



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
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3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
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October 17, 2019

Mark Dudley, Administrator  
Weiser of Cascadia  
331 East Park Street  
Weiser, ID 83672-2053

Provider #: 135010

Dear Mr. Dudley:

On **October 4, 2019**, a survey was conducted at Weiser 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 no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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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 **October 28, 2019**. Failure to submit an acceptable PoC by **October 28, 2019**, may result in the imposition of penalties by **November 18, 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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **November 8, 2019 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **January 2, 2020**. A change in the seriousness of the deficiencies on **November 18, 2019**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **January 4, 2020** includes the following:

Denial of payment for new admissions effective **January 4, 2020**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 4, 2020**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 4, 2020** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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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 **October 28, 2019**. If your request for informal dispute resolution is received after **October 28, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Laura Thompson, RN, Supervisor  
Long Term Care Program

lt/lj

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

PRINTED: 11/01/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/04/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification and complaint survey conducted on September 30, 2019 to October 4, 2019.  The surveyors conducting the survey were:  Presie Billington, RN, Team Coordinator Sallie Schwartzkopf, LCSW  ADL = Activity of Daily Living CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease DON = Director of Nursing LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set RN = Registered Nurse	F 000			
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)  §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.  §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult	F 578		11/5/19	

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

TITLE

(X6) DATE

Electronically Signed

10/25/2019

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 578	<p>Continued From page 1</p> <p>residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents' records included an Advanced Directive or documentation of discussion regarding Advance Directives and their decision not to formulate one. This was true for 2 of 12 residents (#1 and #30) reviewed for Advance Directives. The deficient practice created the potential for harm should residents' wishes regarding end of life care not be honored when they are unable to make or communicate their health care preference. Findings include:</p>	F 578	<p><b>CORRECTIVE ACTION(S)</b></p> <p>Resident #1 was provided with information and education regarding completing advance directives. This information is documented in the resident medical record.</p> <p>Resident #30 discharged on 10/5/19.</p> <p><b>IDENTIFICATION OF OTHER RESIDENTS EFFECTED</b></p> <p>IDT (Interdisciplinary Team) reviewed records of residents currently in facility</p>		

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F 578	<p>Continued From page 2</p> <p>The State Operations Manual (SOM) defined an Advance Directive as "a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." The SOM defined a Physician Orders for Life-Sustaining Treatment (or POLST) as "a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an advance directive. ...If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether he or she has executed an advance directive or not, the facility may give advance directive information to the individual's resident representative in accordance with State Law."</p> <p>The facility's Advance Directives/Health Care Decisions policy and procedure, dated 10/1/17, documented "Residents have the right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate Advance Directives. In states with governance surrounding Advance Directives, facilities are to follow the State's specific requirements."</p> <p>This policy was not followed.</p> <p>1. Resident #1 was admitted on 7/24/18, with multiple diagnoses including COPD (a</p>	F 578	<p>regarding Advance Directive. Based upon the findings in the audit, the DON (Director of Nursing)/designee to review advance directives with resident providing education and documentation and/or records to be updated with resident directives.</p> <p><b>SYSTEMIC CHANGES/PREVENTION MEASURES</b> IDT educated by Clinical Resource RN on providing resident information regarding advance directives. Education includes but not limited to advance directive being provided upon admission as necessary, assisted to formulate advance directives, and resident records included documentation of this process, a copy of the resident's advance directives, or documentation of their decision not to formulate advance directives. Social Services or Designee will assist and document information regarding advance directives upon admission, quarterly, and if necessary, with significant changes. The system is amended to include review post admission and after the quarterly care review in clinical meeting.</p> <p><b>MONITORING OF CORRECTIVE ACTION</b> The DON and/or designee will audit resident records for new admissions and those with quarterly reviews for evidence of Advanced Directives or documentation of discussion regarding Advance Directives and their decision not to formulate weekly for 4 weeks, then every</p>		

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F 578	<p>Continued From page 3</p> <p>progressive lung disease), generalized muscle weakness, anxiety disorder, atrial fibrillation (irregular heart beat), and macular degeneration (retina deterioration causing blindness).</p> <p>Resident #1's record did not include an Advance Directive or documentation Advance Directives were discussed with her.</p> <p>On 10/3/19 at 10:35 AM, the Resident Support Services Manager (RSSM) said within 48-72 hours after admission a conference with a resident and/or a resident's representative was scheduled. She said during the conference the facility reviewed a resident's living will or provided the Idaho Advance Directive information, and if needed, the facility offered Advance Directive completion assistance. The RSSM said if the Advance Directive was not completed at the next conference, the facility reminded the resident and/or resident's representative to complete and provide it to the facility.</p> <p>On 10/3/19 at 10:45 AM and 11:52 AM, the DON confirmed the review process described above was correct and said unless an Advance Directive was scanned into a resident's chart, the resident and/or resident's representative had not provided it. The DON said Resident #1's record did not include an Advance Directive and there was no discussion with Resident #1 and/or her representatives about Advance Directives documented.</p> <p>2. Resident #30 was admitted to the facility on 9/11/18 and was readmitted on 8/30/19, with multiple diagnoses which included diabetes mellitus and hypertension (high blood pressure).</p>	F 578	<p>other week for 8 weeks. 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.</p>		

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F 578	Continued From page 4  Resident #30's record included a Multidisciplinary Care Conference note, dated 9/3/19, which documented "Advance Directive - continue." Resident #30's record did not include an Advance Directive or documentation information was discussed with her about Advance Directives.  On 10/3/19 at 10:35 AM, the RSSM said within 48-72 hours after residents are admitted, a care conference was scheduled for residents and/or their representatives. The RSSM said Advance Directives were discussed during the care conference, and the resident and/or their representatives were asked to provide a copy of the resident's Advance Directive if they had one. The RSSM said the facility offered to help the resident to complete an Advance Directive if they did not have one. The RSSM also said Advance Directives were reviewed with the residents and/or their representatives quarterly.  On 10/3/19 at 11:39 AM, the DON said "Advance Directive - continue" meant to continue what was on Resident #30's Physician Orders for Scope of Treatment (POST), not an Advance Directive. The DON said she was unable to find documentation Advance Directives were discussed with Resident #30.	F 578			
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	F 625		11/5/19	

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F 625	<p>Continued From page 5</p> <p>nursing facility must provide written information to the resident or resident representative that specifies-</p> <p>(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;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(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</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§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 by:</p> <p>Based on record review, policy review and staff interview, it was determined the facility failed to ensure a notice of their bed-hold policy was provided to residents or their representatives upon transfer to the hospital. This was true for 1 of 1 resident (Resident #17) 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>	F 625	<p>CORRECTIVE ACTION(S) Resident #17 no longer a resident</p> <p>IDENTIFICATION OF OTHER RESIDENTS EFFECTED IDT reviewed other residents currently out of the facility for notification of the bed hold policy. Residents have been provided a bed-hold notifications as indicated.</p> <p>SYSTEMIC CHANGES/PREVENTION MEASURES</p>		

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F 625	Continued From page 6  The facility's Bed-Hold Readmission policy and procedure, dated 11/28/17, documented the facility provided written information to the resident, or the resident's representative, about holding a resident's bed prior to or upon transfer to a hospital, and in cases of emergency transfer within 24 hours of transfer.  This policy was not followed.  Resident #17 was initially admitted to the facility on 7/11/17, and readmitted on 10/3/19, with multiple diagnoses including hypertension (high blood pressure), vascular dementia (brain damage caused by multiple strokes), and Type II diabetes mellitus.  A progress note documented Resident #17 was transferred to the hospital for evaluation on 9/26/19, when she exhibited increased weakness and had stopped eating and drinking. Resident #17's record did not include documentation a written notice of the facility's bed-hold policy was provided to her.  On 10/4/19 at 2:03 PM, Resident #17 said she did not remember if she was given a bed-hold notice.  On 10/4/19 at 3:10 PM, The DON said Resident #17's record did not include documentation she was provided written notice of the facility's bed-hold policy.	F 625	Admission Coordinator, Resident Support Services, Resident Care Manager, and DON educated to the bed-hold policy by the administrator and/or designee to include but not limited to notification of the bed-hold policy prior to transfer or verbal notification with transfer and documentation to follow within 24 hours post emergent transfer. The system is amended to include review of resident records who are out of the facility in clinical meeting for validation of bed-hold notification.  <b>MONITORING OF CORRECTIVE ACTION</b> The DON and/or designee will audit records of residents who are out of the facility for validation of bed-hold policy notification weekly for 4 weeks and every other week for 8 weeks. Any concerns will be addressed immediately and discussed with the PI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)  §483.24(a)(2) A resident who is unable to carry	F 677		11/5/19	

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F 677	<p>Continued From page 7</p> <p>out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents were assisted with hand hygiene. This was true for 1 of 12 residents (Resident #40) reviewed for ADL care. This failure created the potential for harm by potentially exposing residents to the risk of infection. Findings include:</p> <p>Resident #40 was admitted to the facility on 8/16/16, with multiple diagnoses which included diabetes mellitus.</p> <p>A quarterly MDS assessment, dated 9/18/19, documented Resident #40 was cognitively intact and she required extensive assistance from one person for most activities of daily living.</p> <p>On 10/2/19 at 1:22 PM, CNA #4 was observed as she provided pericare to Resident #40. CNA #4 unfastened Resident #40's incontinence brief and Resident #40 scratched her genitalia vigorously using her right hand. CNA #4 asked Resident #40 to stop scratching and gave the resident a wet wipe. Resident #40 held onto the wipe, but did not clean her hands. CNA #4 proceeded to clean Resident #40's periaerea and wiped it from front to back. CNA #4 then cleansed around Resident #40's catheter insertion site. Resident #40 then scratched her genitalia again using her right hand and her fingers were observed going to her catheter insertion site. CNA #4 reminded Resident #40 to stop scratching and gave</p>	F 677	<p><b>CORRECTION ACTION(S)</b> Resident #40 was provided handwashing assistance after it was brought to the attention of staff.</p> <p><b>IDENTIFICATION OF OTHER RESIDENTS EFFECTED</b> Residents are identified as potentially being affected by this deficiency. Surveillance observation process is adapted to include observation of resident hand washing after potential soiling.</p> <p><b>SYSTEMIC CHANGES/PREVENTION MEASURES</b> Nursing staff educated by DON and/or designee regarding hand washing to include but not limited to, when there is potential soiling and to offer assistance in hand washing during and after cares. The system is amended to include care observations/surveillance as part of routine rounds.</p> <p><b>MONITORING OF CORRECTIVE ACTION</b> DON and/or designee will conduct audit on a sampling of residents during personal cares weekly for 4 weeks and every other week for 8 weeks. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12</p>		



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NAME OF PROVIDER OR SUPPLIER  <b>WEISER OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</b>		
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F 684	<p>Continued From page 9</p> <p>nursing practice were followed for medication administration, bowel care, and skin care. This was true for 3 of 12 residents (#9, #16, and #30) reviewed for quality of care. These failed practices created the potential for harm should residents experience adverse effects from medications, constipation or fecal impaction, and skin breakdown. Findings include:</p> <p>1. The facility's undated policy for Oral Inhalant Administration, directed staff to instruct residents receiving steroid inhalers to rinse their mouth thoroughly with water immediately following inhalation to wash away steroid residue in the mouth.</p> <p>This policy was not followed.</p> <p>Resident #9 was admitted to the facility on 2/20/17, with multiple diagnoses including dementia and COPD (a chronic inflammatory lung disease that causes obstructed airflow from the lungs).</p> <p>A quarterly MDS assessment, dated 7/22/19, documented Resident #9 had moderate cognitive impairment.</p> <p>Resident #9's October 2019 physician's orders included Breo Ellipta (an inhaler taken orally containing a corticosteroid) 100-25 mcg (micrograms), inhale one puff orally one time a day for shortness of breath and wheezing. The order included special instructions for Resident #9 to rinse their mouth out with water and spit after administration.</p> <p>On 10/3/19 at 7:29 AM, RN #1 was observed</p>	F 684	<p>inhaling the Breo Ellipta.</p> <p>Resident #16 received bowel medications as ordered and they were effective.</p> <p>Resident #30 has discharged from the facility without return anticipated.</p> <p><b>IDENTIFICATION OF OTHER RESIDENTS EFFECTED</b> IDT reviewed other residents who receive steroid inhalers for receiving instructions and assistance as needed for rinsing their mouth after administration. Adjustments have been made as indicated. IDT reviewed other residents to evaluate that the bowel protocol is implemented per physician orders. Adjustments have been made as indicated. IDT reviewed other residents who are care planned to use Prevalon boots and/or a pillow between their knees when in bed. Adjustments have been made as indicated.</p> <p><b>SYSTEMIC CHANGE/PREVENTION MEASURES</b> Licensed nurses educated by DON and/or designee to instruct and assist residents to rinse their mouth after receiving a steroid inhaler and to administer bowel medications as ordered. Nursing staff educated by DON and/or designee to assist with placing Prevalon boots and/or pillows between knees of residents who are to receive these preventative interventions as a part of their plan of care. The system is amended to include</p>		

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F 684	<p>Continued From page 10</p> <p>when she administered Resident #9's medications which included the inhaled medication Breo Ellipta. Resident #9 was observed to take one puff of the Breo Ellipta orally, and then gave the inhaler back to RN #1. RN #1 then asked Resident #9 to take a sip of water. Resident #9 did not rinse his mouth after inhaling the Breo Ellipta.</p> <p>On 10/3/19 at 9:08 AM, RN #1 said she forgot to ask Resident #9 to rinse his mouth after administering the Breo Ellipta. RN #1 said she should have told Resident #9 to rinse his mouth with water and spit it out.</p> <p>2. The facility's Bowel Care protocol, updated on June 2018, documented the following:</p> <p>*Follow specific physician's orders for residents that require an increase in frequency over protocol.</p> <p>* If the resident was 24-48 hours without a bowel movement documented, staff were to administer 30 cc (cubic centimeter) of Milk of Magnesia (MOM) orally.</p> <p>*If the resident was 72 hours without a bowel movement documented, staff were to administer a glycerin suppository rectally as per physician's order.</p> <p>*If no bowel movement was documented by the following morning, staff were to administer a fleet enema rectally as per physician's order.</p> <p>*If no bowel movement within 2 hours, staff were to call the physician for additional orders.</p>	F 684	<p>observing administration of steroid inhalers and for offloading devices in place per plan of care during routine rounds, and review of bowel care in clinical meeting for timely implementation as ordered.</p> <p><b>MONITORING OF CORRECTIVE ACTION</b></p> <p>The DON and/or designee will audit medication administration for 3 residents receiving inhaled medications containing steroids (or all receiving if less than 3) for provision of oral rinsing afterwards weekly for 4 weeks then every other week for 8 weeks.</p> <p>The DON and/or designee will audit for bowel care in morning clinical meeting for residents requiring intervention 3 times a week for 4 weeks and then weekly for 8 weeks.</p> <p>The DON and/or designee will audit 3 (or all receiving if less than 3) residents requiring preventative offloading devices for implementation 3 times a week for 4 weeks then weekly for 8 weeks.</p> <p>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.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	<p>Continued From page 11</p> <p>This policy was not followed.</p> <p>Resident #16 was admitted to the facility on 7/12/18, with multiple diagnoses including altered mental status.</p> <p>A quarterly MDS assessment, dated 8/17/19, documented Resident #16 had severe cognitive impairment, required extensive assistance of two people for toileting, and was always incontinent of bowel.</p> <p>Resident #16's physician's orders dated 7/12/18, documented the following:</p> <ul style="list-style-type: none"> <li>*Fruiteze (laxative) 30 cc as needed for bowel care</li> <li>*MOM suspension, give 30 ml (milliliters) by mouth as needed for bowel care if no bowel movement in 24 - 48 hours.</li> <li>*Glycerin Adult Suppository, insert one suppository rectally as needed for bowel care if no bowel movement in 72 hours.</li> <li>*Fleet Enema 7-19 gm (grams)/118 ml, insert one unit rectally as needed for bowel care if no bowel movement in 72 hours.</li> </ul> <p>Resident #16's Bowel Movement Records, dated 9/5/19 through 10/3/19, documented she did not have a bowel movement between 9/5/19 and 9/7/19 (3 days) and between 9/20/19 and 9/22/19 (3 days).</p> <p>Resident #16's Medication Administration Record (MAR), dated 9/1/19 through 9/30/19, documented bowel medications were not administered as ordered when she did not have a</p>	F 684			

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F 684	<p>Continued From page 12 bowel movement from 9/5/19 to 9/7/19 and 9/20/19 to 9/22/19.</p> <p>On 10/3/19 at 1:27 PM, LPN #1 said he was not aware of the facility's bowel protocol. LPN #1 said physician's orders for bowel medications differed among the residents. LPN #1 reviewed Resident #16's MAR and said Resident #16 was not provided the bowel medications as ordered.</p> <p>3. Resident #30 was admitted to the facility on 9/11/18 and was readmitted on 8/30/19, with multiple diagnoses which included chronic pain and weakness.</p> <p>Resident #30's October 2019 physician's orders included Prevalon boots (a heel protector to keep the heel off the mattress to relieve pressure) while in bed every shift for skin integrity.</p> <p>Resident #30's care plan included interventions for Prevalon boots to each lower extremity when in bed and to have a pillow between her knees.</p> <p>On 10/3/19 at 2:03 PM, CNA #1 and CNA #2 assisted Resident #30 to transfer from her wheelchair to her bed. CNA #1 pulled the bed sheet up to Resident #30's waist and both CNAs left the room. Resident #30 was not provided with a pillow between her knees when she was repositioned in bed, and Prevalon boots were not applied to her lower extremities.</p> <p>On 10/3/19 at 2:27 PM, CNA #2 reviewed the care instructions for Resident #30 and said she did not know Resident #30 needed a pillow between her knees when she was being repositioned in bed. CNA #2 was also not aware</p>	F 684			

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F 684	Continued From page 13 Resident #30 also was to wear Prevalon boots while in bed.	F 684			



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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January 22, 2020

Mark Dudley, Administrator  
Weiser of Cascadia  
331 East Park Street  
Weiser, ID 83672-2053

Provider #: 135010

Dear Mr. Dudley:

On **September 30, 2019** through **October 4, 2019**, an unannounced on-site complaint survey was conducted at Weiser of Cascadia. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008239**

**ALLEGATION #1:**

The facility failed to ensure medications were administered to the residents and not left in their rooms.

**FINDINGS #1:**

Observations of the facility were conducted during the initial tour on 9/30/19 and throughout the survey week at various times, and there were no medications observed left in the residents' rooms.

On 10/3/19, three Licensed Nurses (LNs) were observed during medication pass at different times and none of the LNs were observed leaving medications in residents' rooms. The residents took their medications in front of the licensed nurse.

The facility's Grievance file and Resident Council minutes from May 2019 to October 2019 were reviewed. There were no concerns documented related to medications being left in the residents' rooms.

Six residents were interviewed individually on 9/30/19 and on 10/1/19. The residents said they took their medications in the presence of the LNs. Nine residents attended a group interview on 10/1/19. The residents stated they took their medications in the presence of the LN. The residents stated the LN was not leaving their medications in their rooms. Two residents' representatives were interviewed. The representatives stated they never saw medications left in their family member's room when they visited.

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

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #2:**

The facility failed to provide appropriate care to residents with dementia.

**FINDINGS #2:**

Staff interactions with the residents were observed and no concerns were noted. Residents observed in the dining room, activity room, in the lobby and in the hallway were all appropriately groomed.

Twelve resident records were reviewed, which included 1 record of a resident who had a diagnosis of dementia. No quality of care concerns were identified.

The facility's Grievance file and Resident Council minutes from May 2019 to October 2019 were reviewed. No concerns related to a lack of appropriate care to residents with dementia were documented.

Seven residents were interviewed individually and said they had no concern with the care they received from the facility. The residents said staff were assisting them in timely manner and as needed.

One resident interviewed said he had no concern with the care he received from the facility. The resident said the staff were meeting his needs.

The Administrator was interviewed and said staff was provided with training on dementia upon hire and when necessary.

The staff training records for dementia from were reviewed and documented the facility was providing training on dementia.

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

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #3:**

The facility failed to remove the food trays from the residents' rooms when they were done with their meals.

**FINDINGS #3:**

Residents' rooms were observed and there were no food trays observed sitting in the residents' rooms. Three residents, who were observed eating in their rooms said their food trays were collected by the staff when they were done eating.

The facility's Grievance file and Resident Council minutes from May 2019 to June 2019 were reviewed. No concerns related to food trays not being collected from residents' rooms after they were done eating were documented.

Twelve residents' records were reviewed. One resident's record included Nursing Notes (NN), dated 9/29/19 and 9/30/19, which documented he did not want the staff to pick up his food tray. The NN documented the resident got upset and asked the staff to leave his tray in his room.

One resident was interviewed, and stated he was upset with the staff when they came to pick up his food tray. The resident said he asked the staff to not pick up his food tray and would eat his meal later that day.

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

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #4:**

The facility does not have a Social Worker.

**FINDINGS #4:**

The Resident Support Service Manager (RSSM) was interviewed on 10/2/19 at 3:36 PM. The RSSM stated she helped arrange discharges from the facility for the residents and she helped residents obtain equipment they needed. The RSSM said the facility had a scheduled teleconference once a month with a psychiatrist and they discussed residents' behavior and medications. The RSSM also stated the facility had a visiting Licensed Social Worker (LSW) who came to the facility once a week to review the residents' records. The RSSM stated the LSW saw residents when needed.

At the time of the survey, the facility was licensed for 76 beds. The federal regulations do not require a facility to employ a Social Worker on a full time basis if the facility has less than 120 beds. Therefore, while the facility did not have a Social Worker, regulatory noncompliance was not substantiated and no deficient practice was identified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #5:**

The facility failed to ensure residents' urinary catheters were being change as ordered by the physician.

**FINDINGS #5:**

The Director of Nursing (DON) was interviewed on 10/3/19 at 1:46 PM, and said they followed the Center for Disease Control (CDC) recommendation in changing the urinary catheter. The DON said changing the urinary catheter at fixed intervals was not recommended by the CDC.

The facility's Grievance file and Resident Council minutes from May 2019 to October 2019 were reviewed. No concerns related to residents' urinary catheters not being changed were documented.

Twelve residents' records, including two residents who had urinary catheters were reviewed and there were no concerns noted. One resident's record included a physician's order, dated 8/7/19, which directed the staff to change the resident's urinary catheter as needed. The record documented his urinary catheter was being cleansed with soap and water two times a day and was being changed every 28 days.

Mark Dudley, Administrator  
January 22, 2020  
Page 5 of 5

Two residents who had urinary catheters were asked if the surveyor could observe while staff provided urinary catheter care. One resident refused. Staff was observed providing pericare to the other resident and no concerns were noted.

It could not be determined that the facility failed to ensure residents' urinary catheters were being change as ordered by the physician. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

A handwritten signature in cursive script that reads "Belinda Day". The signature is written in dark ink and is positioned above the typed name of the signatory.

Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj