



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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

December 9, 2019

Benjamin Roedel, Administrator
Shaw Mountain of Cascadia
909 Reserve Street
Boise, ID 83712-6508

Provider #: 135090

Dear Mr. Roedel:

On **December 3, 2019**, a survey was conducted at Shaw Mountain 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.

Benjamin Roedel, Administrator
December 9, 2019
Page 2 of 4

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 **December 19, 2019**. Failure to submit an acceptable PoC by **December 19, 2019**, may result in the imposition of penalties by **January 11, 2020**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; 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 **January 7, 2020 (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 **March 3, 2020**. A change in the seriousness of the deficiencies on **January 17, 2020**, may result in a change in the remedy.

Benjamin Roedel, Administrator
December 9, 2019
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The remedy, which will be recommended if substantial compliance has not been achieved by **March 3, 2020** includes the following:

Denial of payment for new admissions effective **March 3, 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 **June 3, 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 **March 3, 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>

Benjamin Roedel, Administrator
December 9, 2019
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Go to the middle of the page to **Information Letters** section and click on **State** and select the following:

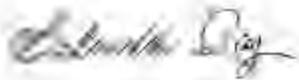
- BFS Letters (06/30/11)

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

This request must be received by **December 19, 2019**. If your request for informal dispute resolution is received after **December 19, 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: 01/09/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2019
NAME OF PROVIDER OR SUPPLIER SHAW MOUNTAIN OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712		
(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 deficiency was cited during a complaint investigation conducted at Shaw Mountain of Cascadia from December 2, 2019 to December 3, 2019. The surveyors conducting the survey were: Presie Billington, RN, Team Coordinator Brad Perry, LSW Kim Saccomando, RN Monica Meister, QIDP, MEd	F 000			
F 919 SS=F	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents had functioning call lights. This was true for 1 of 7 residents (Resident #4) reviewed for call lights, and had the potential to affect all residents in the facility. This deficient practice had the potential for harm if residents could not alert staff for assistance when needed. Findings include: Resident #4 was admitted to the facility on 1/25/19, with multiple diagnoses including post-operative correction of a left ankle fracture.	F 919	This plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Shaw Mountain of Cascadia does not admit that the deficiencies listed on the CMS form 2567 exist, nor does the facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form a basis for the deficiency.	1/3/20	

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

TITLE

(X6) DATE

Electronically Signed

12/19/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2019
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F 919	<p>Continued From page 1</p> <p>An admission Minimum Data Set, dated 2/1/19, documented Resident #4 was severely cognitively impaired and she required extensive assistance of one to two persons for activities of daily living.</p> <p>Resident #4's care plan, initiated on 1/27/19, documented she had mixed incontinence (partial control of her bladder) and staff were directed to offer/encourage her to use the toilet or use the bed pan before and after meals, before bedtime, and if she was awake at night.</p> <p>A Grievance form, dated 2/9/19, documented Resident #4's call light was pushed by her representative for assistance to toilet and get her ready for bed. The Grievance form also documented staff did not respond to Resident #4's call light or come to check on her for 1 and 1/2 hours, when her representative had to find a nurse.</p> <p>Nursing Notes, dated 2/9/19, from 6:00 PM to 1:30 AM, documented Resident #4's representative visited her and closed the door of her room. The notes documented Resident #4's representative approached the nurse at 7:35 PM and stated she turned on Resident #4's call light and no one answered it for 1 and 1/2 hours. The notes documented no staff observed Resident #4's call light on. The Licensed Nurse (LN) and the charge nurse went to check Resident #4's pressure sensitive call light pad and it was not functioning. A new pressure sensitive call light pad was put in place.</p> <p>On 12/3/19 at 11:30 AM, the Maintenance</p>	F 919	<p>CORRECTIVE ACTION: Resident #4 no longer resides at the facility. As documented, resident #4 call light was replaced immediately following the nurse being notified that the call light was not functioning properly.</p> <p>IDENTIFICATION OF OTHER RESIDENTS AFFECTED: All other residents have the potential to be affected. The IDT checked all other call lights within the facility to ensure proper function of the call light. No additional missing or malfunctioning call lights were identified.</p> <p>SYSTEMIC CHANGES/PREVENTION MEASURES: Direct Care Staff and others employees that interact with residents in their room are educated to validate call lights are functioning properly. Re-education provided by CEO or designee to report any problems related to the function of the call light system to Environmental Service Director. If after hours, staff are to utilize an alternate functional call-light if they cannot correct the situation within the nursing team and/or notify the CEO / Environmental Service Director as needed. Environmental Service Director educated by CEO on documenting call-light audits monthly, and present any findings or corrections made to call light system to IDT monthly. The new system will implement an audit tool to document the monthly testing of the call light system</p>		

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

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F 919	<p>Continued From page 2</p> <p>Director said he performed a monthly audit of all the call lights in the facility. Review of the maintenance log documented the call light audit was completed in January 2019 and February 2019, however no other monthly audit was found in the maintenance log. The Maintenance Director said he would look for the other call light monthly audits in his office.</p> <p>On 12/3/19 at 12:50 PM, the Maintenance Director said he was unable to find documentation of call light monthly audits from March 2019 to November 2019.</p> <p>The facility failed to ensure residents were provided with functioning call lights, and there was a consistent method in place to ensure call lights were in working condition.</p>	F 919	<p>which identifies room/call lights that have been tested for proper function.</p> <p>MONITORING OF CORRECTIVE ACTION: Environmental Service Director / designee will audit call lights for proper function 5 rooms per week for 4 weeks, then 2 rooms weekly for 8 weeks starting the week of December 16th. Call light audits will be documented, and results of the audit will be presented to the QAPI Committee. Any concerns will be addressed immediately. The QAPI Committee may adjust the frequency of the audit as they deem appropriate.</p>		



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January 21, 2020

Benjamin Roedel, Administrator
Shaw Mountain of Cascadia
909 Reserve Street
Boise, ID 83712-6508

Provider #: 135090

Dear Mr. Roedel:

On **December 2, 2019** through **December 3, 2019**, an unannounced on-site complaint survey was conducted at Shaw Mountain of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008054

ALLEGATION #1:

The facility failed to ensure residents with injuries of unknown origin were investigated.

FINDINGS #1:

The facility's Grievance file and Resident Council minutes from February 2019 through November 2019 were reviewed. There were no grievances in the Grievance file or concerns in the Resident Council minutes related to residents' abuse or mistreatment.

Seven residents' records, including three closed records, were reviewed for quality of care and quality of life concerns. There were no concerns identified in the resident records reviewed.

Five residents were interviewed on 12/2/19 and none expressed concern regarding the care they received from the facility.

One closed record documented the resident had been admitted to the facility on 1/25/19 and discharged from the facility on 2/12/19. The resident's record included a Skin assessment, dated 2/12/19, which documented the resident's skin was clean, dry, intact and no new skin complaints.

An Accidents and Incidents report (I&A), dated 2/19/19, documented the resident's representative called the facility on 2/12/19 at 5:30 PM and reported to the Case Manager she found a bruise on the resident's arm. The I&A documented the resident's representative said after the resident got discharged from the facility they went out and ran errands. They went to the pharmacy and had lunch in one of the restaurants. The I&A documented the resident was taking Aspirin 81 mg and Rivaroxaban (anticoagulant) tab 10 mg once a day as prophylaxis for deep vein thrombosis and a skin check was completed prior to her discharge from the facility. The I&A also documented the resident was seen by the Restorative Nursing Assistant (RNA), Certified Nursing Assistant (CNA) and by a Nurse on the day of her discharge and did not see a bruise on her.

The facility's Reportables including abuse investigations from February 2019 to November 2019 was reviewed and there were no concerns regarding their investigations of injuries of unknown origin, resident to resident incidents or any mistreatments.

The Staff Development Coordinator (SDC) was interviewed on 12/3/19 at 9:45 AM and said skin assessments were done upon admission, then weekly and upon discharge, also when necessary.

The Director of Nursing (DON) was interviewed and said skin assessments were done upon admission, weekly and when necessary, and upon discharge of the resident from the facility. The DON said the resident had a skin assessment completed prior to her discharge and there was no concern noted. The DON also reviewed the resident's skin assessments dated 1/25/19, 1/29/19, 2/5/19 and 2/12/19 and none documented the resident had a bruise on her arms.

A Registered Nurse (RN) was interviewed on 12/3/19 at 10:45 AM and said she was the nurse on duty when the resident was admitted on 1/25/19. The RN was asked to clarify what she meant by "bilateral arms scattered, flat patches, brown discoloration age spots" which was documented under the "Bruises" section of the Skin assessment form. The RN said she was describing the resident's multiple age spots on her arms. The RN said the resident had scattered bruises on her abdomen upon admission which could be due to an anticoagulant she received from injections while she was at the hospital. The RN said she did not remember the resident having bruises in any other part of her body.

The Administrator was interviewed and said he was the facility's abuse coordinator. The Administrator said any incidents of injuries of unknown origin, any types of abuse: physical, verbal, sexual or misappropriation of residents' property were discussed during their morning meetings. The Administrator said they interviewed the residents, residents' representative, and staff who provided care to the residents. The Administrator also said they asked individual staff involved with the investigation to give their written statements, and if needed they placed the staff on administrative leave while the investigation was going on.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility failed to ensure call lights were functioning and residents were provided assistance with activities of daily living in timely manner.

FINDINGS #2:

The facility's Grievance file and Resident Council minutes from February 2019 through November 2019 were reviewed. The Grievance file included a grievance, dated 2/9/19, filed by the resident's representative regarding her call light was not answered for 1 and 1/2 hours.

The Resident Council minutes, dated 6/18/19, documented a concern regarding call lights not being answered in a timely manner.

The Activity Director (AD) was interviewed and said call light audit response time was completed on 6/10/19, 6/24/19 and on 7/10/19. The call light response time was between 1 to 15 minutes. The AD also said an in-service training was provided to the staff on 7/11/19 regarding answering call lights in a timely manner. The AD said the Resident Council signed off on the call light issue in July 2019.

Seven residents' records, including three closed records, were reviewed for quality of care and quality of life concerns. There were no concerns identified in the residents' record regarding the care they received from the facility.

Five residents were interviewed and none expressed concern regarding the care they received from the facility. The residents said their call lights were answered in timely manner. None of the residents expressed concern regarding their call light response time.

One family member was interviewed and said she was pleased with the care and services her family member was receiving from the facility.

A Nursing Note (NN), dated 2/9/19, documented a resident's representative visited her and closed the door of her room. The NN documented the resident's representative approached the nurse at 7:35 PM and said she turned on the resident's call light and no one answered it for 1 and 1/2 hours. The NN documented none of the staff saw the resident's call light was on. The Licensed Nurse (LN) and the charge nurse went to check the resident's pressure sensitive call light and it was found not functioning. A new call light was put in place.

The Director of Nursing (DON) was interviewed and said when the nurse found out the resident's pressure sensitive call light was not functioning, the nurse replaced the connecting cord that evening. The DON said every nurse station in the facility had an extra cord for the call lights and if the call lights were still not working after they replaced the cord, they would call the Maintenance Director.

The Maintenance Director was interviewed and said he performed a monthly audit of all the call lights in the facility. Review of the maintenance log documented a call light audit was completed in January 2019 and February 2019, however no other monthly audit was found in the maintenance log. The Maintenance Director said he would look for the other call light monthly audit in his office.

During the follow-up interview with the Maintenance Director, he said he was unable to find documentation of monthly call light audits from March 2019 to November 2019.

Based on the investigative findings, the allegation regarding the facility ensuring call lights were functional was substantiated and the facility was cited at F 919, as it related to the resident call system.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

Benjamin Roedel, Administrator
January 21, 2020
Page 5 of 5

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 black ink and is positioned above the typed name and title.

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj



IDAHO DEPARTMENT OF
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January 17, 2020

Benjamin Roedel, Administrator
Shaw Mountain of Cascadia
909 Reserve Street
Boise, ID 83712-6508

Provider #: 135090

Dear Mr. Roedel:

On **December 2, 2019** through **December 3, 2019**, an unannounced on-site complaint survey was conducted at Shaw Mountain of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008167

ALLEGATION #1:

Resident representatives are not informed of residents' financial status and residents are required to deposit their personal funds with the facility.

FINDINGS #1:

During the survey, observations and interviews were conducted and grievances, Resident Council Meeting minutes and residents' records were reviewed.

During observations on 12/2/19 from 11:05 AM - 12:25 PM, five residents and one family member were interviewed about the facility's financial services provided to them. The residents reported they were pleased with the services and had no concerns. One resident's daughter was present during the interview and stated she was pleased with the care and services provided to her mother and had no concerns. The residents were asked about their experiences related to financial services. The residents stated they were informed of their financial status and were not required to deposit their personal funds

with the facility. The residents stated if there were any changes made to charges for other items and services the facility offered, they were notified in writing at least 60 days prior to implementation of the change. The residents stated no changes to charges had been made since their admission.

Resident Grievances and Resident Council Meeting minutes, dated 2/2019 - 7/2019, were reviewed and did not contain any information related to the facility's financial services.

Seven residents' records were selected for review. Of those 7 records, 3 were closed records (meaning the resident no longer resided in the facility). One closed record documented the resident was cognitively intact. The resident's admission information documented the resident did not have an assigned resident representative or a power of attorney.

The resident's Social Service Note, dated 12/12/18, documented "Spoke to (###) today and ask (###) if she had a living Will or DPOH (###) and (###) said no...I offered her a copy of the DPOH and (###) said to leave it with her to discuss wither [SIC] daughter."

The resident's record contained financial documents that were signed by the resident including a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN), dated 9/19/18, and a SNFABN, dated 10/9/18.

The resident's financial record contained a credit card transaction form, dated 10/9/18, that documented the resident paid for the cost of services for 9/2018 and 10/2018, with a Visa card. The credit card transaction form contained the resident's signature.

A second credit card transaction form, dated 2/15/19, documented the resident paid for the cost of services with a Visa card. The document contained a notation of verbal permission from the resident and contained the facility's Social Worker signed statement and signature as a second witness to the transaction.

The resident's General Notes Report, dated 4/8/19, documented the resident's card for the month's cost of services did not go through and that automatic withdraws from the resident's bank account were not allowed by Medicaid. The General Notes Report stated "... (###) said her mom doesn't have enough money to pay her share of cost and her bills too so I should just deal with Medicaid on this..."

A General Notes Report, dated 5/9/19, documented "(###) has come to me on a daily basis in regards to her not having money and not knowing where the money has gone in her bank account. We have called her bank a couple of times to see what might be happening with her income, she had a letter from the bank stating she was overdrawn and they were closing her account. I helped her call the bank and it was her credit card.

I let them know she was in a skilled nursing facility now and had no money, they gave me instructions to create a letter explaining this and they would write off the balance that is due."

A second General Notes Report, dated 5/9/19, documented "I asked (###) if she wanted me to help her with her finances as she was very tearful and wanted to have some money to spend. I told her I could have her social security come to the facility into a trust account and she would have \$40 each month to spend, she didn't like that should (###) could only have \$40, but she said she wanted me to help her and should (###) would be glad to have some money for her wine and items she might need. I applied to get her social security redirected to here for a trust account in her name."

A General Notes Report, dated 5/13/19, documented "Daughter said she wasn't sure what to do about her (###) owing us money, she said the card her mom used to pay us was a credit card and not her debit card."

A General Notes Report, dated 5/17/19, documented a letter was faxed to the resident's bank "...to ask them to make the necessary arrangements with her credit card as was instructed to me from customer service."

A General Notes Report, dated 6/17/19, documented "(###) called me today and asked if I knew what was going on with her mother's social security check. I explained to her that it was now coming into a trust account that is setup in her mother's name. (###) asked what gave [SIC] me the authority to do that when she is the Power of attorney...she kept talking over me and demanding that I put that money back into her mother's [SIC] (###) account. I explained I cannot do that..."

A General Notes Report, dated 6/18/19, documented the Business Office Manager "Spoke with (###) at Social Security and discussed how we might be able to redirect the social security check back to (###) (###) account...(###) stated the only way (###) to redirect the social security is for the daughter to come in and apply for the social security and they will determine who is best to be her rep (###) payee."

The resident's health record documented the resident was discharged to a local hospital on 6/13/19 and re-admitted to the facility on 6/19/19 with hospice services. The resident's record also documented that on 6/21/19, a notarized document was submitted to the facility that stated the resident's daughter was Power of Attorney. The notarized document was signed and dated by the resident on 6/20/18.

When asked, the Business Office Manager stated during an interview on 12/3/19 from 10:05 - 10:38 AM, the resident stated she did not have a power of attorney and the resident did not provide any information related to a Power of Attorney on the admission forms. The Business Office Manager stated Health and Welfare reported the

resident had monthly social security income and a retirement check. The Business Office Manager stated the resident's bank reported they had no accounting of the retirement funds and the resident's daughter had some control over the bank account. The Business Office Manager stated the resident had requested financial assistance from the business office as the resident was not getting her \$40.00 a month for spending.

It could not be determined that Resident Representatives' were not informed of residents' financial status and residents were required to deposit their personal funds with the facility.

Based on the investigative findings, the allegation could not be substantiated, and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Residents are not being offered therapeutic diets as ordered by their physicians.

FINDINGS #2:

During the survey, observations and interviews were conducted and grievances, Resident Council Meeting minutes and residents' records were reviewed.

During observations on 12/2/19 from 11:05 AM - 12:25 PM, five residents and one family member were interviewed about the facility's care and services provided to them. The residents reported they were pleased with their care and services and had no concerns. One resident's daughter was present during the interview and stated she was pleased with the care and services provided to her mother and had no concerns. The residents were asked about their experiences related to dietary and nutritional services. The residents stated they were very pleased with the dietary and nutritional services offered by the facility. The residents stated they received food and fluids as per their preferences and in accordance with their physician orders. Additionally, during the observation, the lunch meal was observed and no concerns were identified.

During the survey, three Certified Nursing Assistants (CNAs), two Registered Nurses (RNs), one Licensed Practical Nurse (LPN), two Activities staff, and the Director of Nursing (DON) were interviewed about residents' dietary and nutritional needs as well as residents' experiencing food allergies. All of the staff stated residents' physician orders were followed and they had not heard or witnessed a resident being served or consuming food or fluids they were allergic to.

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Resident Grievances and Resident Council Meeting minutes, dated 2/2019 - 7/2019, were reviewed and did not contain any information related to residents receiving non-preferred food or fluids or foods and fluids that were not consistent with their physician orders.

Seven residents' records were selected for review. Of those 7 records, 3 were closed records (meaning the resident no longer resided in the facility). One closed record documented the resident was admitted to the facility on 7/26/18 with an allergy to peanuts. The resident's incident reports, dated 2/2019 - 7/2019, and progress notes, dated 12/2018 - 7/2019, were reviewed and did not contain any information related to being served or consuming foods or fluids that the resident was allergic to.

It could not be determined that residents were not being offered therapeutic diets as ordered by their physicians.

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



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj