



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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November 1, 2019

Bryan McNeil, Administrator
Caldwell Care of Cascadia
210 Cleveland Boulevard
Caldwell, ID 83605-3622

Provider #: 135014

Dear Mr. McNeil:

On **October 18, 2019**, a survey was conducted at Caldwell Care 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 a widespread 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 **November 12, 2019**. Failure to submit an acceptable PoC by **November 12, 2019**, may result in the imposition of penalties by **December 4, 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 22, 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 18, 2020**. A change in the seriousness of the deficiencies on **December 2, 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 18, 2020** includes the following:

Denial of payment for new admissions effective **January 18, 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 18, 2020**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 18, 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 **November 12, 2019**. If your request for informal dispute resolution is received after **November 12, 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,



Belinda Day, RN, Supervisor
Long Term Care Program

bd/lj

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

PRINTED: 11/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/18/2019
NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
(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 survey conducted on October 15, 2019 to October 18, 2019. The surveyors conducting the survey were: Presie Billington, RN, Team Coordinator Sallie Schwartzkopf, LCSW Janet Kubisiak, RN Abbreviations include: ADL = Activities of Daily Living CHF = Congestive Heart Failure CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease DON = Director of Nursing LPN = Licensed Practical Nurse MDS = Minimum Data Set RN = Registered Nurse	F 000			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		11/20/19	

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

TITLE

(X6) DATE

Electronically Signed

11/08/2019

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 656	Continued From page 1 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure comprehensive resident-centered care plans included the use of oxygen. This was true for 1 of 6 residents (Resident #47) whose comprehensive care plans were reviewed. This deficient practice created the potential for Resident #47 to receive inadequate care or treatment due to missing information in her care plan. Findings include:	F 656	The clinical management team reviewed resident #47. This resident's care plan was updated to include the use of oxygen per the physician's orders. The clinical management team reviewed residents who have a physician's order for oxygen, and have validated that residents who have physician orders for oxygen also have a care plan to address		

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F 656	Continued From page 2 Resident #47 was admitted to the facility on 10/4/16 with multiple diagnoses including generalized anxiety disorder. An Annual MDS Assessment, dated 9/28/19, documented Resident #47 received oxygen therapy. A physician's order, dated 9/24/19, included an order for oxygen at 2 liters per minute via nasal cannula continuously. Resident #47's care plan did not document her use of oxygen. On 10/15/19 at 3:00 PM, Resident #47 was observed in bed, receiving oxygen at 2 liters per minute via nasal cannula. On 10/17/19 at 10:28 AM, RN #1 said Resident #47's care plan did not address her use of oxygen.	F 656	oxygenation needs and directives. Licensed nursing staff were re-educated by the Director of Nursing and/or designee regarding care plan updates, to include but not limited to, revise resident care plan when oxygen is initiated by a physician order. The system is amended to include review of new orders in clinical meeting and validate care plans are up to date. The Director of Nursing and/or designee will audit resident care plans who have a change in oxygen use weekly for the next 8 weeks to validate oxygen use is updated as indicated with order changes, starting the week of November 11, 2019. The review will be documented on an audit tool. Any concerns will be addressed immediately and presented to the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695		11/20/19	

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F 695	<p>Continued From page 3</p> <p>by: Based on observations, record review, staff interview, and review of the facility's guidelines, the facility failed to ensure the tubing for respiratory equipment included the date it was last changed. This was true for 4 of 6 residents (#5, #32, #35, and #51) reviewed for oxygen therapy. This placed residents at risk of respiratory infections due to the growth of pathogens (organisms that cause illness) in the tubing of respiratory equipment. Findings include:</p> <p>The facility's Respiratory Equipment Change and Cleaning Guidelines, dated 7/6/18, documented the "nasal cannula, weekly...label and date the cannula when changed."</p> <p>This policy was not followed. Examples include:</p> <p>a. Resident #5's record documented the resident had multiple diagnoses including sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts).</p> <p>Resident #5's Quarterly MDS Assessment, dated 9/25/19, documented she required oxygen therapy.</p> <p>Resident #5's Physician's Orders, dated 9/24/19, documented an order for oxygen at 3L/Min (liters per minute) via nasal cannula (in the nostrils) continuously, every shift for shortness of breath. The order instructed staff to change the oxygen tubing and clean the filter every week on Thursday.</p> <p>Resident #5's Care Plan, documented she had altered respiratory status related to sleep apnea</p>	F 695	<p>The oxygen tubing for resident #5, # 32, #35 and #51 was changed and dated.</p> <p>The clinical management team reviewed other resident's oxygen tubing for proper dating of the tubing. It was verified that oxygen tubing for current residents was dated per the regulation. Interdisciplinary rounds continue to validate oxygen tubing is dated. Adjustments have been made as indicated.</p> <p>Licensed nursing staff were re-educated by the Director of Nursing and/or designee on management of oxygen equipment, to include but not limited to placing a date on the tubing for respiratory equipment to indicate last change date. The system is amended to include observation by department managers and licensed nursing on rounds to validate the oxygen tubing is dated and changed as per policy.</p> <p>The Director of Nursing and/or designee will audit 4 residents who have a physician's order for respiratory equipment weekly for the next 8 weeks to validate the tubing is dated indicating when it was last changed , starting the week of November 11, 2019. The review will be documented on an audit tool. Any concerns will be addressed immediately and presented to the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p>		

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F 695	<p>Continued From page 4</p> <p>and oxygen therapy as needed for hypoxia (low oxygen in the blood resulting in low oxygen in body tissue). The care plan directed staff to change oxygen tubing, portable oxygen tubing and mask tubing used with a nebulizer (a drug delivery device used to administer medication in the form of a mist) every week and as needed.</p> <p>On 10/15/19 at 10:30 AM, Resident #5 was sitting up in a chair at bedside, with nasal cannula inserted in bilateral nostrils and connected to a portable oxygen container. There was no date or label on the oxygen tubing to indicate when it had last been changed.</p> <p>b. Resident #32's record, documented she had multiple diagnoses including COPD, a progressive lung disease that results in shortness of breath.</p> <p>Resident #32's Quarterly MDS Assessment, dated 9/30/19, stated she was moderately cognitively impaired and required oxygen therapy.</p> <p>Resident #32's Physician's Orders, dated 9/26/19 documented an order for oxygen at 2L/Min via nasal cannula continuously.</p> <p>Resident #32's Care Plan documented she had altered respiratory status related to COPD, shortness of breath with lying flat and excretion, history of asthma, congestive heart failure and rhinitis (inflammation and swelling of the mucous membrane of the nose). The care plan directed the staff to change the oxygen/nebulizer tubing and clean the filter weekly.</p>	F 695			

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F 695	<p>Continued From page 5</p> <p>On 10/15/19 at 9:58 AM and 10/16/19 at 10:39 AM, Resident #32 was sitting up in a chair at bedside with nasal cannula inserted in bilateral nostrils and connected to a portable oxygen container. There was no date or label on the oxygen tubing to indicate when it had last been changed.</p> <p>c. Resident #35's record documented she had multiple diagnoses including COPD.</p> <p>Resident #35's Quarterly MDS Assessment, dated 9/30/19, documented she was severely cognitively impaired and required oxygen therapy.</p> <p>Resident #35's Physician's Orders, dated 9/26/19, documented an order for oxygen at 2L/Min via nasal cannula continuously every shift related to COPD, to change the oxygen/nebulizer tubing and humidification bottle every week, and to clean the filter every week.</p> <p>Resident #35's Care Plan documented she had altered respiratory status related to COPD, shortness of breath with lying flat and excretion, history of asthma, CHF, and rhinitis. The care plan directed the staff to change the oxygen/nebulizer tubing and clean the filter weekly.</p> <p>On 10/15/19 at 9:33 AM, Resident #35's oxygen tubing had no date or label indicating when the oxygen tubing had last been changed.</p> <p>d. Resident #51's record documented she had multiple diagnoses including COPD.</p>	F 695			

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F 695	Continued From page 6 Resident #51's Quarterly MDS Assessment, dated 8/16/19, documented she was cognitively intact, independent with all ADLs, and required oxygen therapy. Resident #51's Physician's Orders, dated 9/24/19, documented an order for oxygen at 2L/Min via nasal cannula continuously every shift related to COPD. The orders also instructed staff to change the oxygen/nebulizer tubing and humidification bottle and clean the filter on the nightshift every Thursday. Resident #51's Care Plan documented that she had altered respiratory status related to COPD and shortness of breath with lying flat. On 10/15/19 at 9:38 AM, Resident #51's oxygen tubing did not have a date/label indicating when the oxygen tubing had been changed. On 10/17/19 at 9:30 AM, RN #1, said there was not a date or label on the oxygen tubing indicating when it was last changed for Residents #5, #32, #35, and #51. On 10/17/19 at 9:50 AM, RN #1 said the oxygen tubing was changed every week on Thursday on the nightshift and was to be labeled with the date and initialed. On 10/17/19 at 10:00 AM, the DON said "I expect the oxygen tubing to be changed every Thursday night, labeled and dated. It also needs to be changed as needed if soiled."	F 695			
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		11/20/19	

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F 755	Continued From page 7 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview and policy review, it was determined the facility failed to ensure staff disposed of controlled medications consistent with the facility's policies to prevent possible	F 755	No specific residents were identified in the CMS-25467. Licensed Nursing Staff were educated on the proper disposal of medications.		

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F 755	<p>Continued From page 8</p> <p>diversion. This was true for 2 of 2 licensed nurses (RN #1 and LPN #2) interviewed during medication cart inspection. This had the potential to negatively impact each of the 79 residents residing in the facility. This failed practice created the potential for harm if controlled medications were diverted and residents did not receive the medications as ordered. Findings include:</p> <p>The facility's policy for Management and Destruction of Controlled Substances, dated 11/28/17, documented two licensed nurses destroyed the controlled medications by rendering the controlled medications irretrievable by using the following example: Zorbitol plus, Drug Buster, Bleach, Drug Shedder.</p> <p>The facility's policy for Medication Management, dated 11/28/17, documented licensed nurses were to follow appropriate procedures for the destruction and disposal of controlled, cytotoxic (toxic to cells), and non-controlled medications.</p> <p>These policies were not followed.</p> <p>On 10/18/19 at 2:17 PM, during the inspection of the East Medication Cart, RN #1 said controlled medications were destroyed or wasted in the presence of two licensed nurses. RN #1 said both nurses signed and dated the narcotic log book for the controlled medications to be destroyed or wasted. When asked how she destroyed the controlled medications, RN #1 said she put the controlled medications in the sharps container which was attached next to the medication cart.</p> <p>On 10/18/19 at 2:27 PM, LPN #2 said controlled</p>	F 755	<p>Observation on clinical and department leader rounds of licensed nursing staff and sharps containers show proper disposal of medications consistent with the facility policies.</p> <p>Licensed Nursing staff were trained by the Director of Nursing and/or designee in the proper disposal of controlled medications to prevent possible diversion, to include but not limited not placing them in the sharps container. The system is amended to include observation on management and clinical rounds to include monitoring of narcotic disposal.</p> <p>The Director of Nursing and/or designee will audit through observation and questioning two Licensed Nursing Staff weekly for the next 8 weeks to validate proper understanding and disposal of controlled medications, starting the week of November 11, 2019. The audit of proper disposal of controlled medications will be documented on an audit tool. Any concerns will be addressed immediately, and presented to the QAPI Committee. The QAPI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate</p>		

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F 755	Continued From page 9 medications were destroyed in the presence of two licensed nurses. LPN #2 said both nurses signed and dated the narcotic log book. LPN #2 said he put the wasted controlled medications in the sharps container. On 10/18/19 at 2:30 PM, the DON said the controlled medications were destroyed or wasted in the Drug Buster in the presence of two licensed nurses. The DON said two licensed nurses then signed and dated the narcotic log book. The DON said the wasted controlled medication should not be placed in the sharps container.	F 755			
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure the medication error rate was less than 5%. This was true for 2 of 26 medications (11.5%) which affected 1 of 2 residents (Resident #45) whose medication administration was observed during medication pass. This failure created the potential for subtherapeutic effect when Resident #45's Mucinex (an expectorant, helps loosen congestion) was crushed, not administered as ordered, and she was not instructed to rinse her mouth after receiving the inhaled medications. Findings include:	F 759	The clinical management team assessed Resident #45 for sub-therapeutic effect due to resident receiving one of two Mucinex tablets per physician's orders and Mucinex being crushed. In addition, resident oral cavity is free of irritation from not rinsing mouth after receiving the inhaled medication. The MD and resident advocate was notified regarding the discrepancy in practice. Resident #45 was found to not have no adverse reactions due to medication error. The LPN was given an in-service training	11/20/19	

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F 759	<p>Continued From page 10</p> <p>1. Resident #45 was admitted to the facility on 4/7/16, with multiple diagnoses including COPD (a chronic inflammatory lung disease that causes obstructed airflow from the lungs).</p> <p>Resident #45's October 2019 recapitulated physician's order included Breo Ellipta Aerosol Powder Breath Activated (an inhaler taken orally containing corticosteroid) 100-25 mcg/inh (microgram per inhalation), one puff one time a day for COPD. The order included special instructions for Resident #45 to rinse his mouth out with water and spit back into the cup after administration. The order also included Mucinex tablet Extended Release, two tablets by mouth every 12 hours for congestion.</p> <p>On 10/17/19 at 8:40 AM, LPN #1 was observed when she administered Resident #45's Breo Ellipta. Resident #45 was observed to take one puff of the Breo Ellipta orally, and then gave the inhaler back to LPN #1. LPN #1 then administered Resident #45's crushed medications which included one tablet of Mucinex. LPN #1 then gave Resident #45 a glass of "shake" which she finished. Resident #45 was not observed to rinse her mouth after inhaling the Breo Ellipta.</p> <p>On 10/17/19 at 8:49 AM, LPN #1 said she did not ask Resident #45 to rinse her mouth after administering the Breo Ellipta. LPN #1 said she should have told Resident #45 to rinse her mouth with water and spit it out. LPN #1 was then asked to review Resident #45's physician's order for Mucinex. LPN #1 reviewed the physician's order and said she should have given two tablets of Mucinex to Resident #45. The Mucinex should</p>	F 759	<p>on the proper administration of medications as directed by the physician order.</p> <p>The clinical management team reviewed observed other nurses providing residents with Mucinex and inhaled medications. No additional medication errors were identified.</p> <p>Licensed Nursing Staff were re-educated by the Director of Nursing and/or designee to following physician orders, to include but not limited to not crushing Mucinex, dispensing accurate dose per physician orders, and instructing residents to rinse their mouth after receiving inhaled medications. The system is amended to include periodic surveillance of medication pass.</p> <p>The Director of Nursing and/or designee will audit 1 nurse on medication administration for a resident who has Mucinex and/or inhaled medication orders weekly for the next 8 weeks for proper administration practices starting the week of November 11, 2019. The review will be documented on the audit tool. Any concerns will be addressed immediately and presented to the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p>		

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F 759	Continued From page 11 not have been crushed. The website pharmacistsanswers.com, accessed on 11/1/19, identifies Mucinex tables as extended release and they should not be crushed. Crushing may cause the entire dose to be delivered all at once and not over 12 hours as intended. Crushing may result in side effects such as nausea, diarrhea and gastrointestinal distress.	F 759			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		11/20/19	

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F 880	<p>Continued From page 12</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p>	F 880			

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F 880	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and policy review, it was determined the facility failed to ensure staff performed proper hand hygiene during resident cares. This was true for 1 of 15 resident (Resident #30) observed during resident cares. The deficient practice placed residents at risk of infection from cross-contamination. Findings include:</p> <p>The facility's policy and procedure for Hand Hygiene/Handwashing, dated 11/28/17, directed staff to perform hand hygiene when moving from a contaminated body site to a clean body site during patient care, when removing gloves, intermittently after removing gloves, between contact with patients, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments.</p> <p>Resident #30 was admitted to the facility on 2/5/18, with multiple diagnoses including hypertension and heart failure.</p> <p>A Quarterly MDS Assessment, dated 9/24/19, documented Resident #30 required the assistance of one to two persons for ADL.</p> <p>A physician's order dated 10/7/19, directed staff to apply skin prep (a fast drying, sterile, liquid form skin protectant) to Resident #30's right second toe until healed.</p> <p>* On 10/16/19 at 9:16 AM, CNA #2 was observed providing peri care to Resident #30. CNA #2, with gloves on, unfastened Resident #30's soiled incontinence brief and wiped his genitalia and</p>	F 880	<p>Resident #30 is no longer at this facility.</p> <p>The clinical management team observed staff perform care to other residents for proper hand hygiene during resident cares. Adjustments and additional education/reminders have been made as indicated.</p> <p>Nursing staff were re-educated by Director of Nursing and/or designee on proper hand hygiene during resident cares, to include but not limited to handwashing with each glove change, glove change when moving from dirty to clean, and gloves management during treatments. The system is amended to include surveillance of staff for appropriate hand hygiene and glove use.</p> <p>The Director of Nursing and/or designee will audit 2 nursing staff weekly for proper hand hygiene and glove use during cares, for the next 8 weeks starting the week of November 11, 2019. The review will be documented on the surveillance guide and/or audit tool. Any concerns will be addressed immediately and presented to the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p>		

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F 880	<p>Continued From page 14</p> <p>buttocks with a clean wipe. CNA #2 then applied a barrier cream on Resident #30's lower back without changing her gloves. CNA #3 entered the room and helped CNA #2 in repositioning Resident #30. CNA #2 then applied a new incontinence brief to Resident #30 and then removed her gloves and put on new gloves without performing hand hygiene. CNA #2 then cleaned Resident #30's mouth using a mouth swab and combed his hair. CNA #2 and CNA #3 removed their gloves and performed hand hygiene before leaving Resident #30's room.</p> <p>On 10/16/19 at 11:16 AM, CNA #2 said hand hygiene was performed before and after resident contact and between glove changes. CNA #2 said she did not change her gloves when she applied the barrier cream to Resident #30's lower back and she did not perform hand hygiene between glove changes during Resident #30's care.</p> <p>* On 10/16/19 at 10:59 AM, LPN #2 was observed as he performed wound care to Resident #30. LPN #2, with gloves on, removed Resident #30's right Prevalon boot (a heel protector to keep the heel off the mattress to relieve pressure). LPN #2 said Resident #30's right toe was already healed and was being maintained with skin prep. LPN #2 then removed his gloves, put on new gloves, and applied skin prep to Resident #30's right toe. LPN #2 was not observed to perform hand hygiene between glove changes.</p> <p>On 10/16/19 at 11:03 AM, LPN #2 said hand hygiene should be performed before and after resident contacts and between glove changes.</p>	F 880			

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F 880	Continued From page 15 LPN #2 said he did not perform hand hygiene when he changed his gloves to apply skin prep to Resident #30's right toe.	F 880			
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 immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's	F 883		11/20/19	

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F 883	<p>Continued From page 16</p> <p>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</p> <p>(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</p> <p>(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:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents were offered the pneumococcal vaccine and received information and education consistent with the current Center for Disease Control (CDC) recommendations. This was true for 1 of 5 residents (#20) reviewed for pneumococcal immunizations. This failure created the potential for harm to residents should they acquire, transmit, or experience complications from pneumococcal pneumonia. Findings include:</p> <p>The CDC website, accessed on 10/22/19, documented recommendations for Pneumococcal vaccination (PCV 13 or</p>	F 883	<p>Resident #20 was offered and received the pneumococcal vaccine on October 17, 2019.</p> <p>The clinical management team reviewed residents who meet the requirements for the pneumococcal vaccine, to validate they were offered and received the vaccine consistent with the Center for Disease Control (CDC) recommendations. Adjustments were made as indicated and vaccinations provided.</p> <p>Licensed nursing staff were educated by the Director of Nursing and/or designee</p>		

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F 883	<p>Continued From page 17 Pevnar13®, and PPSV 23 or Pneumovax23®) for all adults 65 years or older:</p> <p>* For those who have already received 1 or more doses of PPSV23, or those with unclear documentation of the type of pneumococcal vaccine received: Administer 1 dose of PCV13 at least 1 year after the most recent pneumococcal vaccine dose.</p> <p>* Administer a second dose of PPSV23 at least 1 year after PCV13 and at least 5 years after the previous dose of PPSV23</p> <p>* Administer 1 final dose of PPSV23 at 65 years or older. This dose should be given at least 5 years after the most recent dose of PPSV23.</p> <p>The facility's policy and procedure for the Pneumococcal Program, dated 10/31/17, directed staff to reduce the risk of pneumococcal infection and transmission, residents and their family members were provided education regarding the benefits and potential side effects of the two-step pneumococcal immunization. Residents were offered and given the Pneumococcal vaccine according to physician's orders unless medically contraindicated, they have already received the vaccine, or the vaccine is refused.</p> <p>The policy further documented PCV13 and PPSV 23 were available and recommended for adults over the age of 65 and people with certain medical conditions to include chronic heart and lung disease, diabetes mellitus, liver disease, renal failure, smoking, alcoholism, immunodeficiency's, cancers, organ transplants</p>	F 883	<p>regarding offering and administering the pneumococcal vaccine to residents, to include but not limited to consideration of resident age and when they last received a vaccination consistent with the current Center for Disease Control (CDC) recommendations. The system is amended to include the clinical management team review during resident quarterly care conference and/or monthly to validate residents are current for receiving the pneumococcal vaccine.</p> <p>The Director of Nursing and/or designee will audit newly admitted residents and those with quarterly MDSs completed weekly for offer/administration of pneumococcal vaccination as indicated, for the next 8 weeks starting the week of November 11, 2019.. The review will be documented on the vaccination log and/or audit tool. Any concerns will be addressed immediately and presented to the QAPI committee. The QAPI committee may adjust the training and/or frequency of the monitoring after 8 weeks, as it deems appropriate.</p>		

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F 883	Continued From page 18 and others. Revaccination with PPSV 23 is recommended if more than five years had elapse after the first dose of PPSV 23 and one year after the Prevnar 13. Resident #20 was admitted to the facility on 9/27/17 and readmitted on 9/6/19, with multiple diagnoses including diabetes mellitus and hypertension. Resident #20's Annual MDS Assessment, dated 9/13/19, documented she was up to date with Pneumococcal immunizations. Resident #20's physician's order, dated 9/27/17, documented "May have Pneumovax vaccine if no history of vaccine." Resident #20's record documented, she received PPSV 23 on 1/3/12 when she was 58 years old and Prevnar 13 on 7/10/18 when she was 64 years old. Resident #20's record did not include documentation she received or was offered the second dose of PPSV 23 at least one year after the Prevnar 13 vaccination. On 10/17/19 at 9:15 AM, the DON said she was unable to find documentation Resident #20 was offered the second dose of PPSV 23 vaccine.	F 883			
F 912 SS=E	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident	F 912	The facility has requested to renew the	11/6/19	

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NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
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F 912	<p>Continued From page 19</p> <p>and staff interviews, it was determined the facility failed to ensure rooms with multiple residents had at least 80 square feet space per resident. This was true for 3 of 32 resident rooms (rooms 111, 112 and 114) which did not meet the requirement of 80 square feet per resident. This was true for 6 of 6 residents (#15, #17, #18, #24, #35 and #51) whose rooms did not have 80 square feet of living space. This failure created the potential for residents to experience a loss of well-being due to lack of living space. Findings include:</p> <p>*Resident #35 and Resident #51 were in room 111, which had 78.6 square feet per resident. *Resident #18 and Resident #24 were in room 112, which had 79.0 square feet per resident. *Resident #15 and Resident #17 were in room 114, which had 79.5 square feet per resident.</p> <p>On 10/18/19 at 1:15 PM, Resident #15, #17, #18, #24, and #51 said they liked their rooms. The furniture in the rooms was observed to be arranged in a manner that provided for ease of access to the beds and closets.</p> <p>The facility had a room size requirement waiver for rooms 111, 112 and 114 which was granted on 9/12/18 and was in effect until the next on-site survey.</p> <p>On 10/18/19 at 2:00 PM, the Administrator said the facility wanted to renew its room size requirement waiver.</p>	F 912	room size requirement waiver for rooms 111, 112 and 114 which was previously granted on 09/13/2018.		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/18/2019
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C 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the state licensure survey conducted on October 15, 2019 to October 18, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Presie Billington, RN, Team Coordinator Sallie Schwartzkopf, LCSW</p>	C 000		
C 422	<p>02.120,05,p,vii Capacity Requirments for Toilets/Bath Areas</p> <p>vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water.</p> <p>This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to maintain a tub or shower for every 12 licensed beds. This had the potential to affect all residents who resided in the facility, if they did not receive baths or showers due to an insufficient number of tubs and showers. Findings include:</p> <p>The facility was licensed for 71 beds and had 59 residents who lived in the facility. Seventy-one licensed bed divided by 12 equals 5.916 or 6 tubs or showers.</p> <p>On 10/18/19 at 1:25 PM, Housekeeping Manager</p>	C 422	<p>The facility has requested to renew the shower and bathing area waiver which was previously granted on 08/02/2018.</p>	11/6/19

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 11/08/19
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/18/2019
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C 422	Continued From page 1 showed the bathing areas of the facility. They were: East tub room with 1 tub, the Spa room with 1 shower, and the West Bath with 1 shower. On 10/18/19 at 2:00 PM, the Administrator said the facility wanted to renew their waiver for the tub and shower requirement.	C 422		
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