



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE- Governor
DAVE JEPPESEN- Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

April 1, 2020

Royal Jensen, Administrator
Cascadia of Boise
6000 W. Denton St
Boise, ID 83704

Provider #: 135146

Dear Mr. Jensen:

On **March 5, 2020**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **February 4, 2020**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- **F686 -- S/S: G -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer**
- **F693 -- S/S: D -- 483.25(g)(4)(5) -- Tube Feeding Mgmt/restore Eating Skills**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 11, 2020**.

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

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

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

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

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

As noted in the Bureau of Facility Standards' letter of **January 8, 2020**, following the survey of **December 13, 2019**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **June 13, 2020**, if substantial compliance is not achieved by that time. The findings of non-compliance on **March 5, 2020**, has resulted in a continuance of the remedie) previously mentioned to you by CMS. CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after March 13, 2020
- Civil Money Penalty

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

If you believe the deficiencies have been corrected, you may contact please contact Debby

Royal Jensen, Administrator
April 1, 2020
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Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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

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

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

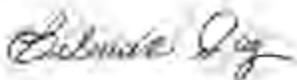
- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **April 11, 2020**. If your request for informal dispute resolution is received after **April 11, 2020**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Belinda Day, RN, or Laura Thompson, RN, Supervisors at (208)334-6626, option #2.

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj
Enclosures

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

PRINTED: 04/20/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/05/2020
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NAME OF PROVIDER OR SUPPLIER CASCADIA OF BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 W DENTON ST BOISE, ID 83704
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000}	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the follow-up survey conducted at the facility on March 2, 2020 through March 5, 2020.</p> <p>The surveyors conducting the survey were:</p> <p>Presie C. Billington, RN, Team Coordinator Monica Meister, QIDP Carmen Blake, RN</p> <p>Abbreviations:</p> <p>DON = Director of Nursing MDS= Minimum Data Set RN= Registered Nurse</p>	{F 000}		
{F 686} SS=G	<p>Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on policy review, record review, observation, and staff interview, it was determined the facility failed to ensure</p>	{F 686}	<p>This plan of correction is submitted to meet requirements established by state law. This plan of Correction constitutes</p>	4/10/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 04/09/2020
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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 686}	<p>Continued From page 1</p> <p>professional standards of practice were followed to prevent the development and worsening of a wound. This was true for 1 of 13 residents (Resident #620) reviewed for quality of care. This failure resulted in harm when Resident #620 developed a blister on her right heel which required debridement (removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue). Findings include:</p> <p>The National Pressure Ulcer Advisory Panel, 2016, defined pressure ulcers as follows:</p> <p>Stage 1- Intact skin with a localized area of non-blanchable erythema (red discoloration of skin as a result of injury) which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate a deep tissue pressure injury.</p> <p>Stage 2 - Partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough (non-viable yellow, tan, gray, green, or brown tissue) and eschar (dead or weakened tissue that is hard or soft in texture - usually black, brown, or tan in color) are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel.</p> <p>Stage 3 - Full-thickness loss of skin, in which</p>	{F 686}	<p>this facility's demonstration of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency existed or that one was cited correctly.</p> <p>Resident Specific Resident #620 had a skin evaluation completed and interventions in place.</p> <p>Other Residents IDT reviewed current residents with high risk for developing pressure injuries and/or with pressure injuries present, were reviewed for preventative and treatment interventions and adjustments made as indicated.</p> <p>Facility Systems Nursing staff educated by CNO and/or designee to facility Prevention and Treatment of Pressure Ulcers and Other Skin Alterations Policy, to include but not limited to complete skin risk assessments upon admission, readmission, at designated intervals throughout their stay and with change of condition in order to evaluate the resident's risk and to implement preventative interventions as indicated. The system is amended to include review by the clinical management team in clinical meeting of residents identified as high risk for</p>		

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{F 686}	<p>Continued From page 2</p> <p>adipose is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining (when the tissue under the wound edges becomes eroded, resulting in a pocket beneath the skin at the wound's edge) and tunneling (channels that extend from a wound into and through the tissue or muscle below) may occur. Fascia, muscle, tendon, ligament, cartilage or bone is not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.</p> <p>Stage 4 - Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole, undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.</p> <p>Unstageable - Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be softened or removed.</p> <p>The Lippincott Manual for Nursing Practice, tenth edition, page 184, stated measures to prevent pressure ulcer development included</p>	{F 686}	<p>pressure injuries for preventative interventions implemented as indicated and timely. Clinical rounds to include review of person centered skin prevention plan implementation. This system is further amended to include weekly wound meetings with IDT to evaluate the plan of care in order to identify needed changes.</p> <p>Monitoring The CNO and/or designee will audit skin risk assessments for timely completion and preventative interventions in place 5 days a week for 4 weeks, then 2 days a week for 8 weeks. Starting the week of 4/10/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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{F 686}	<p>Continued From page 3</p> <p>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>The facility's policy for Prevention and Treatment of Pressure Ulcers and Other Skin Alterations, revised 7/31/18, documented:</p> <p>*The facility had a system in place to promote skin integrity, prevent pressure ulcer development/other skin alterations, promote healing of existing wounds consistent with professional standards of practice.</p> <p>*A risk assessment was completed upon admission and at designated intervals throughout the resident's stay to evaluate the resident's risk...</p> <p>*Residents at risk for developing pressure ulcers were identified by using the Braden Scale (evaluates patient's risk of developing a pressure ulcer).</p> <p>*Pressure ulcer and other wound and skin related interventions were created by the interdisciplinary team and implemented in order to identify, prevent or reduce the risk of acquiring pressure and/or non-pressure related wounds. Interventions included but not limited to:</p> <ul style="list-style-type: none"> -Redistribute pressure such as repositioning, protecting and/or offloading heels. -Provide appropriate, pressure redistributing support surfaces. -Provide non-irritating surfaces. -Maintain or improve nutrition and hydration 	{F 686}			

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{F 686}	<p>Continued From page 4 status when feasible.</p> <p>Resident #620 was admitted to the facility on 1/28/20, with multiple diagnoses which included diabetes mellitus and fracture of the right humerus (upper arm).</p> <p>Resident #620's initial nursing assessment, dated 1/28/20, documented she had multiple bruises, a cast to her right arm, and her skin was intact with no other wounds.</p> <p>Resident #620's Alteration in Skin care plan, initiated on 1/28/20, directed staff to perform weekly skin assessments and to check her footwear.</p> <p>A progress note by the Wound Nurse, dated 1/31/20, documented Resident #620 had no alteration in skin integrity.</p> <p>Resident #620's admission MDS assessment, dated 2/3/20, documented she had moderate cognitive impairment and required extensive assistance of one staff member with cares. The MDS documented she had no current skin impairments. The MDS also documented she used a pressure reducing device for her bed.</p> <p>Resident #620's Braden Scale assessments, dated 1/28/20, 2/5/20, and 2/14/20 documented she was at high risk for the development of pressure ulcer related skin injuries.</p> <p>Resident #620 developed a blister to her right outer heel which was identified on 2/10/20.</p> <p>Weekly skin assessments for Resident #620</p>	{F 686}			

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{F 686}	<p>Continued From page 5 documented the following:</p> <ul style="list-style-type: none"> - A Weekly Skin Alteration report, dated 2/10/20, documented Resident #620 had a new wound on the outer aspect of her right heel and stated it was a friction injury. The report stated the wound was an intact blister which contained both blood and serum (the liquid part of blood). The Weekly Skin Alteration report stated the wound measured 2 cm by 2.4 cm by 0 cm with redness to the area surrounding the wound. The report directed staff to offload the area of the wound. The Weekly Skin Alteration report documented the wound was cleansed, skin prep (a liquid dressing) was applied, and the wound was covered with silicone bordered foam. The report stated wound dressing changes were scheduled for twice a week and as needed. - A Weekly Skin Alteration report, dated 2/19/20, documented Resident #620's wound had deteriorated and the blister on her right heel had ruptured. The report documented Resident #620 had a macerated (softened) wound which measured 5 cm by 5.5 cm by 0.1 cm with redness around the wound and was blanchable (turns pale or white in appearance when pressure was applied). The report stated Resident #620's wound treatment was changed to a betadine (a topical anti-septic containing Povidone-iodine) swab daily and to cover the wound with gauze. - A Weekly Skin Alteration Report, dated 2/24/20, documented Resident #620's wound had improved measured 5 cm by 5.5 cm by 0.1 cm. The report documented the wound was pink and white in color with blood tinged drainage. The 	{F 686}			

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{F 686}	<p>Continued From page 6</p> <p>Weekly Skin Alteration report documented the wound treatment was changed to betadine swab daily and to cover the wound with the gauze. The wound measurements and treatment had not changed from the Weekly Skin Alteration report dated 2/19/20, 5 days earlier.</p> <p>On 3/4/20 at 9:50 AM, Resident #620 was observed during a wound dressing change. She had a standard mattress and not the hybrid mattress for offloading. A golf-ball sized purple and red, open area was observed to the right outside portion of Resident #620's. The Wound Nurse said Resident #620's wound started with ill-fitting shoes which she no longer wore.</p> <p>Resident #620's record included a referral to a wound clinic for evaluation of the wound to her right heel, revised on 3/4/20, 23 days after the wound was identified.</p> <p>A Wound Clinic progress note, dated 3/4/20, documented Resident #620 had a diabetic ulcer on her right lateral heel, measuring 4 cm by 4 cm by 0.2 cm with serosanguineous discharge and required debridement. The clinic's progress note documented the wound had 1-25% slough (non-viable yellow, tan, gray, green or brown tissue), and 26-50% eschar (dead or weakened tissue that was hard or soft in texture-usually black, brown or tan in color). The Wound Clinic progress note stated Resident #620 had been wearing thick socks with tennis shoes during physical therapy.</p> <p>A progress note by the Wound Nurse, dated 3/5/20 at 9:25 AM, documented Resident #620 had a blister on her right outer heel which was</p>	{F 686}			

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{F 686}	Continued From page 7 identified on 2/10/20. The note stated the wound was a large blood-filled blister with mild redness around the wound bed which blanched. The progress note documented Resident #620 said she was working with therapy and her shoes had been rubbing. The progress note stated Resident #620's shoes were inspected and found to have a misshaped heel, which jutted into the foot space. The progress note documented Resident #620 was also wearing thick non-skid socks at that time. On 3/5/20 at 11:00 AM, Clinical Resource Nurse #2 reviewed Resident #620's record and said she did not find in Resident #620's record she had interventions to prevent skin breakdown when she was assessed to be a high risk for a skin breakdown. Clinical Resource Nurse #2 said Resident #620 had a standard mattress as of 3/4/20, and they just placed a specialty, low air loss pressure reducing mattress on her bed. Clinical Resource Nurse #2 also stated the facility failed to follow the facility's policy and procedure to assess and implement preventative measures to ensure Resident #620 did not develop preventable skin breakdown.	{F 686}			
{F 693} SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to	{F 693}		4/10/20	

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{F 693}	<p>Continued From page 8</p> <p>eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and</p> <p>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure enteral feedings and flushing of a feeding tube were administered appropriately for 1 of 3 residents (Resident #18) reviewed for the use of a feeding tube. This created the potential for harm if complications developed from improper feeding tube practices. Findings include:</p> <p>The facility's policy for Enteral Feeding, dated 1/1/18, documented the following steps for administering through a feeding tube:</p> <ul style="list-style-type: none"> *Review physician's orders to validate enteral nutrition orders. *Flush feeding tube with specified amount of warm water ordered by the physician. *Fill the syringe with formula. *Slowly unclamp the feeding tube and allow 	{F 693}	<p>Resident Specific: Resident #18 assessed and no adverse effects noted from citation.</p> <p>Other Residents: Current residents with feeding tubes in use were reviewed to validate they receive tube feeding as ordered and per facility policy including validation of not using the plunger forcibly to administer via feeding tube. Orders for flushing feeding tubes were reviewed for clarity and adjustment were made as indicated.</p> <p>Facility Systems Licensed nursing staff educated by CNO and/or</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 693}	<p>Continued From page 9 formula to flow over 15-20 minutes by gravity. Raise or lower the syringe to regulate the rate of flow.</p> <p>*Do not use plunger to forcibly administer formula.</p> <p>*When syringe is 1/4 full, add more formula until the prescribed amount is given.</p> <p>This policy was not followed:</p> <p>Resident #18 was admitted to the facility on 10/9/19, with multiple diagnoses including dysphagia (difficulty swallowing) and traumatic brain injury.</p> <p>Resident #18's quarterly MDS assessment, dated 1/15/20, documented she used a feeding tube for nutritional support.</p> <p>Resident #18's physician orders documented the following:</p> <p>*75 ml of water before and after tube feeding via bolus, five times a day, ordered on 1/2/20</p> <p>*Jevity 1.5 (therapeutic nutrition), 360 ml (milliliters) tube feeding five times a day for enteral nutrition via bolus, ordered on 1/7/20.</p> <p>*Water flush - every shift for Enteral Nutrition Precautions, flush feeding tube with 30-315 ml of water before and after medication administration and 15-30 ml between each individual medication.</p> <p>It was unclear in the physician's order how much</p>	{F 693}	<p>designee to facility Administration of gravity feed through an Enteral Feeding Tube Policy, to include but not limited to, following physician's orders for flushing the feeding tube with specified amount of water before and after administration of tube feeding and not to use the plunger to forcibly administer water flush, medications or tube feeding. The system is amended to include competencies completed on hire and annually with licensed nursing staff for tube feed administration via enteral feeding tube</p> <p>Monitoring The CNO and/or designee will audit gravity feed administration through feeding tubes 2 times a week for 2 weeks, then weekly for 4 weeks, and monthly times 2. Starting the week of 4/10/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the</p>		

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{F 693}	<p>Continued From page 10</p> <p>water staff needed to use to flush Resident #18's feeding tube before and after her medication administration.</p> <p>Resident #18's care plan directed staff to flush her feeding tube with 30-315 ml of water before and after medication administration and 15-30 ml between each individual medication. It was unclear from the care plan how much water staff needed to use to flush Resident #18's feeding tube before and after her medication administration.</p> <p>On 3/3/20 at 8:12 AM, LPN #1 said Resident #18 received Jevity 1.5 five times a day and 360 ml of water to flush the feeding tube.</p> <p>On 3/3/20 at 8:21 AM, LPN #1 was observed administering Jevity 1.5 to Resident #18. LPN #1 attached the 60 ml syringe to Resident #18's gastrostomy tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach) and poured Jevity 1.5 into the syringe. LPN #1 then used the plunger of the syringe to push the Jevity 1.5 into Resident #18's stomach. LPN #1 poured the Jevity 1.5 again into the syringe and again used the plunger to push the Jevity 1.5 into Resident #18's stomach. LPN #1 repeated these steps 4 more times, and at 8:27 AM, LPN #1 poured 300 ml of water into the syringe and let it flow by gravity. LPN #1 completed the task of feeding Resident #18 in six minutes.</p> <p>On 3/3/20 at 9:55 AM, LPN #1 said she gave Resident #18 300 ml of water after she was done administering her 360 ml Jevity 1.5. LPN #1 said she did not flush Resident #18's feeding tube</p>	{F 693}	frequency of the monitoring after 6 weeks, as it deems appropriate.		

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{F 693}	<p>Continued From page 11 with water prior to her administration of Jevity 1.5. LPN #1 then reviewed Resident #18's physician orders and said she should have flushed Resident #18's gastrostomy tube with 75 ml of water before and after her enteral feeding.</p> <p>On 3/4/20 at 11:40 AM, during a telephone interview, LPN #1 said she used a plunger to push Resident #18's Jevity 1.5 into her stomach because it was a little thick.</p> <p>On 3/4/20 at 3:10 PM, the DON said a plunger should not be used to push the feeding solution into the residents' stomach. The DON said the feeding solution should be allowed to flow freely by gravity. The DON also stated the physician's order regarding water flushes needed to be clarified.</p>	{F 693}			