted to the facility on 9/25/18, with multiple diagnoses including a stroke with hemiplegia.</p>	F 883	<p>deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p><b>Resident Specific</b> The ID team reviewed resident #23 immunization record. MD notified of resident not meeting CDC recommendations for pneumococcal vaccination for order clarification.</p> <p><b>Other Residents</b> The ID team reviewed other residents' clinical records to validate residents meeting CDC criteria for Pneumococcal immunization have consent forms signed by the resident or responsible party as well as validate vaccine has been received if indicated.</p> <p><b>Facility Systems</b> Director of Nursing and/or designee will educate nurses on the CDC Pneumococcal recommendation guidelines and the facility Pneumococcal Program policy and procedure. The system is amended to include a review of new admission clinical records in the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/15/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1204 SHRIVER ROAD OROFINO, ID 83544</b>		
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F 883	Continued From page 43  The quarterly MDS assessment, dated 12/2/18, documented Resident #23 was not up to date or offered the pneumococcal vaccine.  Resident #23's Pneumococcal Vaccine Consent form, dated 9/28/18, documented she gave consent for the pneumococcal vaccine.  Resident #23's record did not include documentation she received the PCV13 or the PPSV23 vaccine.  On 2/14/19 at 8:45 AM, the Infection Control Nurse stated Resident #23 was not on the facility's tracking record and Resident #23 did not receive the pneumococcal vaccine.	F 883	Clinical review meeting to validate CDC recommendation guidelines and facility policy and procedure for Pneumococcal vaccination policy is being followed. If the resident does not meet criteria to receive vaccination, the physician will be notified for clarification order, and information placed into the immunization record.  Monitor The Director of Nursing and/or designee will audit new admissions by the following day. Starting the week of March 31st 2019, the review will be documented on immunization log. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001140</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/15/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1204 SHRIVER ROAD OROFINO, ID 83544</b>
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C 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the licensing survey conducted on February 10, 2019 to February 15, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Edith Cecil, RN, Team Coordinator Jenny Walker, RN Kate Johnsrud, RN</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of Infection Control Committee attendance records, it was determined the facility failed to ensure the Dietary Manager, or a representative from the dietary department, participated in the Infection Control Committee meetings at least quarterly. This failure created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings included:</p> <p>On 2/14/19 at 1:10 PM, the Administrator stated the facility's Infection Control Committee met monthly. Review of the monthly sign-in sheets, from January 2018 to December 2018, showed the Dietary Manager, or a representative from the dietary department attended the meeting in August 2018. There was no documentation of dietary participation for the other meetings during 2018.</p>	C 664	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Clearwater Health and Rehabilitation of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>Resident Specific No residents were identified as being affected by this alleged practice.</p>	4/2/19

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  03/18/19
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001140</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/15/2019</b>
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C 664	Continued From page 1  On 2/14/19 at 2:00 PM, the Administrator stated he thought the Dietary Manager attended the meetings but he was unable to find any additional signatures that represented the dietary department.	C 664	<p>Other Residents Facility residents have the potential of being affected by this alleged practice.</p> <p>Facility Systems Clinical Resource Nurse will educate department heads on the required Member attendance for the monthly Infection Control Committee meeting. The system is amended to include a revised committee sign-in attendance sheet with specified department sign-in sections on the form to validate each department head and/or department designee has signed. The Administrator and/or designee will be responsible of validating each department required to attend has signed prior to end of the meeting and attends at least quarterly.</p> <p>Monitor The Executive Director and/or designee will audit monthly for 3 months. Starting the next PI meeting in March of 2019, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>	



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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June 24, 2019

Thomas Welker, Administrator  
Clearwater of Cascadia  
1204 Shriver Road,  
Orofino, ID 83544-9033

Provider #: 135048

Dear Mr. Welker:

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

**Complaint #ID00008000**

ALLEGATION #1:

The facility failed to ensure a resident's safety during dining.

FINDINGS #1:

An unannounced complaint investigation was conducted on 2/10/19 to 2/15/19. Observations were conducted throughout the facility. Interviews were conducted with residents, family members, and staff members. Seventeen resident records were also reviewed .

One resident's record documented she ingested a fork mashable Brussels sprout and choked. Staff assisted the resident to the floor from her wheelchair, and her head hit the floor. The record documented the staff were able to clear her airway enough for some air to pass with respiratory effort. Emergency Medical Services transferred the resident to the emergency room (ER). The physician's report of the ER encounter documented the Brussels sprout removed from the

resident's airway did not have teeth marks on it indicating the resident did not chew it.

Review of the occurrence report and witness statements documented the vegetable was fork mashable, making it appropriate for mechanical soft diets. The Registered Dietitian, on 2/13/19, stated the facility now slices the Brussels sprouts for all residents.

The diets were reviewed for twelve residents with no other concerns identified.

There were no concerns voiced in the Resident Council Meeting related to residents not receiving their diets as ordered.

#### CONCLUSIONS:

The allegation was substantiated and the facility was cited at F692.

#### ALLEGATION #2:

The facility failed to ensure sufficient numbers of nursing staff were assigned on weekends.

#### FINDINGS #2:

Observations were conducted throughout the facility. Interviews were conducted with residents, family members and staff members. Seventeen resident records were reviewed.

Review of staffing for the week of 2/10/19 to 2/15/19 showed adequate staff to meet resident needs. At the Resident Council Meeting there were no staffing complaints from the residents who attended.

#### CONCLUSIONS:

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

ALLEGATION #3: A resident was not receiving Physical Therapy as needed.

#### FINDINGS #3:

Seventeen resident records were reviewed and observations were conducted.

One resident's record documented they received skilled therapy and it was discontinued due to lack of progress. The Occupational Therapy discharge note stated, "...limited ability to participate with strengthening tasks, unable to transfer- cont continues to require mechanical lift, progress

Thomas Welker, Administrator  
June 24, 2019  
Page 3

was limited by pain, behaviors, anxiety." A Physical Therapy discharge note stated "...res resident with very limited ability to assist with sitting balance activities due to control, balance and pain in various joints. Decreased functional ROM range of motion limits positioning and standing, continues to need max maximum assist. Restorative program created..." The resident's record documented he continued to receive restorative services as directed in his plan of care.

CONCLUSIONS:

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

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,



LAURA THOMPSON, RN, Supervisor  
Long Term Care Program

LT/slj