STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135146	A. Building B. Wing	12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascadia of Boise	6000 W Denton St Boise, ID 83704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31867 Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to respect and maintain each residents' dignity. This was true for 6 of 21 residents (#6, #13, #24, #55, #66, and #420) who were reviewed for dignity. Resident #66 was harmed when he experienced emotional distress when he was incontinent of stool and was unable to use his call light to request assistance. These deficient practices also created the potential for residents to experience embarrassment and decreased sense of self-worth. Findings include: 1. Resident #66 was admitted to the facility on [DATE], with multiple diagnoses including stroke, muscle weakness, transient paralysis (unable to move intermittently), and diabetes. Resident #66's Physical Therapy Evaluation, dated 10/11/19, documented severe weakness of the left and right hands. Resident #66's admission MDS assessment, dated 10/21/19, documented upper extremity impairment (shoulder, elbow, wrist, and hand) on both sides of the body. The assessment also documented Resident #66 required extensive assistance by two or more staff for physical assistance with dressing, bathing, and personal hygiene. The admission assessment documented Resident #66 was always incontinent and required extensive assistance with two staff for toileting. Resident #66's care plan documented he had limited physical mobility related to physical weakness and stroke. There were no interventions included in the care plan for Resident #66's incontinence. A Physical Therapy Progress report, dated 12/1/19 to 12/7/19, documented Resident #66's remaining impairments included body awareness deficits, decreased functional capacity, gross motor coordination deficits, motor control deficits, and sensation and strength impairments. On 12/8/19 at 1:01 PM, Resident #66 shook his head side to side indicating no when asked if he was cleaned up quickly when soiled (incontinent of stool). On 12/10/19 at 9:08 AM, Resident #66 was in his room lying on his back in bed and there was a strong odor of stool. The following was observed: * At 9:08 AM, Activities Assistant #1 went into Resident #66's room and delivered a paper for his roommate to read then left the room. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Actual harm Residents Affected - Few	* At 9:14 AM, CNA #9 walked by Resident #66's room, looked in the room then walked away. * At 9:18 AM, CNA#9 again walked by Resident #66's room, looked in the room then walked away. There was a distinct odor of stool in the hallway outside Resident #66's room. CNA #9, RN #5, and RN #8 walked by Resident #66's room without entering from 9:21 AM to 9:37 AM. An alarm sounded from Resident #66's room for his roommate's ventilator. At 9:40 AM, RN #5 entered the room, the alarm was then quiet, and RN #5 exited the room. The odor was still present upon her exit. There continued to be the odor of stool in the hallway outside Resident #66's room. CNA #15 and RN #5 walked by the room without entering from 9:46 AM to 9:56 AM. At 10:24 AM, Resident #66 was observed crying while lying in his bed in his room. When asked if he had a soiled brief he nodded his head up and down indicating yes. When asked if he could reach his call light on his chest he shook his head side to side indicating no. At 11:11 AM, CNA #9 stated incontinent residents were checked every 2 hours. CNA #9 stated she checked Resident #66 one hour ago. At 11:21 AM, Physical Therapist #1 entered Resident #66's room to perform bedside therapy. Physical Therapist #1 attempted to sit Resident #66 up at the side of the bed and Resident #66 was observed shaking his head side to side indicating no. Physical Therapist #1 then laid him back down into bed and left the room. At 11:26 AM, CNA #15 went into the room and performed incontinence care for Resident #66. On 12/10/19, Resident #66 experienced emotional distress when he was incontinent of stool and unable to use his call light, and remained in an adult brief soiled with stool for 2 hours and 18 minutes (9:08 AM to 11:26 AM). On 12/12/19 at 1:46 PM, Resident #66 was in bed with his call light on his chest. The call light was a hard sided, push button type of call light. When asked if he could use his call light, Resident #66 shook his head side to side indicating no. When asked if he could reach his call light, Resident #66 tried to move his left arm to his chest, but his arm could not move off of the bed. When asked if he had ever had a different type of call light, Resident #66 shook his head side to side indicating no. On 12/11/19 at 8:33 AM, Charge Nurse #1 stated they kept a close eye on residents who required incontinence care. He stated residents were to be checked at a minimum of every two hours. 2. Resident #24, whose age was in the mid-30's, was admitted to the facility on [DATE], with multiple diagnoses including cerebral palsy (brain injury which most often happens before or during a baby's birth, or during the first 3-5 years of a child's life, that affects muscle tone, movement, and motor skills, and may also cause sight, hearing, and learning problems) and intellectual disability. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	Resident #24's care plan, dated 8/6/19 and 11/21/19 respectively, documented she used a mitt for her right hand for skin protection, used a bottle with a nipple with all liquids, and wore a clothing protector to protect clothing and skin from moisture. On 12/8/19 at 11:52 AM, Resident #24 was in the day room in her wheelchair with a baby bottle and an oven mitt in her lap. She had on a small clothing protector with M&M caricatures on it. On 12/8/19 at 12:47 AM, Resident #24 was at the dining room table with a baby bottle with milk in it and her diet meal ticket at the table documented, Baby bottles for beverages. On 12/9/19 at 9:46 AM, Resident #24 was in the day room in her wheelchair with an oven mitt on her right hand with a detachable strap holding the oven mitt in place around her elbow. She had on a small clothing protector with M&M caricatures on it. On 12/10/19 at 8:50 AM, Resident #24 was at the dining room table drinking juice from a baby bottle. She again had on a small clothing protector with M&M caricatures on it and an oven mitt in her lap. On 12/8/19 at 11:59 AM, RN #8 said Resident #24's oven mitt was used to protect her hand from skin breakdown because she chewed and sucked on her hand. RN #8 said the clothing protector was to protect her skin from breakdown due to oral secretions. On 12/11/19 at 3:15 PM, the Director of Therapy said the facility had not been successful in finding a more appropriate adult-like glove or other option for Resident #24 who chewed on her hand. She said the baby bottle had not been assessed for appropriateness. On 12/11/19 at 3:53 PM and 4:19 PM, the Clinical Resource nurse, with the DON present, said Resident #24's family was providing the baby bottles, the clothing protectors, and the oven mitts. She said she could see how the baby bottles and clothing protectors could be viewed as babyish. The DON said she did not expect Resident #24's meal tray ticket to document the use of a baby bottle. 3. Residents were not served their meals at the same time as their tablemates. a. On 12/8/19 from 12:24 PM to 12:33 PM, Residents #6, #13, #24, and #55 were seated at the same dining room table in the Alpine unit. Resident #13 was assisted with his lunch meal by CNA #9. Residents #6, #24, and #55 had not received their meals. At 12:33 PM, Resident #13 was finished with his meal and CNA #9 assisted him from the dining room. At 12:40 PM, Residents #6, #24, and #55 received their meals and were then individually assisted by three CNAs. At 12:50 PM, CNA #9 said there were not enough staff to assist the residents with their meals. On 12/10/19 at 1:28 PM, UM #2 said residents at the assistance table had not received their meals at the same time because the CNAs were not available to assist them at that time. On 12/11/19 at 4:19 PM, the DON said she expected all of the residents at the same table to be served at the same time with staff there to assist them. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	b. On 12/8/19 at 12:26 PM, Resident #420 and one other resident were sitting at a table in the dining room. At another table, next to them, there were three residents sitting at the table waiting to be served lunch. The four other residents were served lunch and began eating, while Resident #420 was waiting to be served. On 12/8/19 at 12:33 PM, Resident #420 stated he did not know why he did not receive his meal with the other four residents. At 12:44 PM, LPN #2 observed Resident #420 without a plate in front of him and she notified the kitchen server. At 12:47 PM, Resident #420 was served his meal and he began to eat. The four other residents stayed and visited with each other, while Resident #420 ate his meal. On 12/8/19 at 12:52 PM, LPN #2 stated all the residents at a table should be served their meal at the same time. On 12/8/19 at 1:10 PM, UM #2 stated all the residents should have been served at the same time. 37263 42315

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F 0552 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17679 Based on observation, record review, staff interview, resident and family interview, and policy review, it was determined the facility failed to ensure appropriate consent was obtained from a resident's Co-Guardians for a laboratory test when the resident did not have the capacity to make their own medical decisions. This was true for 1 of 26 residents (Resident #69) reviewed for resident rights. This deficient practice caused psychosocial harm by causing emotional distress to Resident #69 after he refused to provide urine for a laboratory test which was later obtained by straight catheter after four staff approached him and stated it was physician ordered. Findings include: The facility's policy Resident Rights, with a release date of 11/28/2017, stated Each resident has the right to exercise their rights as a resident of the Facility and as a citizen or resident of the United States without interference, coercion, discrimination, and reprisal and be supported by the facility in the exercise of those rights . Throughout the Resident Rights policies, the term resident also applies to resident or resident and/or a surrogate decision-maker (any person who may, under state law, act on the resident's behalf when the resident is unable to act for himself or herself). Resident Rights include the resident's right to exercise his or her rights . and participate in decisions .To request, refuse, and/or discontinue treatment .In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law . This policy was not followed. Resident #69 was admitted to the facility on [DATE], with multiple diagnoses including a stroke affecting his left non-dominant side, bipolar disorder (unusual shifts in mood and activity levels), and schizoaffective disorder (symptoms of hallucinations or delusions, mania, and depression). Resident #69's record included a Letter of Co-Guarding which documented two people were duly appointed and qualified as Co-Guardians for Resident #69 on 6/14/18. The letter documented Resident #69 was an incapacitated and protected person. A quarterly MDS assessment, dated 7/19/19, documented Resident #69 was cognitively intact but he had unclear speech. The assessment documented he required two or more staff for bed mobility, transfers, personal hygiene, toilet use, and dressing. The assessment also documented Resident #69 had impairment on one side of his upper and lower extremities. A Care Plan, revised on 8/5/19, identified Resident #69 had impaired cognitive function with impaired thought processes related to impaired decision making due to traumatic brain injury. The goals included communicating with family regrading his capabilities and needs. The care plan interventions included for Resident #69 to be able to communicate his basic needs, to remain oriented to person, place, situation, and time, and to maintain his current level of cognitive function. (continued on next page)

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F 0552 Level of Harm - Actual harm Residents Affected - Few	A behavior progress note by the IDT, dated 7/31/19 at 10:40 AM, stated on 7/29/19 Resident #69 was observed acting out of the ordinary from his base line. A CNA asked Resident #69 what was wrong, and he informed the CNA his caregiver, hired by his family for socialization, had given him a marijuana brownie. The physician was informed, and an order was written for a urine drug screen. The note documented Resident #69's family was informed of the situation also. A physician's order, dated 7/31/19 at 4:30 PM, documented Urine drug/tox [toxicity] screen. One time only for Urine lab for 1 Day. A progress note, dated 8/2/19 at 8:26 PM, documented urine needed to be collected for a drug/toxicity screen on 7/31/19 for Resident #69. The note stated Resident #69 was refusing to use his urinal and was incontinent of urine and this was reported to the nurse practitioner on call and an order was received to use a straight catheter to obtain the urine sample if Resident #69 allowed. The note documented Resident #69 refused the straight catheter and the nurse practitioner was informed. A nurse's progress note, dated 8/3/19 at 5:56 AM, documented two nurses and a CNA approached Resident #69 and asked him if he would consent to a urine laboratory test ordered by a physician. They told him they would obtain the urine by a straight catheter. Resident #69 agreed to obtaining the urine for the laboratory test. Two nurses and two CNAs obtained the urine sample using a straight catheter. On 12/10/19 at 9:50 AM, Co-Guardian #1 stated after telling the facility not to do a laboratory test for Resident #69, the facility went ahead and did the laboratory test anyway without permission from the guardian. The family member stated there was no need for the test and he had told them that. On 12/12/19 at 3:21 PM, the DON was interviewed regarding the urinalysis obtained without the guardian's permission. The DON said the one guardian had returned after the other guardian had left and said it was okay to do the urinalysis. The DON was asked where it was documented the one guardian had given permission. The DON looked in the notes and stated, I guess no one documented it. On 12/12/19 at 3:25 PM, the Administrator was interviewed regarding the court appointed Co-Guardians of the resident. The Administrator was asked if the Co-Guardians were to decide on Resident #69's medical care and treatments. The Administrator said the guardians had been appointed by the court to oversee Resident #69 in everything but his housing. The housing where Resident #69 was placed was the only thing they both had to agree upon.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31867 Based on observation, policy review, record review, resident interview, and staff interview, it was determined the facility failed to ensure residents needs were accommodated when a resident's call light was out of reach and was inadequate for the resident's physical limitations, the double doors leading to the Activity Room were difficult to open and keep open, and a resident's urinal was out of reach. This was true for 4 of 8 residents (#4, #9, #27, and #30) in the Resident Group interview and 2 of 21 residents (#15 and #66) reviewed for accommodation of needs. This failure created the potential for harm if residents fell trying to open and keep open doors and when reaching for urinals, and if residents needs were not met when call lights were inappropriate or unavailable. Findings include: The facility's Resident's Environment policy, dated 11/28/19, documented the facility was to provide residents with reasonable accommodation of needs and preferences, including common areas frequented by residents, and call lights that are adapted to meet the needs of the residents. This policy was not followed. 1. Resident #66 was admitted to the facility on [DATE], with multiple diagnoses including stroke, muscle weakness, transient paralysis (unable to move intermittently), and diabetes. Resident #66's Physical Therapy Evaluation, dated 10/11/19, documented he had severe weakness of the left and right hands. An Occupational Therapy note, dated 10/14/19, documented Resident #66 had impaired range of motion, and impaired fine and gross motor coordination in both hands. An admission MDS assessment, dated 10/21/19, documented Resident #66 had upper extremity impairment (shoulder, elbow, wrist, and hand) on both sides of his body. Resident #66's care plan documented he had limited physical mobility related to physical weakness and stroke. A Physical Therapy summary, dated 12/1/19 to 12/7/19, documented Resident #66 had impairments which included body awareness deficits, decreased functional capacity, gross motor coordination deficits, motor control deficits, and sensation and strength impairments. On 12/8/19 at 12:02 PM, CNA #10 was asked how Resident #66 called for assistance and CNA #10 stated Resident #66 could use the call light provided by pushing the button on the call light with his thumb. CNA #10 stated Resident #66 could answer yes and no questions with head movement. CNA #10 stated there was a need for better communication with Resident #66. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/19 at 9:08 AM, Resident #66 was lying on his back in bed and a strong odor of stool was present. The call light was on Resident #66's chest. At 10:24 AM, CNA #15 looked into Resident #66's room and stated she was doing rounds. Resident #66's call light remained on his chest. When Resident #66 was asked if he could reach his call light, he shook his head no. At 11:01 AM, RN #5 entered and exited the room. The call light remained on Resident #66's chest. On 12/11/19 at 2:58PM, Resident #66's call light was on the floor by the left side of his bed. On 12/12/19 at 8:56 AM, CNA #10 stated Resident #66 did not use his call light even though we put it in his hand and staff had to check on him. On 12/12/19 at 9:17 AM, RN #4 stated Resident #66 had a squeeze type of call light that RN #4 had checked to make sure Resident #66 could use. When asked if Resident #66 had a push button call light, RN #4 stated he thought Resident #66 had a squeeze type of call light. On 12/12/19 at 1:46 PM, Resident #66 was in bed with his call light on his chest. The call light was a hard sided, push button type of call light. When asked if he could use his call light, Resident #66 shook his head side to side indicating no. When asked if he could reach his call light, Resident #66 tried to move his left arm to his chest, but he was unable to move his arm off of the bed. When asked if he had ever had a different type of call light, Resident #66 shook his head side to side indicating no. When asked if he would like another type of call light, Resident #66 shook his head up and down indicating yes. On 12/12/19 at 1:50 PM, UM #1 was asked about Resident #66's call light use and if he had ever witnessed him use it. UM #1 answered he had to check. UM #1 did not provide additional information. 2. On 12/10/19 at 2:35 PM, during the Resident Group interview in the Activity Room, Resident #30 said the Activity Room doors were hard to open, especially for those with wheelchairs. He said he had told various staff members, including the Maintenance Director. He said all the staff knew about the door because they had to hold them open so residents could come and go from the room. At 3:15 PM, Resident #4 joined the group interview in the Activity Room and a staff member assisted to open the door, so he could navigate his wheelchair into the room. Residents #4, #9, #27, and #30 said they had trouble opening the doors and keeping them open to get in and out of the room. On 12/10/19 at 3:40 PM, the double doors to the Activity Room had straight handles on the hallway side of the doors with a latch at the top of the doors. The other side of the Activity Room doors had a push bar function. When opened, the doors closed on their own. On 12/11/19 at 9:33 AM, the Activity Director said residents had difficulty coming into the Activity Room because she was told by the Maintenance Director the doors had to be kept closed and they closed automatically. On 12/11/19 at 9:54 AM, the Maintenance Director said he was aware the Activity Room doors were a concern for residents and Resident #30 had spoken to him about his concern. The Maintenance Director said the door closed automatically because it was a fire safety feature. He said he had thought of keeping the doors opened with magnets and they would close if the fire alarm went off. He said he had not placed magnets on the Activity Room doors. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #15 was readmitted to the facility on [DATE], with multiple diagnoses including morbid (severe) obesity and rectal fistula (an abnormal connection between the end of the bowel and the skin). An admission MDS, dated [DATE], documented Resident #15 required extensive assistance of two staff members for most of his ADLs except for eating. Resident #15's ADL care plan, revised on 9/19/19, documented Resident #15 had two urinals at his bedside. On 12/13/19 at 11:08 AM, Resident #15 was observed in bed. Resident #15 said he needed to use his urinal but he could not reach it. Resident #15's two empty urinal containers were observed on top of his overbed table located at the foot of his bed and was out of his reach. On 12/13/19 at 11:11 AM, CNA #7 entered Resident #15's room and assisted Resident #15 to use his urinal. CNA #7 said the urinals should be within reach of Resident #10. 36193 42315

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 31867 Based on Resident Council meeting minutes, Resident Group interview, policy review, and staff interview, it was determined the facility failed to ensure Resident Council concerns were addressed. This was true for 3 of 8 residents (#9, #30, and #44) who participated in the Resident Group interview. This deficient practice had the potential to cause psychosocial harm for residents frustrated by the perception their concerns were not valued or addressed by the facility. Findings include: The facility's Grievance policy, dated 11/28/17, documented the facility would make prompt efforts to resolve grievances, including Resident Council concerns, and to keep residents notified of progress toward resolution. Resident Council Meeting minutes, dated 9/4/19, documented concerns with call light response times up to 30 minutes and very slow response times during meals. Resident Council Meeting minutes, dated 10/2/19, documented concerns with call light response times up to one and a half hours, not enough staff, staff saying they would come back to help residents and did not, and breakfast served in resident rooms were late. There was no documentation what actions were taken to resolve the concerns identified in the 9/4/19 meeting. Resident Council Meeting minutes, dated 11/6/19, documented concerns with call light response times up to two hours, long response times during shift change, staff saying they would come back to help residents and did not come back, and room trays were late due to not enough staff to pass out trays. There was no documentation what actions were taken to resolve the concerns identified in the 9/4/19 or 10/2/19 meetings. Resident Council Meeting minutes, dated 12/4/19, documented concerns with not enough staff on the weekends and not all the residents were getting showers as scheduled. There was no documentation what actions were taken to resolve the concerns identified in the 9/4/19, 10/2/19, and 11/6/19 meetings. On 12/10/19 at 2:35 PM, during the Resident Group interview, Residents #9, #30, and #44 said there were still issues with slow call light response times, not enough staff, low food temperatures, and late delivery of trays. They stated these concerns were not addressed by the facility. On 12/11/19 at 9:36 AM, the Activity Director said she emailed the Resident Council meeting notes to the department heads. She said she had not been given direction to readdress the old complaints during the Resident Council meetings. The Activity Director said the Administrator met individually with the Resident Council President to address the Resident Council concerns. On 12/11/19 at 1:10 PM, the Administrator said he met with the Resident Council President and relied on the council's President to report back to the Resident Council. The Administrator provided minutes for meetings with the council's President for 11/11/19 and 11/27/19. The minutes did not document a discussion of not enough staff, staff saying they will come back to help residents and then not coming back, and late meal trays. The Administrator said he did not see where concerns were readdressed in the Resident Council minutes. The Administrator said he expected Resident Council concerns to be addressed.

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	135146	A. Building B. Wing	12/13/2019

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Cascadia of Boise	6000 W Denton St Boise, ID 83704

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39184 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents' advance directive information was reviewed quarterly with the resident and/or their representative. This was true for 1 of 9 residents (Resident #19) whose advanced directives were reviewed. This failed practice created the potential for harm if the resident's documented wishes were not accurate and up-to-date regarding their advance directive information. Findings include: The facility's policy regarding Advanced Directives/Health Care Decisions, dated 10/1/17, documented the following: * The facility determined upon a resident's admission whether the resident had executed an advanced directive or other instructions to indicate their care preferences in the event the resident became incapacitated. * If the resident or their representative had executed an advance directive, a copy was obtained and maintained in the resident's record. * If the resident had not executed an advance directive, the facility informed the resident and their family of their right to establish an advance directive. * The facility documented discussion about advance directives and any healthcare decisions in the resident's record. * If the resident wanted to formulate an advance directive, a nurse or social worker provided written information regarding the right to make decisions regarding medical care. * The facility established processes for documenting and communicating the resident's choices to the interdisciplinary team. * The facility identifies, clarifies, and periodically reviews at least quarterly, after a life altering event . and after return from a hospitalization , as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. This policy was not followed. Resident #19 was admitted to the facility on [DATE], with multiple diagnoses including stroke, hemiplegia and hemiparesis (weakness and paralysis on one side), and aphasia (loss of ability to understand or express speech). A Multidisciplinary Care conference note, dated 2/18/19 at 9:14 AM, documented a care conference meeting was held with Resident #19 and her son in attendance. The note documented advance directive information was offered and it was declined at that time. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Multidisciplinary Care conference note, dated 5/22/19 at 8:42 AM, documented a care conference meeting was held with Resident #19, and her son did not attend. The note documented advance directive information was offered. There was no documentation in Resident #19's record the advanced directive information was reviewed or offered to Resident #19 and/or her representative after 5/22/19. Resident #19's significant change MDS assessment, dated 10/16/19, documented she was moderately cognitively impaired. On 12/10/19 at 11:50 AM, the DON said there was only a POST form in Resident #19's record, but her care plan was updated to say she was not cognitively able to make the decision regarding advance directives. On 12/11/19 at 3:06 PM, the DON said the Resident Services Manager (RSM) discussed advanced directive information with residents at their care conferences. On 12/11/19 at 3:15 PM, the RSM said she asked residents at their care conferences if they had an advanced directive, and she asked for a copy if they had one. The RSM said if the resident did not have an advance directive, she asked if they would like one and the Social Worker helped them fill it out if they wanted to complete it. The RSM said an advance directive or Living Will was offered at every care conference meeting. The RSM said a care conference meeting was held with Resident #19's son. The RSM said Resident #19's son was asked if he wanted information regarding advance directives, he said yes, and the facility informed him Resident #19 did not have the cognitive ability to make that decision so she could not complete the advance directive. The RSM said at the care conference on 2/21/19, Resident #19's son did not want information regarding advance directives. The RSM said there was no advance directive or Living Will completed for Resident #19 prior to her admission to the facility or change in condition. The RSM said the last time Resident #19's advance directive information was reviewed was in May 2019, and it should be reviewed quarterly. The RCM said Resident #19 had a change in condition, and she should have had another care conference since then but she did not.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31923 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure the guardian was notified of a significant medication error. This was true for 1 of 26 residents (Resident #70) whose records were reviewed for notification of changes. This deficient practice placed Resident #70 at risk due to lack of information sharing and residents right to be informed. Findings include: The facility's Resident Change of Condition policy, dated 11/28/17, documented the facility was to immediately inform the resident, the physician, and the resident representative when there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); or a need to alter treatment significantly. This policy was not followed. Resident #70 was admitted to the facility on [DATE], with multiple diagnoses including atrial fibrillation (irregular heart rhythm), diabetes, and hypertension (high blood pressure). A quarterly MDS assessment, dated 6/24/19, documented Resident #70 was moderately cognitively impaired. A Nurse's Progress Note, dated 7/10/19 at 5:28 AM, documented the wrong medications were administered to Resident #70 on 7/9/19. The note documented Resident #70 received eight medications in error at 7:00 PM on 7/9/19. The medications he received were as follows: - Ranitidine (used to decrease stomach acid production) - Lithium (used to treat psychiatric disorders) - Morphine IR (an opioid pain medication with an immediate release) - Soma (a muscle relaxer) - Lyrica (used to treat seizures, nerve pain, and fibromyalgia) - Gabapentin (used to treat nerve pain) - Simvastatin (used to treat high cholesterol) - Trazodone (used to treat depression and insomnia) The progress note did not include documentation the guardian was notified. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Medication/Treatment/Lab Error Report, dated 7/9/19 at 7:15 PM, documented Resident #70 received the wrong medications. The report documented Resident #70 was notified of receiving the wrong medications on 7/10/19. The report documented the physician was notified and received orders to monitor Resident #70's pulse and oxygen saturations. The report documented Resident #70 was lethargic and vital signs were stable. On 12/10/19 at 3:02 PM, Resident #70's guardian said neither of Resident #70's guardians were notified of the medication error that occurred on 7/9/19. On 12/12/19 at 1:12 PM, the DON said Resident #70's record did not include documentation the guardians were notified of the medication error on 7/09/19. Resident #70's guardians were not notified when he received the wrong medications. 36193

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31867 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure a resident's private health information was protected when an arm bracelet displayed private health information. This was true for 1 of 21 residents (Resident #6) reviewed for privacy. This failure created the potential for residents to experience a decreased sense of self-worth when their confidential health information was displayed to the public. Findings include: The facility's quality of life policy, dated 11/28/17, directed staff not to display confidential clinical or personal information. This policy was not followed. Resident #6 was readmitted to the facility on [DATE], with multiple diagnoses including osteoarthritis. Resident #6's care plan, dated 9/17/19, documented she was at risk for falls. On 12/8/19 at 12:35 PM and on 12/10/19 at 8:33 AM, Resident #6 was in the dining room in her wheelchair and had a yellow bracelet on her right wrist which had the words FALL RISK imprinted on it. On 12/10/19 at 9:39 AM, Resident #6 said she did not know why she had the FALL RISK bracelet on. On 12/10/19 at 1:39 PM, LPN #2 said Resident #6 had a history of falling and said she had the bracelet on her wrist for at least three or four weeks. She said she was not sure where the bracelet came from since the facility did not use them. On 12/11/19 at 3:35 PM, Resident #6 was in her bed with the yellow bracelet on her wrist. On 12/11/19 at 3:39 PM, Hospice RN #1 said Resident #6 was at risk for falling. She said the hospice provider did not use fall risk bracelets and said she thought the facility had placed the bracelet on her wrist. On 12/11/19 at 3:42 PM, the DON said the facility did not use fall risk bracelets and expected staff to remove them if residents had them on.

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	135146	A. Building B. Wing	12/13/2019

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41819 Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure grievances were responded to and investigated, and prompt corrective action was taken to resolve the grievances. This was true for 2 of 26 residents (#30 and #56) reviewed for grievances. This failure created the potential for harm if residents' verbal grievances were not acted upon and residents were not provided appropriate care to meet their care and needs. Findings include: The facility's Complaints and Grievances Policy and Procedure, dated 11/28/17, documented: * Residents had the right to voice grievances verbally or in writing. * The facility should make prompt efforts to resolve grievances the resident may have. * Complaints/grievances may be brought by any individual or group. * Complaints/grievances were acknowledged, investigated, and the complainant was apprised of progress toward a resolution and took appropriate corrective action if the alleged violation was confirmed by the facility. This policy was not followed. 1. Resident #56 was admitted to the facility on [DATE], with multiple diagnoses including hemiplegia and hemiparesis affecting the left side (paralysis or weakness on one side of the body) following a stroke and seizure disorder. Resident #56's quarterly MDS assessment, dated 11/18/19, documented she was cognitively intact. On 12/8/19 at 11:48 AM, Resident #56 said she had no shampoo or face wash due to her prior roommate using it and then her roommate took some with her. She said they were expensive products. Resident #56 said she told staff and they told her the items would not be replaced because they were not on her inventory, and the staff had thrown the remaining bottles away. Her roommate was discharged prior to 11/29/19. On 12/9/19 at 10:40 AM, Resident #56 said she was missing leggings and a concert T-shirt and she had reported it to facility staff. Resident #56 stated she was told laundry service looked for the clothing items but did not find them. She stated nothing happened after that. The facility's grievance file did not include a grievance for Resident #56. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/19 at 10:34 AM, the RSM said a resident would let her know their grievance and she wrote the grievance, checked the laundry, and if a missing item was not found it was replaced. The RSM said Resident #56 had not reported her missing clothes, and she knew about Resident #56's missing face wash and hair products. The RSM said she had suggested to Resident #56 it would be better to get a physician order for the scalp shampoo. The RSM said they offered to get an order and purchase scalp shampoo and Resident #56 said that would be okay. Resident #56's record did not include documentation of a physician order for special scalp shampoo. On 12/13/19 at 9:44 AM, the RSM reviewed Resident #56's record and said she did not see an order for shampoo. She said if a written grievance for Resident #56's missing property was not found in the grievance file then she had not written a grievance on Resident #56's behalf. The facility failed to ensure Resident #56's grievances were documented, investigated, and acted upon. 31867 2. On 12/10/19 at 2:35 PM, during the Resident Group interview, Resident #30 said the Activity Room door was hard to open, especially for those with wheelchairs. He said he had told various staff members, including the Maintenance Director. He said all the staff knew about the door because they had to hold them opened so residents could come and go from the room. On 12/11/19 at 9:54 AM, the Maintenance Director said he was aware the Activity Room door was a concern for residents and Resident #30 had spoken to him about his concern. The Maintenance Director said he had not filed a grievance regarding the concern. On 12/11/19 at 10:43 AM, the RSM said she was the grievance coordinator. She said there was not a grievance for Resident #30 regarding the Activity Room door. She said she expected staff to help residents file grievances when concerns were brought to them. The facility did not ensure Resident #30's grievance was documented and acted upon.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 36193 Based on employee record review and staff interview, it was determined the facility failed to ensure employee reference checks were completed prior to potential employees starting work in the facility. This was true 4 of 5 (Staff A, C, D and E) staff whose personnel files were reviewed for pre-employment background checks. This had the potential to place each of the 74 residents residing in the facility at increased risk of adverse events. Findings include: The facility's Preventing Abuse policy, revised 7/13/18, directed the facility to complete at least two reference checks for employees upon hire. This was not followed. On 12/10/19 at 4:32 PM, five employees' personal files were reviewed for reference checks as follows: *Staff A was hired on 1/20/19 *Staff C was hired on 10/1/19 *Staff D was hired on 11/5/19 *Staff E was hired on 12/3/19 Staff A, C, D, and E's files did not contain reference checks at the time of review. HR/Payroll Staff #1 said she was not working in the facility when Staff A was hired, and she did not know why Staff A did not have reference checks completed. HR/Payroll Staff #1 said they had 30 days to complete the employees' personnel files and due to lots of paper work it might have slipped her mind that Staff C, Staff D, and Staff E did not have a reference checks.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on staff interview, record review, facility policy review, and review of Incident and Accident (I&A) reports, it was determined the facility failed to ensure an alleged perpetrator was not allowed to report for work while an investigation of alleged abuse was being conducted. This was true for 1 of 5 residents (Resident #10) reviewed for abuse and neglect. The deficient practice placed residents at risk of ongoing abuse. Findings include: The facility's Abuse policy, revised 7/23/19, documented staff implicated in an abuse/neglect situation would be suspended pending investigation results, and interview notes should contain the full name of the person interviewed, time and date. This policy was not followed. Resident #10 was admitted to the facility on [DATE], with multiple diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (stroke) and anxiety. Resident #10 annual MDS assessment, dated 10/1/19, documented she was severely cognitively impaired and required extensive assistance of 1 - 2 staff members for her ADLs. Resident #10's physician's orders included Aspirin (may interfere with blood clotting at low doses) 81 mg one tablet one time a day for cardiac (heart) precautions, ordered on 12/4/18. A Nursing Note, dated 1/27/19 at 5:30 PM, documented the nurse was called by a CNA to check on the bruise found on Resident #10's arm. The bruise measured 11 cm x 9 cm extending down to her right breast measuring 8 cm x 5 cm. Resident #10 denied pain and did not know how it happened. An I&A report documented Resident #10's bruise was found on 1/27/19. The I&A report documented during witness statement collection Staff A went and looked at Resident #10's bruise and reported to the nurse she thought her bruise could have happened during her therapy session with Staff F on 1/26/19 with the STS lift. The I&A report documented the Administrator and DON were notified and Staff F was put on suspension pending investigation. The I&A report also documented Staff F was interviewed by the Director of Therapy on 1/28/19 and two more staff were interviewed on the same day. The I&A report also documented five residents who were under the care of Staff F were interviewed on 1/30/19 and there were no concerns noted. On 12/11/19 at 8:46 AM, HR/Payroll Staff #1 provided the 1/25/19 through 1/30/19 Time Card Report of Staff F. Staff F's Time Card Report documented the following: *1/27/19 - In at 9:59 PM and Out at 10:10 PM *1/28/19 - In at 8:00 AM and Out at 4:00 PM *1/29/19, In at 9:15 AM and Out at 6:50 PM (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*1/30/19, In at 9:00 AM and Out at 5:49 PM On 12/11/19 at 10:25 AM, the Administrator said he was the Abuse Coordinator and he enlisted the assistance of the DON, LSW and other departmental Supervisors in investigating an abuse incident. The Administrator said the alleged perpetrator would be suspended immediately until the abuse was ruled out which could be from an hour to 24 hours or more and they could return to work after it was determined it was not abuse. The Administrator reviewed Staff F's Time Card Report and said PT staff could check in remotely to finish their documentation. The Administrator said Staff F was informed of the incident on Sunday, 1/27/19 and could have written her statement on 1/27/19 between 9:59 PM and 10:10 PM as shown on her Time Card Report. When asked why Staff F was allowed to come back to work on 1/28/19 through 1/30/19 while the investigation was still in progress, the Administrator said he had a conference call with DON, LSW and the Director of Therapy on the night of 1/27/19 and they determined abuse did not occur to Resident #10 based on Staff A, Staff F, and Resident #10's interviews, and her bruise was caused by the sling from the STS lift. The facility failed to ensure the alleged perpetrator was not allowed to report for work while the alleged abuse was being investigated as documented in its Abuse Policy.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on staff interview, policy review, and record review, it was determined the facility failed to ensure required information was provided to the receiving facility when a resident was transferred to the hospital. This was true for 4 of 5 residents (#15, #36, #39 and #62) reviewed for transfers. This deficient practice had the potential to cause harm if the residents were not treated in a timely manner due to lack of information. Findings include: The facility's Transfer & Discharge policy, dated 11/28/17, documented when the discharge or transfer of a resident was necessary, the following information should be provided to the receiving provider: *Contact information of the practitioner responsible to the care of the resident. *Resident representative information including contact information. *Advance Directive information. *Special instructions and/or precautions for ongoing care such as need for oxygen use, isolation precautions, and other risk factors such as risk for falls, bleeding, aspiration precautions and pressure ulcer injury. *The resident's comprehensive care plan. *List of medications, relevant laboratory and diagnostic test, diagnoses and allergies. This policy was not followed. Examples include: 1. Resident #15 was readmitted to the facility on [DATE], and again readmitted on [DATE], with multiple diagnoses including acute respiratory failure with hypoxia (decreased oxygen supply to the body tissues) and hypercapnia (excessive carbon dioxide in the bloodstream caused by inadequate respiration) and rectal fistula (an abnormal connection between the end of the bowel and the skin). A Nurse's Progress Note, dated 9/1/19, documented Resident #15 told a CNA he was not feeling well. Resident #15 was observed to stutter I need a repeatedly. The physician was notified and ordered Resident #15 be transferred to the hospital due to altered mental status. The Nurse's note documented Resident #15 left the facility at 10:40 PM via gurney accompanied by paramedics and two copies of discharge paperwork was sent to the hospital. Resident #15's medical record did not include what discharge paperwork was sent with him to the hospital. On 12/10/19 at 11:12 AM, UM #1 said the facility had a Discharge/Transfer Checklist which directed the staff what documents were required to be sent with the resident when they transferred to the hospital. UM #1 said Resident #15's medical record did not include what discharge paper work was sent to the hospital with Resident #15. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/19 at 1:00 PM, the DON said she did not find the discharge paper/documents for Resident #15. 2. Resident #39 was admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including congestive heart failure and respiratory failure. A Nurse's Progress Note, dated 11/17/19 at 10:27 PM, documented Resident #39's behavior and mood were outside of his baseline. He was confused and did not eat his breakfast and lunch. The Nurse's Note documented he was sent to the hospital and his family representative was notified of his transfer. Resident #39's record did not include documentation information was provided to the hospital to ensure safe and effective transition of care. On 12/10/19 at 11:12 AM, UM #1 said Resident #39's record did not include what discharge paper work was sent to the hospital with Resident #39. On 12/10/19 at 1:00 PM, the DON said she did not find the discharge paper/documents for Resident #39. 42315 3. Resident #62 was readmitted from the hospital to the facility on [DATE], with multiple diagnoses including quadriplegia, dependence on a ventilator (a machine that helps a person breathe), and a colostomy (a surgical opening in the abdominal wall to bypass a damaged colon). Resident #62's discharge MDS assessment, dated 11/2/19, documented he had an unanticipated discharge to the hospital. Resident #62's Nurse's Progress Note, dated 11/2/19 at 7:08 PM, documented he was feeling unwell with a temperature of 102.4 Fahrenheit. His abdomen was large, round, firm, and tender. Resident #62's family decided they wanted him sent to the emergency department, and the physician was notified. Resident #62's record did not include documentation what information had been provided to the receiving hospital or provider. On 12/12/19 at 10:57 AM, the DON stated there was no additional information in the in Resident #62's record other than the Progress Note from 11/2/19 at 7:08 PM. The DON stated she would look in the medical records department to see if there was additional documentation. On 12/12/19 at 4:30 PM, the DON stated she did not find additional documentation regarding Resident #62's transfer to the hospital. 37263 4. Resident #36 was admitted to the facility on [DATE], with multiple diagnoses including a traumatic brain injury. A discharge MDS assessment, dated 12/9/19, documented Resident #36 was discharged to a hospital. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascadia of Boise	6000 W Denton St Boise, ID 83704

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Nurse's Progress Note, dated 12/9/19 at 6:41 PM, documented Resident #36 had a fall with a change in his neurological status. The note documented Resident #36 had increased confusion, was unable to hold a conversation, and his eyes were heavy. Resident #36's physician was notified and a non-emergent transport was called. The note documented Resident #36 was sent to a local hospital for further evaluation. Resident #36's record did not document information regarding what time the non-emergent transport arrived and left the facility, his condition when leaving the facility, or who transported him to the hospital. Resident #36's record did not include documentation that information was provided to the non-emergent transport staff members, the emergency room , and the hospital to ensure a safe and effective transition of care. On 12/11/19 at 3:31 PM, LPN #2 stated after assessing Resident #36 she notified non-emergent transport. LPN #2 stated she did not provide documentation to the non-emergent transport staff members of Resident #36's change of condition. The DON stated Resident #36's record did not include documentation the Transfer/Discharge Form and paperwork were provided to the non-emergent transport staff members, a physician's order to transport him, and the reason for admission to the hospital. The DON stated the documentation should have included when non-emergent transport arrived and left the facility.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37263 Based on staff interview, policy review, and record review, it was determined the facility failed to ensure written notice was provided to the resident and the resident's representative prior to transfer to the hospital and that a copy of the written transfer/discharge notice was sent to the State Ombudsman. This was true for 4 of 5 residents (#15, #36, #39, and #62) reviewed for transfer/discharge to the hospital. This created the potential for harm if residents were not made aware of or able to exercise their rights related to transfers. Findings include: The facility's Transfer and Discharge policy, dated 11/28/17, stated If the facility determines a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility complies with the requirements: .Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner the [sic] understand . This policy was not followed. 1. Resident #36 was admitted to the facility on [DATE], with multiple diagnoses including a traumatic brain injury. A discharge MDS assessment, dated 12/9/19, documented Resident #36 was discharged to a hospital. A Nurse's Progress Note, dated 12/9/19 at 6:41 PM, documented Resident #36 had a fall with a change in his neurological status and was transported to the hospital for further evaluation. On 12/11/19 at 3:31 PM, LPN #2 stated she did not notify the resident or his family representative in writing. The DON stated Resident #36's record did not include documentation a written notice was provided to Resident #36 and his family representative at the time of his transfer to the hospital. 42315 2. Resident #62 was readmitted from the hospital to the facility on [DATE], with multiple diagnoses including quadriplegia, dependence on a ventilator (a machine that helps a person breathe), and a colostomy (a surgical opening in the abdominal wall to bypass a damaged colon). Resident #62's discharge MDS assessment, dated 11/2/19, documented he had an unanticipated discharge to the hospital. Resident #62's Nurse's Progress Note, dated 11/2/19 at 7:08 PM, documented he was feeling unwell with a temperature of 102.4 Fahrenheit. His abdomen was large, round, firm, and tender. Resident #62's family decided they wanted him sent to the emergency department, and the physician was notified. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/12/19 at 10:57 AM, the DON stated there was no additional information in Resident #62's medical record, other than the Nurse's Progress Note from 11/2/19 at 7:08 PM about a notification of transfer to the resident and the resident representative. The DON stated she would look in the medical records department to see if there was additional documentation. On 12/12/19 at 4:30 PM, the DON stated she could not find additional documentation regarding Resident #62's notification of transfer to the hospital. 36193 3. The facility's Transfer and Discharge policy, dated 11/28/17, stated a copy of written transfer/discharge notices were to be sent to a representative of the Office of the State Long-Term Care Ombudsman. This policy was not followed. a. Resident #15 was readmitted to the facility on [DATE], and again readmitted on [DATE], with multiple diagnoses including acute respiratory failure with hypoxia (decreasesd oxygen supply to the body tissues) and hypercapnia (excessive carbon dioxide in the bloodstream caused by inadequate respiration) and rectal fistula (an abnormal connection between the end of the bowel and the skin). A Nurse's Progress Note, dated 9/1/19, documented Resident #15 told a CNA he was not feeling well. Resident #15 was observed to stutter I need a repeatedly. The physician was notified and ordered Resident #15 be transferred to the hospital due to altered mental status. The Nurse's note documented Resident #15 left the facility at 10:40 PM via gurney accompanied by paramedics and two copies of discharge paperwork was sent to the hospital. Resident #15's medical record did not include what discharge paperwork was sent with him to the hospital. Resident #15's record did not include documentation a written transfer/discharge notice was sent to the Ombudsman. b. Resident #39 was admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including congestive heart failure and respiratory failure. A Nursing Progress Note, dated 11/17/19 at 10:27 PM, documented Resident #39's behavior and mood were outside of his baseline. He was confused and did not eat his breakfast and lunch. The Nursing Note documented he was sent to the hospital and his family representative was notified of his transfer. Resident #39's record did not include documentation a written transfer/discharge notice was sent to the Ombudsman. On 12/13/19 at 9:46 AM, the Admission/Discharge Nurse said she was made aware she needed to send a list of their discharges to the Ombudsman about two days ago.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on staff and resident interview, policy review, and record review, it was determined the facility failed to ensure a bed hold notice was provided to residents or their representatives upon transfer to the hospital. This was true for 3 of 5 residents (#10, #15 and #62) 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. Findings include: The facility's Bed Hold Readmission policy, dated 11/28/19, stated the policy applied to all residents, regardless of payment source. The policy stated the notice of a bed hold was provided to the resident and if applicable their representative, at the time of transfer, or in cases of emergency transfer, within 24 hours of the transfer. This policy was not followed. Examples include: 1. Resident #15 was readmitted to the facility on [DATE], and again readmitted on [DATE], with multiple diagnoses including acute respiratory failure with hypoxia (decreased oxygen supply to the body tissues) and hypercapnia (excessive carbon dioxide in the bloodstream caused by inadequate respiration) and rectal fistula (an abnormal connection between the end of the bowel and the skin). A Nurse's Progress Note, dated 9/1/19, documented Resident #15 told a CNA he was not feeling well. Resident #15 was observed to stutter I need a repeatedly. The physician was notified and ordered Resident #15 be transferred to the hospital due to altered mental status. The Nurse's note documented Resident #15 left the facility at 10:40 PM via gurney accompanied by paramedics. Resident #15's record did not include documentation that a bed hold notice was provided to him or to his representative when he was transferred to the hospital. On 12/8/19 at 3:00 PM, Resident #15 said he was hospitalized due to an infection. Resident #15 could not remember if he was given a bed hold notice. On 12/10/19 at 11:17 AM. UM #1 said he was unable to find the bed hold notice for Resident #15. On 12/10/19 at 1:00 PM, the DON said a bed hold notice should have been provided to Resident #15 when he was sent to the hospital. The DON said she did not find documentation that a bed hold notice was provided to Resident #15. 2. Resident #39 was admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including congestive heart failure and respiratory failure. A Nurse's Progress Note, dated 11/17/19 at 10:27 PM, documented Resident #39's behavior and mood were outside of his baseline. He was confused and did not eat his breakfast and lunch. The Nurse's Note documented he was sent to the hospital and his family representative was notified of his transfer. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #39's record did not include documentation that a bed hold notice was provided to him or to his representative when he was transferred to the hospital. On 12/10/19 at 11:17 AM. UM #1 said he was unable to find the bed hold notice for Resident #39. On 12/10/19 at 1:00 PM, the DON said a bed hold notice should have been provided to Resident #39 when he was sent to the hospital. The DON said she did not find documentation a bed hold notice was provided to Resident #39. 42315 3. Resident #62 was readmitted from the hospital to the facility on [DATE], with multiple diagnoses including quadriplegia, dependence on a ventilator (a machine that helps a person breathe), and a colostomy (a surgical opening in the abdominal wall to bypass a damaged colon). Resident #62's discharge MDS assessment, dated 11/2/19, documented he had an unanticipated discharge to the hospital. Resident #62's Nurse's Progress Note, dated 11/2/19 at 7:08 PM, documented he was feeling unwell with a temperature of 102.4 Fahrenheit. His abdomen was large, round, firm, and tender. Resident #62's family decided they wanted him sent to the emergency department, and the physician was notified. Resident #62's record did not include documentation a bed hold notice was provided to him or to his representative when he was transferred to the hospital. On 12/12/19 at 10:57 AM, the DON was interviewed regarding Resident #62's transfer to the hospital. The DON stated there was no additional information in Resident #62's record regarding a bed hold notice. The DON stated she would look in the medical records department to see if there was additional documentation. On 12/12/19 at 4:30 PM, the DON stated she could not find any documentation regarding a bed hold notice for Resident #62.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31867 Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure residents were accurately assessed. This was true for 2 of 21 residents (Resident #24 and #55) reviewed for assessments. This resulted in a lack of adequate information being available on which to make intervention decisions necessary to ensure each resident's highest practicable physical, mental, and psychosocial well-being was achieved. Findings include: 1. Resident #24, whose age was in the mid-30s, was admitted to the facility on [DATE], with multiple diagnoses including cerebral palsy (brain injury which most often happens before or during a baby's birth, or during the first 3-5 years of a child's life, that affects muscle tone, movement, and motor skills, and may also cause sight, hearing, and learning problems) and intellectual disability. a. Resident #24 was noted to have and use a baby bottle during the following observations: - On 12/8/19 at 11:52 AM, Resident #24 was in the day room in her wheelchair with a baby bottle. - On 12/8/19 at 12:47 AM, Resident #24 was at the dining room table with a baby bottle with milk in it. - On 12/10/19 at 8:50 AM, Resident #24 was at the dining room table drinking juice from a baby bottle. Resident #24's care plan, dated 11/21/19, documented Occupational and Speech Therapy was to screen and provide adaptive equipment for feeding as needed. The care plan directed staff to use a bottle with a nipple for all liquids. The care plan documented Resident #24's family had attempted numerous types of cups and Resident #24 would only drink fluids with a nipple. Resident #24's record did not include an evaluation regarding the need for a baby bottle or documentation of the other types of cups which had been tried and found to be ineffective prior to the use of the baby bottle. On 12/11/19 at 3:15 PM, the Director of Therapy said Resident #24's baby bottle had not been assessed. b. Resident #24's record included a physical restraint assessment, dated 7/24/19, which documented she wore a glove on her right hand to protect her skin due to chewing on her fingers. However, the assessment did not include information related to why Resident #24 was chewing on her fingers (e.g. oral stimulation, tactile stimulation, etc.) or documentation of less restrictive interventions which had been tried and found to be ineffective prior to the use of the oven mitt. Resident #24 was noted to have an oven mitt during the following observations: - On 12/8/19 at 11:52 AM, Resident #24 was in the day room in her wheelchair with an oven mitt in her lap. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 12/9/19 at 9:46 AM, Resident #24 was in the day room in her wheelchair with an oven mitt on her right hand with a detachable strap holding the oven mitt in place around her elbow. - On 12/10/19 at 8:50 AM, Resident #24 was at the dining room table. She had an oven mitt in her lap. On 12/11/19 at 3:15 PM, the Director of Therapy said therapy staff had tried several other gloves and mittens to prevent skin breakdown for Resident #24. She said the oven mitt helped to prevent skin breakdown because the material was thicker. On 12/11/19 at 3:53 PM, the Clinical Resource nurse said she expected therapy staff to evaluate for Resident #24's needs. 42346 2. Resident #55 was admitted to the facility on [DATE], with multiple diagnoses which included Parkinson's Disease and Lewy Body Dementia (a progressive brain disorder marked by abnormal deposits of protein in the brain). A quarterly MDS assessment, dated 11/11/19, documented Resident # 55 was cognitively intact and was totally dependent on two staff members with bathing, bed transfers, and bed mobility. On 12/8/19 at 10:34 AM, Resident #55 was observed reclining in a tilt-back wheelchair with a seat belt fastened across his waist. On 12/9/19 at 11:16 AM, Resident #55 stated his wife said he needed the seat belt so that he would not fall. Resident #55 stated he was able to remove the seat belt. On 12/10/19 at 11:50 AM, Resident #55's wife stated he was admitted to the facility with his tilt-back wheelchair and the seat belt. Resident #55's record did not include an assessment of the tilt-back wheelchair or the use of a seat belt. On 12/9/19 at 11:31 AM, the DON stated there should have been an assessment for the tilt-back wheelchair and the seat belt. On 12/10/19 at 10:58 AM, UM #2 stated he was unable to find a documented assessment for the seat belt or wheelchair. UM #2 stated Resident #55 was able to move his arms and release the seat belt, but he was unable to locate an assessment that stated Resident #55 was able to remove the seat belt. On 12/10/19 at 4:19 PM, the MDS Coordinator stated she did not document an assessment for the seat belt or specialized wheelchair for Resident #55.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42346 Based on record review, observation, and family, resident and staff interview, the facility failed to ensure MDS assessments accurately reflected the resident's status. This was true for 3 of 26 residents (#19, #55, and #66) whose MDS assessments were reviewed for accuracy. This failure created the potential for harm should residents receive inappropriate care related to discrepancies in the MDS assessments. Findings include: 1. Resident #55 was admitted to the facility on [DATE], with multiple diagnoses, which included Parkinson's Disease (a progressive disease of the nervous system that affects movement) and Lewy Body Dementia (progressive brain disorder triggered by abnormal deposits of protein in the brain). A quarterly MDS assessment, dated 11/11/19, documented Resident # 55 was cognitively intact and was totally dependent on two staff members with bathing, bed transfers and bed mobility. The MDS did not include documentation Resident #55 used a tilt-back wheelchair with a seat belt strapped across his waist. On 12/8/19 at 10:34 AM, Resident #55 was observed reclining in a tilt-back wheelchair with a seat belt strapped across his waist. On 12/9/19 at 11:16 AM, Resident #55 stated his wife said he needed the seat belt, so he would not fall. Resident #55 stated he was able to remove the seat belt. On 12/10/19 at 11:50 AM, Resident #55's wife stated he was admitted to the facility with his tilt-back wheelchair and use of a seat belt. On 12/9/19 at 11:31 AM, the DON stated there should have been an assessment for Resident #55's seat belt. On 12/10/19 at 10:58 AM, UM #2 stated he was unable to find a documented assessment for the seat belt or wheelchair. UM #2 stated Resident #55 was able to move his arms and release the seat belt, but he was unable to locate an assessment. On 12/10/19 at 4:19 PM, the MDS Coordinator stated she did not document an assessment for the specialized wheelchair for Resident #55. 39184 2. Resident #19 was admitted to the facility on [DATE], with multiple diagnoses including stroke and hemiplegia and hemiparesis (weakness and paralysis on one side) affecting the left side. Resident #19's care plan documented she had a deficit in ADL performance related to hemiplegia on the left side, initiated on 3/11/19. Resident #19's significant change MDS assessment, dated 4/9/19, documented she had functional limitations in range of motion with impairment on one side involving the upper and lower extremity. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #19's quarterly MDS assessment, dated 8/7/19, documented she had no impairment related to functional limitation in range of motion. Resident #19's significant change MDS assessment, dated 10/16/19, documented she had functional limitations in range of motion with impairment on one side involving the upper and lower extremity. On 12/8/19 at 10:34 AM, Resident #19 was in her room in a wheelchair. She was not observed moving her left arm and left leg. Upon multiple observations throughout the survey, Resident #19 was not observed using her left arm and leg. On 12/10/19 at 11:17 AM, the DON said Resident #19's MDS, dated [DATE], was incorrect when it documented she had no impairment, and Resident #19 had hemiparesis. 42315 3. Resident #66 was admitted to the facility on [DATE], with multiple diagnoses including stroke, muscle weakness, and transient paralysis (unable to move intermittently). The admission MDS assessment, dated 10/21/19, documented Resident #66 walked in his room and the corridor once or twice with two or more people giving physical assistance. The MDS assessment documented Resident #66 was totally dependent on two or more for locomotion on the unit, locomotion off the unit, and transfers. The MDS also documented Resident #66 required extensive assistance with two or more people for bed mobility. Resident #66's care plan, dated 11/21/19, documented the following: * He required 1-2 staff assistance for repositioning in bed. * He required a Hoyer mechanical lift for transfers. * He had limited physical mobility related to contractures, limited range of motion, physical weakness, and stroke. * He was totally dependent on help from others for ambulation and locomotion. Resident #66's Progress note documented, 10/30/19, documented he continued to be a full assist due to reduced function and mobility. Resident #66's Progress note, dated 11/2/19, documented he required assistance with ADL's, and was unable to self-propel. Resident #66's Physical Therapy Progress Report, dated 12/1/19 -12/7/19, documented he attempted to walk on 10/24/10 with total dependence and distance traveled was 0 feet. On 12/7/19 the report documented Resident #66 attempted to walk with maximum assistance, and he walked 0 feet. Resident #66's record documented he did not ambulate in his room or corridor with total assistance as documented by his MDS assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/19 at 10:29 AM, Therapist #3 came into Resident #66's room and assisted Resident #66 to sit on the side of his bed. Therapist #3 moved Resident #66's legs to the side of the bed without assistance from Resident #66. He then raised Resident #66's trunk to a sitting position without assistance from Resident #66 and held his shoulders as Therapist #3 squatted beside the bed to provide counterbalance for Resident #66's weight so he would not fall off the bed. Resident #66 sat on the side of his bed for less than 5 seconds, shook his head from left to right to indicate no. Therapist #3 then laid Resident #66 back down in bed. Resident #66 was not observed to walk with total assistance in his room or corridor as documented in his MDS assessment. On 12/10/19 at 4:40 PM, when asked if Resident #66's MDS assessment was correct, the MDS Coordinator stated Resident #66 was partially paralyzed so he probably could get up with assistance and walk. When the MDS coordinator was asked why Resident #66's care plan stated the resident required total assistance, she stated she would have to look into it because she did not know the answer. On 12/12/19 at 3:21 PM, Therapist #4 stated the only way Resident #66 attempted to walk since admission to the facility was with the neuro walker (an alternative positioning device to help support individuals with disabilities) in the therapy room. The MDs assessment did not document Resident #66 required the neuro walker to ambulate. On 12/12/19 at 4:00 PM, When the MDS coordinator was asked again about Resident #66's MDS assessment stating he ambulated in his room and the corridor, she stated a CNA charted Resident #66 was walking in room and hallway on the task documentation section of his chart. The MDS Coordinator stated the documentation came from the CNA's daily charting. The MDS Coordinator did not say the documentation came from an assessment.

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	135146	A. Building B. Wing	12/13/2019

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31867 Based on record review and resident and staff interview, it was determined the facility failed to develop and implement comprehensive resident centered care plans. This was true for 2 of 26 residents (#9 and #120) whose care plans were reviewed. This failure created the potential for residents to receive inappropriate or inadequate care. Findings include: 1. Resident #9 was admitted to the facility on [DATE], with multiple diagnoses including end stage renal disease (ESRD - chronic kidney disease where kidneys can no longer meet the body's needs), chronic obstructive pulmonary disease (COPD - a progressive lung disease with increasing breathlessness), diabetes, and gout (a form of inflammatory arthritis). Low Back pain was added to her diagnosis information on 6/27/19. Resident #9's record included a pain assessment, dated 4/29/19, which documented her pain was due to gout, renal dialysis, chronic disease, and made worse by overexertion, and routine medication was provided and effective. Resident #9's record included a pain assessment, dated 7/29/19, which documented Resident #9 received scheduled medication for pain. The pain assessment documented her scheduled and PRN medications were effective, her pain was relieved in 30 minutes, and she used medications, relaxation, and frequent position changes for pain relief. A Quarterly MDS Assessment, dated 10/5/19, documented Resident #9 was cognitively intact, on a scheduled pain medication regimen and received pain medications as needed. A common pain scale used was a numerical pain scale from 0 to 10. Zero (0) indicated no pain, 1 to 3 indicated mild pain, 4 to 7 was considered moderate pain, and 8 and above was severe pain. The Assessment documented Resident #9's pain was present frequently at a 5 on the pain scale, making it hard for her to sleep at night and limiting her day-to-day activities. On 12/10/19 at 1:23 PM, Resident #9 said she was on a pain management schedule. Resident #9's Order Summary Report included the following: * Indicate non-pharmacological interventions attempted prior to PRN pain medication administration, ordered on 7/30/19. * Pain monitor: Document pain rating scale at the start of each shift, using verbal/non-verbal 0-10 scale, ordered on 1/28/19. * Aspercreme with Lidocaine Cream 4%, applied to lower back/affected area topically every 6 hours as needed for pain, ordered on 10/15/19. * Gabapentin Capsule 300 mg, 1 capsule given orally 3 times a day for neuropathy (damage to the nerves), ordered on 10/16/19. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135146	A. Building B. Wing	12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascadia of Boise	6000 W Denton St Boise, ID 83704

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Tramadol HCl Tablet 50 mg, 1 tablet given by mouth every 6 hours as needed for pain, ordered on 7/7/19. * Tylenol Extra Strength Tablet 500 mg, 2 tablets given by mouth three times a day for pain, not to exceed 3 grams of Tylenol in 24 hours from all sources, ordered dated on 3/8/19. Resident #9's Care Plan did not include information and interventions related to pain management and pain medications as listed in her orders above. On 12/10/19 at 2:02 PM, UM #2 said he did not see a care plan for pain in Resident #9's record. On 12/10/19 at 2:11 PM, the MDS Coordinator said she did not see a care plan for pain in Resident #9's record, and Resident #9 needed one. 2. Resident #120 was admitted to the facility on [DATE], with multiple diagnoses including fracture of the sacrum (tailbone) and dementia with Lewy bodies (progressive brain disorder triggered by abnormal deposits of protein in the brain). Resident #120's physician's order, dated 11/26/19, documented she received occupational therapy. Resident #120's care plan, dated 12/4/19, directed staff to keep her routine consistent to decrease confusion. On 12/10/19 at 9:23 AM, Resident #120 was in her room and said she had therapy scheduled at 10:00 AM every morning. At 9:41 AM, PTA #1 was near the nurses station engaged in a conversation with Resident #120. PTA #1 asked Resident #120 if she was ready for therapy and Resident #120 told PTA #1 that she needed to eat breakfast before therapy. At 9:43 AM, PTA #1 said she had heard from other therapy staff that Resident #120 liked to do therapy in the morning and she would check back with the resident after she ate. On 12/12/19 at 11:14 AM, the DON said Resident #120's preferences regarding her therapy time was not on the care plan. She said she expected her preferences to be on the care plan. 41819

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	135146	A. Building B. Wing	12/13/2019

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42315 Based on observation, record review, policy review, and staff and family interview, it was determined the facility failed to ensure resident's care plans were revised and updated to maintain accuracy. This was true for 1 of 26 residents (Resident #10) whose care plans were reviewed. This failure created the potential for harm if care was based on inaccurate care plan information. Findings include: The facility's policy for Care Plans dated 11/28/19 documented: * The care plan was revised and updated as necessary to reflect the Resident's current status. * The care plan was reviewed and revised based on the resident's changing goals, preferences and needs of the resident in response to current interventions. 36193 1. Resident #10 was admitted to the facility on [DATE], with multiple diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a stroke, and dysphagia (difficulty swallowing). A Diet Order and Communication form, dated 11/19/19, and a physician order, dated 11/22/19, directed staff to provide Resident #10 pureed solids and moist mechanical soft oatmeal and cottage cheese. Resident #10's care plan, revised 11/11/19, directed staff to provide and serve Resident #10 a regular diet, mechanical soft textures, and regular consistency. On 12/11/19 at 4:10 PM, the Registered Dietitian said mechanical soft was not the same as a pureed texture. The RD said Resident #10's care plan should have been updated to reflect her current diet. 42346 17679

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42315 Based on record review, policy review, and family and staff interview, it was determined the facility failed to provide communication assistance as needed to 2 of 3 Residents (Residents #14, and #66). This failure placed the residents at risk for decreased quality of life and psychosocial distress, depression, and negative behaviors related to the inability to communicate effectively. Findings include: The facility's policy for quality of life, dated 11/28/17, documented the facility provided appropriate treatment and services to maintain or improve a resident's ability to carry out daily living activities. The facility's policy for activities of daily living, dated 11/28/17, described the use of a functional communication system as an activity of daily living and stated reasonable accommodations were made for activities of daily living. These policies were not followed. 1. Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including chronic respiratory failure (when the airways in the lungs become narrow and damaged), quadriplegia (paralysis of all four limbs), and [NAME] Nile virus infection with encephalitis (inflammation of the brain). Resident #14's MDS assessment, dated 10/10/19, documented his functional status was total dependence with two or more persons for physical assistance with all ADLs. The assessment also documented Resident #14 had no difficulty with hearing, but had no speech, and he was rarely or never understood. The assessment also documented Resident #14 could clearly understand others. Resident #14's care plan, dated 9/30/19, documented staff were to monitor his need for a speech and language program. On 12/12/19 at 8:54 AM, CNA #10 stated she communicated with Resident #14 by having him stick out his tongue left or right for yes or no. On 12/12/19 at 9:02 AM, RN #4 stated he communicated with Resident #14 by having him blink once for yes and twice for no. RN #4 also stated Resident #14 had a yes/no gaze board (a communication board with the words yes and no on it, so people who cannot verbalize can point their eyes in the direction of the word to communicate their needs). From 12/8/19 to 12/13/19, no yes/no gaze board was observed out in plain sight or used by Resident #14. The facility did not provide Resident #14 with a functional communication system as directed by their policy. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #66 was admitted to the facility on [DATE], with multiple diagnoses including stroke, muscle weakness, transient paralysis (unable to move intermittently), respiratory failure, and diabetes. Resident #66 also was admitted with a tracheostomy (a tube placed directly in the windpipe for breathing). Resident #66's admission MDS assessment, dated 10/21/19, documented he had upper extremity impairment (shoulder, elbow, wrist, and hand) on both sides of his body. The assessment documented Resident #66's hearing was adequate, and he usually understood others, but his speech was usually unclear. Resident #66's physician orders, dated 11/21/19, documented speech therapy was to evaluate and treat as Resident #66 as indicated. Resident #66's fiberoptic endoscopic evaluation of swallowing exam documented a long-term goal was for Resident #66 to demonstrate improved communication by utilizing a picture communication board for improved safety and quality of life. On 12/8/19 at 1:05 PM, Resident #66's wife stated she did not have enough communication with Resident #66 and he needed an adaptive device for communication that he could use. On 12/10/19 at 11:26 AM, Resident #66 was observed lip talking yes/no to get his needs met. Resident #66 was unable to express any other thoughts or ideas not framed as a yes/no question. On 12/11/19 at 2:37 PM, Speech Therapist #1 stated Resident #66 communicated by facial expressions and yes/no lip reading. Speech Therapist #1 stated he was advancing Resident #66 with use of his speaking valve (a one-way air flow valve placed on a tracheostomy that helps with vocalization) and the picture board was ineffective. Speech Therapist #1 stated nothing else was used to advance Resident #66's immediate communication. On 12/11/19 at 2:57 AM, CNA #14 stated Resident #66 nodded yes or no, but did not talk. CNA #14 stated a visual board did not work for him. On 12/12/19 at 8:56 AM, CNA #10 stated the facility communicated with Resident #66 through lip reading his yes/no answers to questions. CNA #10 stated Resident #66 tried to talk but was not understood. The facility did not provide Resident #66 with a functional communication system as directed by their policy.

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	135146	A. Building B. Wing	12/13/2019

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31867 Based on observation, record review, policy review, Resident Council minutes, and resident and staff interview, it was determined the facility failed to ensure bathing and/or grooming, incontinence care, and transfers were provided consistent with residents' needs. This was true for 5 of 21 residents (#24, #47, #52, #55, and #120) reviewed for ADL care and 5 of 8 residents (#9, #20, #27, #30 and #44) in the Resident Group interview. This created the potential for residents to experience skin breakdown and a negative effect to their psychosocial well-being when care was not provided as needed. Findings include: The facility's ADLs and Quality of Life policies, dated 11/14/17 and 11/28/19; respectively, directed staff to assist residents with toileting, grooming, and provide bathing as scheduled; and to provide treatment and services to maintain or improve residents' ability to carry out ADLs. These policies were not followed. 1. Resident #52 was admitted to the facility on [DATE], with multiple diagnoses including a stroke affecting his right dominant side, aphasia (an impairment of language due to brain injury, affecting the production or comprehension of speech and the ability to read or write), dysphagia (difficulty swallowing), and edema (swelling caused by excess fluid trapped in your body's tissues). A significant change MDS assessment, dated 11/15/19, documented Resident #52 was severely cognitively impaired and was totally dependent on staff with all bed mobility, transfers, toileting, grooming, hygiene, eating, and bathing. The assessment documented he had an indwelling catheter and was always incontinent of bowel. The assessment documented Resident #52 was at risk for developing pressure ulcers, had two Stage 3 pressure ulcers, and was on a turning and repositioning program. a. Resident #52's skin impairment care plan, dated 2/6/19, stated Resident #52 was to be repositioned by staff 2 to 3 times per shift and as needed. Resident #52's ADL care plan, revised on 7/23/19, documented he was totally dependent on staff for incontinence care and staff were to apply barrier cream to his scrotum/peri area with incontinence care. The care plan documented Resident #52 required 2-person assistance for all mechanical lift transfers. On 12/10/19 at 8:11 AM, Resident #52 was observed in his wheelchair in the dining room for breakfast. At 9:17 AM, he was observed in his wheelchair in the dining room. At 10:03 AM, a CNA asked Resident #52 if he was doing okay and then walked away. At 10:27 AM, Resident #52 remained in the dining room and had been sleeping much of the morning since 8:11 AM, when the observations of him were initiated. On 12/10/19 at 10:44 AM, the roommate of Resident #52 stated staff had taken Resident #52 out of his room at approximately 6:30 AM that morning. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/19 at 10:57 AM, CNA #11 stated residents who were dependent on staff and required incontinent care were to be checked every 2 hours. CNA #11 stated he and CNA #6 got Resident #52 up and ready for breakfast at 7:30 to 7:45 AM and he stated that was 3 hours ago. CNA #11 stated Resident #52 was dependent on staff to provide incontinence care and repositioning. CNA #11 stated Resident #52 had not yet received care since before breakfast. On 12/10/19 at 11:01 AM, CNA #6 stated she had not provided any care for Resident #52 that morning except to assist him with his breakfast. CNA #6 stated Resident #52 had been taken to the dining room for breakfast at approximately 7:00 AM. CNA #6 stated Resident #52 needed to be provided care now. On 12/10/19 at 1:27 PM, the Clinical Resource Nurse stated Resident #52 should have been checked every 2 hours per his care plan. On 12/10/19 at 1:44 PM, CNA #6 and CNA #11 were observed assisting Resident #52 to bed using the mechanical lift. CNA #11 stated this was the first time since about 11:00 AM Resident #52 had been checked for incontinence. CNA #11 stated that was 2 hours and 45 minutes ago. b. Resident #52's ADL care plan, dated 2/6/19, documented he required 1-person assistance for personal hygiene. On 12/8/19 at 11:10 AM, Resident #52 was observed in the hallway outside of his room. He was unshaven and had dried food caked around his mouth. On 12/9/19 at 9:36 AM, 1:03 PM, and 4:58 PM Resident #52 was observed and he was unshaven. On 12/10/19 at 8:11 AM, 9:17 AM, and 10:27 AM Resident #52 was observed and he was unshaven. On 12/10/19 at 1:44 PM, CNA #6 and CNA #11 were asked if Resident #52 had been shaved since before 12/8/19, both CNAs stated they knew he had not been shaved during at least the past 3 days. CNA #6 stated Resident #52 would be shaved during his shower on 12/11/19. 2. Resident #47 was readmitted to the facility on [DATE], with multiple diagnoses including amyotrophic lateral sclerosis (a progressive degenerative nervous system disease that affects nerve cells in the brain and the spinal cord). A quarterly MDS assessment, dated 11/11/19, documented Resident #47 was cognitively intact and required extensive, 2-person assistance for bathing. The ADL Care Plan, undated, documented Resident #47 was dependent on staff for bathing. He was to be assisted with bathing twice per week and PRN. Resident #47's ADL Reports for October, November, and December 2019 documented he did not receive a bath/shower from 10/5/19 to 10/11/19 (6 days), from 10/16/19 to 10/22/19 (6 days), from 10/23/19 to 11/4/19 (11 days), from 11/5/19 to 11/25/19 (20 days), and from 12/7/19 to 12/11/19 (5 days). On 12/8/19 at 10:25 AM, Resident #47 stated the time between showers/baths had gotten longer. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/12/19 at 8:57 AM, Resident #47 said his regular scheduled shower days were Wednesdays and Saturdays and he said the facility wanted to change his Saturday schedule to a different day and he told them no. On 12/12/19 at 3:56 PM, the Clinical Resource Nurse said Resident #47's record did not include additional baths/showers received in October, November, and December. 3. Resident #24, whose age was in the mid-30s, was admitted to the facility on [DATE], with multiple diagnoses including cerebral palsy (brain injury which most often happens before or during a baby's birth, or during the first 3-5 years of a child's life, that affects muscle tone, movement, and motor skills, and may also cause sight, hearing, and learning problems) and intellectual disability. Resident #24's annual MDS assessment, dated 10/21/19, documented she required extensive, 2-person assistance with personal hygiene and was totally dependent, requiring 2-person assistance with bathing. Resident #24's care plan, dated 11/21/19, documented she was dependent on staff and directed staff to provide assistance with her bathing and personal hygiene. Resident #24's ADL Reports for November and December 2019, documented her bathing days were Tuesday and Friday and PRN. The reports documented she was not bathed from 11/20/19 to 11/26/19 (7 days) and from 11/27/19 to 12/3/19 (7 days). On 12/8/19 at 11:52 AM, Resident #24 was in her wheelchair in the Alpine unit day room watching TV. Her hair was matted and appeared unkempt. She had a non-stained clothing protector around her neck and chest area. She had on a sweater that was stained with streaks of food and excessive oral secretions underneath the clothing protector. The top left of her pants were soiled with food stains, near her hip. On 12/8/19 at 11:59 AM, RN #8 assisted Resident #24 to her room and changed her sweater with a new shirt and a new clothing protector. RN #8 said the stain to Resident #24's shirt was probably pudding she had eaten earlier in the day. RN #8 then assisted Resident #24 out of her room. RN #8 did not attempt to change Resident #24's pants or brush her matted hair. On 12/9/19 at 9:56 AM, CNA #2 assisted Resident #24 to her room to change her wet and stained shirt. After placing the new shirt on her, CNA #2 began to take Resident #24 from the room. CNA #2 said Resident #24's chest had been wet from oral secretions and CNA #2 had not attempted to clean Resident #24's chest before placing the new shirt on. On 12/10/19 at 8:13 AM, CNA #12 said Resident #24 received 2 showers a week. She said as long as staff wiped off her excessive oral secretions and groomed her hair, then 2 showers a week was fine for Resident #24. CNA #12 said if showers were not completed during the day shift then the evening shift was to complete them. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/19 at 3:53 PM and 4:19 PM and on 12/12/19 at 11:09 AM, the DON, with the Clinical Resource Nurse present, said she expected staff to provide Resident #24 with showers as scheduled, to wipe her oral secretions off, provide grooming, and to change her clothes when soiled. The Clinical Resource Nurse said due to Resident #24's age she might need to be reassessed to see if 2 showers a week was adequate. 4. Resident #55 was admitted to the facility on [DATE], with multiple diagnoses, which included Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors) and Lewy Body Dementia (progressive brain disorder triggered by abnormal deposits of protein in the brain). A admission MDS assessment, dated 11/11/19, documented Resident #55 was cognitively intact and was totally dependent on two staff members with bathing, bed transfers and bed mobility. The facility's shower schedule documented Resident #55's shower schedule was Mondays and Thursdays in the morning. Resident #55's care plan, revised on 11/18/19, documented he required extensive assistance of 1-2 staff for bathing. Resident #55's ADL report for November 2019 documented there were no showers given or offered from 11/6/19 through 11/10/19 (5 days), and 11/12/19 through 11/17/19 (6 days). Resident #55's ADL report for December 2019 documented there were no showers given or offered from 12/6/19 through 12/10/19 (5 days). On 12/10/19 at 2:15 PM, Resident #55 stated his last shower was on 12/5/19. On 12/10/19 at 2:22 PM, UM #2 stated that Resident #55 refused his shower on 12/9/19, and he was scheduled to receive a makeup shower. UM #2 said hospice services did most of Resident #55's showers. UM #2 was unable to find documentation that Resident #55 refused his shower on 12/9/19. On 12/13/19 at 9:19 AM, UM #2 stated Resident #55 did not receive showers as scheduled. 5. Resident #120 was admitted to the facility on [DATE], with multiple diagnoses including muscle weakness and Parkinson's disease. Resident #120's admission MDS assessment, dated 12/2/19, documented she required 1-person assistance with bathing. Resident #120's care plan, dated 11/26/19, directed staff to provide 1-person assistance with bathing. Resident #120's ADL Reports for November and December 2019, documented her bathing days were Wednesday and Saturday and PRN. The reports documented she was not bathed from 11/28/19 to 12/2/19 (5 days) and from 12/5/19 to 12/9/19 (5 days). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/8/19 at 11:33 AM, Resident #120 said since she had been admitted to the facility, she had not received her showers as scheduled. On 12/12/19 at 11:10 AM, the DON said Resident #120's showers were missed on 11/30/19 and 12/7/19. She said if staff did not complete the residents' showers she expected staff to offer the shower the next day. 6. Resident Council minutes, dated 12/4/19, documented residents were not receiving their scheduled showers. On 12/10/19 at 2:35 PM, during the Resident Group interview, Residents #9, #20, #27, #30, and #44 said showers were not being completed, especially on Saturdays. 18639 42346

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42315 Based on observation, record review, policy review, activity calendar review, and family and staff interview, it was determined the facility failed to ensure activities met the needs of the residents and were varied to provide residents mental stimulation. This was true for 3 of 8 residents (#14, #62, and #66) reviewed for activities and had the potential to affect all other 71 residents in the facility. This failure created the potential for residents to experience boredom, depression, an increase in negative behaviors, and lack of meaningful engagement throughout their stay. Findings include: The facility's policy for activities, dated 11/28/19, documented the following: *The facility provided an ongoing program of activities to meet the resident's interests and support the physical, mental and psychosocial well-being of each resident. *Activities were individualized and customized based on resident's preferences. *Care Plans addressed activities that are appropriate for each resident *The recreation program promoted a sense of usefulness and provided a sense of belonging and stimulation for residents. This policy was not followed. The facility's activity calendar, for November 2019 and December 2019, documented there were no activities on Sundays. For November 2019 activities, the calendar documented: * Six daily activities were cancelled. * Bingo was offered every weekday morning at the same time, for the entire month. * Each Saturday activity, except November 2, bingo, a movie, and [NAME], were scheduled. On Saturday, November 2, bingo was not offered. * Each Movie Night was scheduled for the same TV channel at the same time. For December 2019 activities, the calendar documented: * Six activities were cancelled (from December 1 to December 13). * Bingo was offered every day except on December 25th. * Each Movie Night for the month was on the same TV channel at the same time. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascadia of Boise	6000 W Denton St Boise, ID 83704

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* Each Saturday activity was a movie and [NAME]. 1. Resident #14 was admitted to the facility on [DATE] with multiple diagnoses including chronic respiratory failure (when the airways in the lungs become narrow and damaged), quadriplegia (paralysis of all four limbs), and [NAME] Nile virus infection with encephalitis (inflammation of the brain). Resident #14's MDS assessment documented he was rarely or never understood, and Resident #14's cognitive skills for daily decision making were severely impaired. Resident #14's care plan, dated 9/30/19, documented his activities of interest included watching movies, watching hunting and fishing shows, watching the History Channel, listening to old country music, and being outdoors. Resident #14's activity assessment, dated 11/6/19, documented Resident #14 enjoyed activities, including watching the History Channel, playing card games, and watching drag racing. Resident #14's activity flow sheet for October 2019, documented he participated in two group activities for the month. His 1:1 activities were documented as family visits and audio stimulation. The flow sheet documented Resident #14's independent activities were watching television 24 of 31 days and two activities of playing board games. Resident #14's activity flow sheet for November 2019, documented 1:1 activity visits as family/friend visits and audio stimulation. Self-directed activities were watching television 21 out of 30 days and participating in a board game on two days. Resident #14's activity flow sheet for December 2019, documented 1:1 activities were family visits and audio stimulation with the self-directed activity as watching television. On 12/8/19 at 10:14 AM, Resident #14's wife stated there were no activities he was interested in at the facility. On 12/9/19 at 10:45AM, Resident #14's wife stated he did not like the activities at the facility and she had to do activities with him. 2. Resident #62 was readmitted to the facility on [DATE], with multiple diagnoses including quadriplegia, dependence on a ventilator (a machine that helps a person breathe), and a colostomy (a surgical opening in the abdominal wall to bypass a damaged colon). Resident #62's care plan, dated 11/12/19, documented he had a communication problem and staff should anticipate and meet his needs. His care plan documented staff should invite, encourage, remind, and escort Resident #62 to activity programs consistent with his interests. Resident #62's activity assessment, dated 8/22/19, documented he enjoyed activities which included walking, football, classical and gospel music, reading the comics, cooking and pet visits. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #62's activity record for November 2019, documented he had 1:1 activity once for the month of November, categorized as a family visit and audio stimulation. The activity record documented his self-directed activities were watching television, reading mail, and family visits. There was no documentation Resident #62 participated in group activities. Resident #62's activity record for December 2019, documented he had two 1:1 activities, and self-directed activities were watching television and current events. There was no documentation Resident #62 participated in group activities. On 12/8/19 at 11:39 AM, Resident #62's daughter stated he liked to go to activities, but they did not get him out of bed. 3. Resident #66 was admitted to the facility on [DATE], with multiple diagnoses including stroke, muscle weakness, transient paralysis (unable to move intermittently), and diabetes. Resident #66's admission MDS assessment, dated 10/17/19, documented his cognitive skills for daily decision making were severely impaired. Resident #66's care plan, dated 10/11/19, documented Resident #66 had impaired communication and needed staff to anticipate and meet his needs. Resident #66's care plan documented his activities needed to be related to his areas of interest. The care plan documented staff interventions were to arrange 1:1 visits with Resident #66 and allow him to participate in sports, card, and music activities as much as he could participate. Resident #66's activity assessment, dated 10/16/19, documented some of his enjoyed activities were football, poker, reading, walking, and pet visits. Resident #66's November 2019 activity record documented he participated in three group activities for the month and 19 of 22 self-directed activities were watching TV. The activity record also documented a single 1:1 activity for the month that was documented as a family/friend visit. There were no activity preferences documented on his activity plan. Resident #66's December 2019 activity record for the first 13 days of the month documented he participated in one group activity, had three family visits, and 7 of 8 independent activities were watching television. On 12/9/19 at 12:50 PM, Resident #66 was observed alone, sitting in a manual wheelchair in front of the facility's Christmas tree without interaction with staff. On 12/12/19 at 11:10 AM, the Activities Director stated she completed the baseline activity assessments. When asked about activities, she stated the facility counted any activity as an activity, even those not organized by the activity department. On 12/12/19 at 11:25 AM, the Activity Director was asked how residents activities were documented on the activity assessment or flow sheet. She replied she did not do all the activities she put on the care plan. The Activity Director stated activities noted on residents' care plan depended on the CNAs to carry out as she can't do everything for everyone.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on observation, policy review, record review, and staff and resident interview, it was determined the facility failed to ensure professional standards of practice were followed for 5 of 26 residents (#10, #15, #55, #120, and #600) reviewed for standards of practice. * Resident #10's order for application and removal of her heel protector and hand splint were not followed. * Resident #15's wound dressings were not completed as ordered, he did not have hyperglycemic protocol order, his blood glucose (BG) of over 300 mg (milligrams)/dl (deciliter) were not referred to the physician, referral for endocrinologist and laboratory order for an A1C (blood test that measures your average blood sugar levels over the past 3 months) were not completed. * Resident #55 was not assessed for positioning, and her order for positioning after meals was not followed. * Resident #120 received her Parkinson's medications late several times. * Resident #600 was not monitored when her blood pressure was high and an ordered blood pressure medication was not available. These failed practices had the potential to adversely affect or harm residents whose care and services were not delivered according to accepted standards of clinical practices. Findings include: 1. Resident #15 was admitted to the facility on [DATE], and again readmitted on [DATE], with multiple diagnoses including obesity, diabetes mellitus with chronic kidney disease (condition characterized by gradual loss of kidney function over time) and a rectal fistula (small tunnel that develops between the end of the bowel and the skin near the anus). a. Resident #15' physician's order, dated [DATE], directed staff to cleanse his wound on his right buttock daily and as necessary (PRN), and cover it with a Border Foam. Resident #15's [DATE] through [DATE], documented his wound dressing was not completed on [DATE], [DATE] and on [DATE]. On [DATE] at 10:54 AM, RN #7 and CNA #16 entered Resident #15's room and said they would provide pericare to him. CNA #16 asked Resident #15 to turn on his left side while RN #7 stood on the left side of his bed supporting him. There was no Border Foam observed on Resident #15's buttock wound. On [DATE] at 3:08 PM, Resident #15 said a nurse placed a cover on his wound. Resident #15 said he had to remind the nurses to clean his wound and was always told the Wound Care Certified (WCC) nurse would do the wound dressing changes. When asked who performed his wound dressing changes when the WCC nurse was not on duty, Resident #15 said Whoever feel sorry for me. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:44 AM, the WCC nurse was observed to remove the undated Border Foam dressing covered Resident #15's wound. Wound dressings are often dated to verify when the wound dressing was last changed. The WCC nurse said Resident #15's wound should be cleaned every day and PRN, and covered with Border Foam 24 hours a day to prevent infection. The surveyor informed the WCC nurse Resident #15's wound was observed to have no cover on Sunday, [DATE], during pericare. The WCC nurse said she worked Monday through Friday and left the wound dressing supplies in Resident #15's room before she left on Friday, [DATE], so the nurse on duty could change the dressing during the weekend. The WCC nurse said she did not know why Resident #15's wound did not have a Border Foam cover on [DATE]. b. The facility's Hyperglycemia and Diabetic Coma policy, revised [DATE], directed staff to call the physician if the resident's BG level was over 300 mg/dl (milligrams per deciliter - measurement that indicates the amount of a particular substance, such as glucose, in a specific amount of blood) and the resident was not on sliding scale insulin. Resident #15's [DATE] MAR, documented the following medications: * Victoza Solution Per-injector 18 mg/ml, inject 1.2 mg subcutaneously one time a day for diabetes mellitus, ordered on [DATE]. *Humulin R U-500 KwikPen Solution Per-injector 500 unit/ml, inject 100 unit subcutaneously with meals for diabetes ordered on [DATE]. Resident #15's Diabetic Administration Record, dated [DATE] through [DATE], documented his BG level was checked three times a day, and he had 70 BG levels ranging from 302 mg/dl to 535 mg/dl, during the 42 day time period. A Nurse Practitioner's Progress Note, dated [DATE], documented Resident #15's A1C was 6.8% on [DATE] and would be repeated on [DATE]. The CDC website, accessed on [DATE], states an A1C result of 6.5% or above, indicates a person is diabetic. A Nurse Practitioner's Progress Note, dated [DATE], documented Resident #15's BGs levels were trending in the ,d+[DATE]'s mg/dl range despite aggressive insulin therapy with Humulin R U-500 and Victoza. The note documented while it was likely somewhat related to his current infection, he had difficulty in the past with adequately controlling his blood glucose levels. The Nurse Practitioner's Progress Note further documented Will consult endocrine for assistance in management. A Nursing Note, dated [DATE], documented orders were received for an endocrinology referral for Resident #15. A Nursing Note, dated [DATE] at 8:30 PM, documented Resident #15's BG level was 427 mg/dl and he was asymptomatic. The note documented the Nurse Practitioner was informed and the facility was awaiting a response from the Nurse Practitioner. A Nursing Note, dated [DATE] at 9:00 PM, documented an order to give Resident #15 an additional 10 units of Humulin R U-500 for BG of 427 and to increase the dose from 75 units to 85 units at 2:00 PM and at 9:00 PM. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Nursing Note, dated [DATE] at 9:10 PM, documented the Nurse Practitioner was notified of Resident #15's BG level of 429 and the staff was directed to give him 10 units of Humulin R U-500 insulin. A Nursing Note, dated [DATE] at 9:43 PM, documented a new order for Resident #15 to receive 100 units of Humulin R U-500 with breakfast, lunch, and dinner. A Physician Progress Note, dated [DATE], documented the physician ordered a nutrition consult for Resident #15. A Nursing Note, dated [DATE] at 3:15 PM, documented a nutrition referral was received from the physician and the message was sent to the RD. A Nursing Note, dated [DATE] at 9:56 PM, documented Resident #15 was seen by the physician related to uncontrolled BG levels. The note documented Resident #15 said he had a life changing talk with the physician and decided to go on diet. A Nursing Note, dated [DATE] at 6:57 PM, documented the Nurse Practitioner was notified of Resident #15's BG level of 518 mg/dl. A Nursing Note, dated [DATE] at 10:50 AM, documented the Nurse Practitioner reviewed Resident #15's BG levels and they remained uncontrolled. The note stated an endocrinology follow-up was pending. The need for an endocrinology follow up was documented by the Nurse Practitioner on [DATE]. There was no other documentation the Nurse Practitioner or physician was notified of Resident #15's BGs levels over 300 mg/dl. On [DATE] at 8:41 AM, LPN #4 was observed to take Resident #15's BG level and said it was 505 mg/dl. LPN #4 said Resident #15 asked her to recheck his BG level because it was 520 mg/dl when she checked it earlier. On [DATE] at 10:08 AM, UM #1 said he did not find Resident #15's A1C test result in Resident #15's record. UM #1 said it was in the physician's plan to recheck Resident #15's A1C on [DATE], but there was no order given to the nurse. UM #1 also said he did not find Resident #15's report from the endocrinologist in his record. UM #1 said the Transportation Coordinator scheduled the residents' appointments. On [DATE] at 11:18 AM, the Transportation Coordinator said she received the order to schedule Resident #15 for an endocrinology consult on [DATE], and faxed the request to the Endocrinology clinic on [DATE]. On [DATE] at 11:39 AM, the DON reviewed the Nurse Practitioner's progress note, dated [DATE] and said the nurse should have scheduled the A1C blood test of Resident #15. The DON said also said when the Nurse Practitioner requested the endocrinology consult, it should have been given to the appointment scheduler immediately. On [DATE] at 11:43 AM, the Clinical Resource Nurse said she did not find documentation Resident #15 was seen by the RD after he was seen by the physician on [DATE], and the physician ordered a nutrition consult. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:17 PM, LPN #4 said Resident #15 had a hypoglycemic (low blood glucose) protocol but not hyperglycemic (high blood glucose) protocol. LPN #4 said she was told to notify the physician if a resident's BG level was over 400 mg/dl. When asked if she had notified the physician of Resident #15's blood glucose levels over 500 mg/dl on [DATE], LPN #4 said she had not because she was running busy. LPN #4 said she had 24 residents and she prepared 3 residents to go to their dialysis appointments. On [DATE] at 1:27 PM, UM #1 said he did not find an individualized hyperglycemic protocol order for Resident #15. UM #1 said he knew the physician should be notified when a resident's BG was over 300 mg/dl. UM #1 also said they had a hypoglycemic protocol order but he did not know if they have hyperglycemic protocol order. On [DATE] at 2:25 PM, the RD said he was not aware the physician had ordered the nutrition consult for Resident #15. The RD said he saw Resident #15 on [DATE], and he expressed no interest in making changes with his meals. On [DATE] at 3:57 PM, the Clinical Resource Nurse said Resident #15 should have a hyperglycemic protocol order in his record. 2. Resident #10 was admitted to the facility on [DATE], with multiple diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following a cerebral infarction (stroke). Resident #10's physician's order, dated [DATE], directed staff to apply a hand splint on her right upper extremity at 10:00 PM and removed it at 6:00 AM (total of 8 hours). Resident #10's care plan, directed the staff to apply a hand splint to her as she could tolerate for eight hours a day. Resident #10's care plan also directed staff to apply heel protectors to her when she was in bed. On [DATE] at 1:06 PM, UM #1 and the surveyor observed Resident #10 in bed with a hand splint applied on her right hand. UM #1 then removed Resident #10's hand splint and said it should have been removed at 6:00 AM. The surveyor asked UM #1 to check Resident #10's lower extremities. UM #1 asked Resident #10 if he could check on her lower extremities and Resident #10 agreed. UM #1 said Resident #10's right leg was floated on top of a pillow and she was not wearing a heel protector. UM #1 said Resident #10 had an order to wear a heel protector and had a care plan for it. 3. Resident #120 was admitted to the facility on [DATE], with multiple diagnoses including Parkinson's disease (a progressive disease of the nervous system that affects movement). Resident #120's physician order, dated [DATE], directed licensed nurses to provide Carbidopa-Levodopa , d+[DATE] MG three times a day and at bedtime. Resident #120's ,d+[DATE] and ,d+[DATE] MARs, directed licensed nurses to provide Carbidopa-Levodopa , d+[DATE] MG at 5:00 AM, 10:00 AM, 3:00 PM, and at 8:00 PM. The ,d+[DATE] MAR documented she received the medication on [DATE] at 5:32 PM for the 3:00 PM medication time, and at 10:24 PM for the 8:00 PM medication time. The ,d+[DATE] MAR documented she received the medication on [DATE] at 11:01 AM for the 10:00 AM medication time, and on [DATE] at 10:01 PM for the 8:00 PM medication time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:08 AM, Resident #120 said she had received her medication for her Parkinson's disease as late as two hours on a few occasions. She said when her medication was late, her feet and legs can become stiff, making it difficult to walk; and her arms and hands spasmed. On [DATE] at 11:21, the DON said she expected nurses to deliver Resident #120's medications on time to avoid side effects. 4. The American Heart Association website, accessed on [DATE], states normal blood pressure is a Systolic (top number) reading less than 120 and a Dystolic (bottom number) reading less than 80. Resident #600 was admitted to the facility on [DATE], with multiple diagnoses including hypertension, atrial fibrillation (irregular heartbeat, and a stroke with hemiplegia and hemiparesis affecting her left side. Resident #600's Admission Evaluation Assessment, dated [DATE], documented her cognition was impaired with a confused conversation and her pupils were equal and reactive. Resident 600's vital signs were: blood pressure ,d+[DATE], pulse 77, and she had regular cardiac (heart) rhythm. Resident #600's left side had no motor skill response. A nurse's progress note, dated [DATE] at 6:41 PM, Resident #600 was alert and oriented to self. The note documented she was unable to carry on a viable conversation and required extensive assistance with bed mobility and transfers. A nurse's progress note, dated [DATE] at 9:28 PM, documented Resident #600 was alert and was a new admission with a diagnosis of a stroke with left sided weakness. The note documented she required a Hoyer (mechanical) lift to transfer with the assistance 2 staff members and staff would continue to monitor her. A nurse's progress note, dated [DATE] at 9:53 AM, documented Resident #600 was admitted to the facility for therapy services. A nurse's progress note, dated [DATE] at 5:58 PM, documented Resident #600's blood pressure was , d+[DATE] and new physician's orders were received to administer Hydralazine 25 mg four times a day, as needed, for hypertension. There was no documentation Resident #600 was further assessed for changes of condition. A nurse's progress note, dated [DATE] at 8:40 PM, documented Resident #600 was found unresponsive at 7:13 PM, was reassessed by the RN, and was pronounced deceased at 7:15 PM. The note documented Resident #600's family and physician was notified and her body was released to the mortician on [DATE] at 8:05 PM. The nurse's notes did not include documentation of assessments between 5:58 PM and 7:15 PM on [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:47 PM, the DON stated Resident #600 had high blood pressure and the nurse notified the physician and received new orders for the Hydralazine. The DON stated the medication was not in the facility's emergency medication kit and had to be ordered and delivered from the pharmacy. The DON stated the nurse's progress notes should have included Resident #600's condition throughout the day on [DATE] up to when Resident #600 passed away. 5. Resident #55 was admitted to the facility on [DATE], with multiple diagnoses, which included Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors) and Lewy Body Dementia (progressive brain disorder triggered by abnormal deposits of protein in the brain). A quarterly MDS assessment, dated [DATE], documented Resident # 55 was cognitively intact and was totally dependent on two staff members with bathing, bed transfers, and bed mobility. Resident #55 was observed sitting in specialized wheelchair leaning over the left side of the wheelchair as follows: *On [DATE] at 10:27 AM, 12:22 PM, 12:42 PM, 12:54 PM *On [DATE] at 10:37 AM, 12:40 PM, 12:52 PM *On [DATE] at 8:38 AM On [DATE] at 11:50 AM, Resident #55's wife stated staff were not keeping him upright and not using his pillow on his left side to keep him upright. On [DATE] at 1:33 PM, the Director of Therapy stated Resident #55 leaned to his left side in the wheelchair and needed more than a pillow for positioning. 31867 31923 37263 42315 42346

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42315 Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents received appropriate care to prevent and treat pressure ulcers. This was true for 2 of 4 residents (#52 and #62) reviewed for pressure ulcers. This deficient practice resulted in harm to Resident #52 when he developed an avoidable pressure ulcer and harm to Resident #62 when he developed two avoidable pressure ulcers and he did not receive treatment for the wounds as ordered. Findings include: The National Pressure Ulcer Advisory Panel, 2016, defined pressure ulcers as follows: Stage 1- Intact skin with a localized area of non-blanchable erythema (red discoloration of skin as a result of injury) which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate a deep tissue pressure injury. Stage 2 - Partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough (non-viable yellow, tan, gray, green, or brown tissue) and eschar (dead or weakened tissue that is hard or soft in texture - usually black, brown, or tan in color) are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. Stage 3 - Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining (when the tissue under the wound edges becomes eroded, resulting in a pocket beneath the skin at the wound's edge) and tunneling (channels that extend from a wound into and through the tissue or muscle below) may occur. Fascia, muscle, tendon, ligament, cartilage or bone is not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Stage 4 - Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable - Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be softened or removed. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascadia of Boise	6000 W Denton St Boise, ID 83704

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Deep tissue pressure injury - Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The [NAME] Manual for Nursing Practice, tenth edition, stated measures to prevent pressure ulcer development included repositioning every two hours, using special devices to cushion the specific area, and use an alternating pressure mattress or air fluidized bed for patients who are at high risk. The facility's Prevention and Treatment of Pressure Ulcers and Other Skin Alterations policy and procedure, released 11/28/17, documented: The facility has a system in place to promote skin integrity, prevent pressure ulcer development/other skin alterations .unless the individual's clinical condition demonstrates they were unavoidable .'Avoidable' means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with the resident needs, resident goals, and professional standard of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. The facility's policy and procedure stated Procedure Prevention Steps: A risk assessment is completed upon admission and at designated intervals throughout the resident's stay to evaluate the resident's intrinsic risk . that may have an impact on the development, treatment and/or healing of [pressure ulcers/pressure injuries] . Residents at risk for developing pressure ulcers are identified by using the Braden Scale (a tool that predicts the risk for developing a facility acquired pressure injury) .Pressure ulcer and other wound and skin related interventions are created in collaboration with the interdisciplinary team and implemented in order to identify, prevent or reduce the risk of acquiring pressure and/or non-pressure related wounds or skin issues . This policy was not followed. 1. Resident #62 was admitted on [DATE] and readmitted on [DATE], with multiple diagnoses including acute respiratory failure (fluid buildup in the air sacs of the lungs), quadriplegia (paralysis of all four limbs), congestive heart failure (a weakness of the heart that leads to buildup of fluid in the lungs and surrounding body tissues), and a colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon). a. An admission MDS assessment, dated 8/23/19, documented Resident #62 was at high risk for developing pressure ulcers and had one unhealed Stage 1 pressure ulcer on admission. A significant change MDS assessment, dated 10/16/19, documented Resident #62 had three unstageable pressure ulcers with suspected deep tissue injury and two of these unstageable pressure ulcers were present upon admission/reentry. However, his admission MDS assessment, dated 8/23/19, did not include documentation that Resident #62 had two unstageable pressure ulcers upon admission. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A nurse's progress note, dated 11/2/19 at 7:08 PM, documented Resident #62 was not feeling well during the afternoon; he had an elevated temperature and his abdomen was round, firm, and tender to touch. The note documented the Medical Director was notified and x-rays were ordered. The note documented Resident #62's family wanted him sent to the Emergency Department for an evaluation and not to wait for the x-rays at the facility. There was no further documentation if Resident #62 was transferred out of the facility. A nurse's progress note, dated 11/12/19 at 3:46 PM, documented Resident #62 was readmitted from a local hospital. The progress note stated Resident #62 had existing pressure ulcers to his coccyx (tailbone), right buttock, and left ankle. The progress note did not include descriptions or measurements of the pressure ulcers. A weekly skin report, dated 11/12/19, documented Resident #62 was readmitted to the facility and had pressure ulcers to his coccyx, right buttock, and left ankle. The report also documented Resident #62 had scabbing to his abdomen and arms and mentioned his neck/tracheostomy but did not document what skin impairment was present in that area. There was no further descriptions or measurements of the pressure ulcers. The report stated [Resident #62] readmitted to [facility name] with the above-mentioned injuries to skin; some he had prior to discharge. It was unclear in the documentation which skin injuries/wounds Resident #62 had prior to his discharge to the hospital. A care plan, initiated on 11/12/19, identified Resident #62 had skin impairment/pressure ulcers and the interventions included offloading pressure to the back of his head with an occipital ring, Prevalon boots (boots used to minimize pressure, friction and shear on the feet, heels and ankles of non-ambulatory individuals) to both lower extremities at all times, a pressure relieving cushion for his wheelchair, turning and repositioning every 2 to 3 hours as tolerated, a pressure reducing air mattress on his bed, and following wound clinic orders for treatment of pressure ulcers. Resident #62's record documented he developed avoidable pressure ulcers while at the facility, which included a wound to his right ankle and a wound to his right heel, as follows: * A nurse's progress note, dated 11/15/19 at 7:52 PM, documented Resident #62 had a new suspected deep tissue injury to his right ankle (developed within 3 days of his readmission to the facility). The note documented Resident #62 was wearing the Prevalon boots with hard wedges attached to both sides. The note stated there was a linear shaped purple area surrounded swelling with redness which did not blanch. The nurse documented the wedges were removed from the Prevalon boots and the area was cleansed with normal saline, skin prep (a liquid protective film or barrier) was applied, and the wound was covered with a foam dressing. A wound clinic assessment note, dated 11/19/19, documented Resident #62 had four pressure wounds and that the wound on his coccyx was moisture associated skin damage, not a pressure wound. The clinic note documented the pressure wounds as three unstageable pressure wounds (one on his left ankle with an unknown date of origin, one on the back of his left lower leg which was acquired on 9/17/19, and one on his right buttock which was acquired on 11/12/19), and one deep tissue pressure injury (on his right ankle which was acquired on 11/15/19). * On 12/8/19 at 10:33 AM, Resident #62 was lying in his bed, the sheets were not covering his legs and he had a pillow positioned under each leg. In addition to the right and left ankle pressure wounds, Resident #62 was observed to have an 8 cm, dark rusty-brown, blood blister on his right heel. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A wound clinic assessment note, dated 12/10/19, documented the wound to Resident #62's right heel as an unhealed pressure ulcer. The assessment note stated Deep Tissue Pressure Injury, persistent non-blanchable deep red, maroon or purple discoloration measuring 4.2 cm x 1.7 cm x 0. The assessment note did not include information related to when the wound was acquired. On 12/11/19 at 8:38 AM, the Wound Nurse stated the left ankle pressure ulcer and the deep tissue pressure injury to Resident #62's right heel developed in the facility. b. Resident #62's record documented treatment orders, which were not implemented and inconsistent healing of Resident #62's wounds. A wound clinic assessment note, dated 11/19/19, documented Resident #62 had four pressure wounds. The clinic note documented the pressure wounds as three unstageable pressure wounds and one deep tissue injury. The wound clinic note documented the status of the wounds as follows: *The left ankle pressure ulcer had an unknown date of origin. It was an unstageable pressure ulcer with full-thickness skin and tissue loss with measurements of 1.5 cm x 1.3 cm x 0.1 cm. *The left back lower leg wound was acquired on 9/17/19. It was an unstageable pressure injury with full-thickness skin and tissue loss with measurements of 0.4 cm x 0.2 cm x 0.1 cm. *The right ischial (buttock) pressure ulcer was acquired on 11/12/19. It was an unstageable pressure injury with full-thickness skin and tissue loss with measurements of 1.3 cm x 0.5 cm x 0.1 cm. *The right ankle pressure ulcer was acquired on 11/15/19. It was described as a deep tissue pressure injury with a small amount of fluid coming from the wound with measurements of 3.5 cm x 1.5 cm x 0.1 cm. Wound clinic treatment orders for the pressure wounds, dated 11/19/19, included the following: * Left ankle: cleanse wound with normal saline or wound spray, apply skin protectant, apply Alginate with silver (absorbent wound dressing that contains silver), cover with a bordered foam dressing, change the dressing three times a week and as needed for soiling, saturation, or accidental removal. * Left lower leg: cleanse wound with normal saline or wound spray, apply skin protectant, apply Alginate with silver, cover with a bordered foam dressing, change the dressing three times a week and as needed for soiling, saturation, or accidental removal. * Right buttock: cleanse wound with normal saline or wound spray, apply zinc oxide-based cream four times a day and as needed with peri-care. * Right ankle: cleanse wound with normal saline or wound spray, apply skin protectant, cover wound with bordered foam dressing, change dressing every other day and as needed for soiling, saturation, or accidental removal. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #62's wound clinic assessment note, dated 11/26/19, documented his left lower leg pressure ulcer had healed and his left ankle wound had decreased in size, but his two other wounds increased in size as follows: * The right ischial pressure ulcer advanced to a Stage 3 with a measurement of 1.5 cm x 2.9 cm x 0.1 cm with a scant amount of drainage. * The right ankle pressure ulcer was described as an unstageable pressure injury with full-thickness skin and tissue loss and had increased in size to 5 cm x 1 cm x 0.2 cm. Resident #62's wound clinic assessment did not include documentation regarding why Resident #62's right buttock and right ankle pressure wounds had increased in size. Resident #62's 11/26/19 wound treatment orders, modified the dressing changes and included Santyl (an enzyme used to heal skin ulcers). The orders stated: * Right and left ankles: Cleanse with normal saline or wound spray, apply skin protectant, apply debriding (removal of dead or infected skin) agent Santyl (an enzyme used to heal skin ulcers) and cover with slightly moist gauze, then cover with dry gauze securing with a cloth tape, change dressing daily and as needed for soiling, saturation, or accidental removal. * Right buttock: cleanse the wound with normal saline or wound spray and apply skin protectant, it did not include applying a zinc oxide-based cream. Resident #62's wound clinic assessment note, dated 12/3/19, documented his buttocks and right ankle wounds had decreased in size, but his left ankle wound had increased in size from 1.5 cm x 1.3 cm x 0.1 cm on 11/19/19 to 1.8 cm x 1.6 cm x 0 cm. The note also documented the left ankle wound had a scant amount of drainage. Wound clinic treatment orders for Resident #62, dated 12/3/19, stated to continue the previous wound care recommendations. Resident #62's December 2019 TAR did not include documentation the 11/26/19 orders were implemented until 12/05/19 (nine days after the 11/26/19 order). The December 2019 TAR documented the Santyl start date for the left and right ankles was 12/5/19. The December 2019 TAR documented the dressing changes, also started on 12/5/19, that the dressing were to be changed Monday through Friday, which was not consistent with the 11/26/19 order which stated the dressings were to be changed every day and as needed for soiling, saturation, or accidental removal. The December 2019 TAR did not include documentation that the wound dressings on Resident #62's left and right ankles were changed on 12/7/19 and 12/8/19. On 12/8/19 at 10:33 AM, Resident #62 was lying in his bed and the sheets were not covering his legs and he had a pillow positioned under each leg, there were no dressings observed on his ankle wounds. On 12/8/19 at 10:56 AM, at 11:28 AM, at 11:40 AM, and at 12:02 PM, Resident #62's feet were touching the footboard of his bed and there were no dressings observed on his ankle wounds. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/9/19 at 9:32 AM, Resident #62 was lying in his bed with his heels resting on pillows. There were no dressings observed on his ankle wounds. On 12/11/19 at 8:24 AM, UM #1 was asked about Resident #62 not having any dressing on his pressure ulcers on 12/8/19 and 12/9/19. He stated if the dressings got wet they were changed and Resident #62 was a very edematous guy so the dressings may have slipped off. The facility failed to ensure Resident #62's treatment orders were followed. c. Resident #62 was not observed to receive preventative measures for his pressure wounds as ordered: On 12/11/19 at 8:38 AM, the Wound Nurse stated the staff were offloading Resident #62's legs to help prevent pressure ulcers. The Wound Nurse stated Resident #62 was wearing Prevalon boots to prevent pressure ulcers from developing. The Wound Nurse also stated Resident #62 was wearing Prevalon boots since admission and was being followed by a wound clinic since admission. Resident #62's wound clinic assessment note, dated 11/26/19, documented interventions which included repositioning Resident #62 every 2 to 3 hours to alleviate pressure and wearing off-loading boots (Prevalon) to both lower extremities. Wound clinic treatment orders for Resident #62, dated 12/3/19, stated to continue the previous wound care recommendations. Resident #62's December 2019 TAR did not include documentation the 11/26/19 orders were implemented until 12/8/19 (twelve days after the 11/26/19 order). The December 2019 TAR documented Resident #62 was to have bilateral heel protectors while in bed, with a start date of 12/8/19. * On 12/8/19 at 10:33 AM, Resident #62 was lying in his bed and the sheets were not covering his legs and he had a pillow positioned under each leg. He did not have the Prevalon boots on. * On 12/8/19 at 10:56 AM, at 11:28 AM, at 11:40 AM, and at 12:02 PM, Resident #62's feet were touching the footboard of his bed and he did not have the Prevalon boots on. * On 12/9/19 at 9:32 AM, Resident #62 was lying in his bed with his heels resting on pillows. He did not have the Prevalon boots on. On 12/8/19 at 11:28 AM, Resident #62 was repositioned by four staff. On 12/8/19 at 11:06 AM, Resident #62 said staff did not reposition him that much, he said they did it a couple of times a day. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/11/19 at 9:56 AM, UM #1 stated for pressure ulcer care the staff floated both hips then rolled Resident #62 from side to side throughout the day. He stated staff did not document position changes in Resident #62's record, but he trusted it was being done by staff. UM #1 stated it was not unexpected Resident #62's Prevalon boots were not on and it was everyone's responsibility to ensure they were. When asked if Prevalon boots were normally on the MAR/TAR UM #1 stated Resident #62 had them as of 11/17/19. When asked why they were not in his orders, UM #1 stated he did not know if it was the facility policy to have them in orders.When asked if he knew Resident #62 had not been wearing the boots, he stated Resident #62 should have Prevalon boots on at all times and there was no reason he would not have them on that he could think of. The facility failed to ensure Resident #62's received preventative measures for his pressure wounds as ordered. 2. Resident #52 was admitted to the facility on [DATE], with multiple diagnoses including a stroke affecting his right dominant side, aphasia (an impairment of language due to brain injury, affecting the production or comprehension of speech and the ability to read or write), dysphagia (difficulty swallowing), and edema (swelling). Resident #52's record included a care plan which documented he was at risk for skin impairment related to his impaired mobility. The care plan included interventions, initiated on 2/6/19, for the use of pillows for positioning, keep his skin clean and dry, offload heels while in bed using heel protectors, use of a pressure reducing mattress and wheelchair cushion, and to reposition 2 to 3 times a shift and as needed. A quarterly MDS assessment, dated 9/20/19, documented Resident #52 was at risk for the development of pressure ulcers and had no unhealed pressure ulcers. A Braden Scale for Predicting Pressure Sore Risk, dated 11/4/19, documented Resident #52 was at high risk for the development of pressure ulcers. A significant change MDS assessment, dated 11/15/19, documented Resident #52 had severe cognitive impairment and he was dependent on staff for activities of daily living including bed mobility, transferring, toilet use, personal hygiene, and bathing. The assessment documented he had an indwelling catheter and was always incontinent of bowel. The assessment documented Resident #52 was at risk for developing pressure ulcers and had two Stage 3 pressure ulcers which were not present upon admission. A weekly skin report, dated 10/31/19 at 5:28 PM, documented Resident #52 had a new skin condition or change since the last documented skin check. The report documented Resident #52 had a medical device related pressure injury to his right outer ankle and both of his lower extremities were edematous (swollen). The report documented this was a new pressure ulcer and the Comments/Summary section documented Resident #52 had an unstageable pressure injury, potentially caused by suprapubic catheter tubing in his pant leg. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Weekly Pressure Ulcer report, dated 11/1/19 at 1:53 PM, documented Resident #52 had a new onset unstageable pressure ulcer to his right outer ankle. The measurements were 5.5 cm x 2.0 cm x 0.2 cm and the report stated it was caused by a medical device. The report documented Resident #52's wound had a small amount of serosanguineous (yellowish fluid with small amounts of blood) drainage and was obscured by necrosis/unstageable/deep tissue injury. Progress notes dated 11/6/19, 11/12/19, 11/19/19, 11/26/19, and 12/4/19 all documented Resident #52's right outer ankle pressure ulcer was decreasing in size. On 12/13/19 at 9:49 AM, the Wound Nurse was observed while changing the dressing for Resident #52's pressure ulcer. The Wound Nurse stated Resident #52's pressure ulcer to his right outer ankle measured approximately 2.0 cm x 0.5 cm x 0 cm. The Wound Nurse stated Resident #52's legs were very swollen at the time the pressure ulcer developed. The Wound Nurse stated Resident #52 was at a higher risk for the development of pressure ulcers due to the edema in his bilateral lower extremities. On 12/10/19 at 3:30 PM, the DON stated Resident #52 was at a higher risk for development of pressure ulcers with edema in his bilateral lower extremities. The DON stated the development of the pressure ulcer on Resident #52's right outer ankle could have been avoided if the staff had monitored the position of the catheter tubing and the length of time the catheter tubing had been applying pressure to his skin. 18639

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42315 Based on observation, record review, policy review, and family and staff interview, it was determined the facility failed to ensure residents received treatment and services to prevent a decrease in range of motion (ROM). This was true for 2 of 9 residents (#14 and #62) reviewed for restorative therapy. This failure created the potential for residents to experience a decline in ROM. Findings include: The facility's policy for restorative nursing, dated 2/28/19, documented: * Restorative nursing helped the resident restore function. * Restorative nursing programs were initiated when the resident was discharged from formal therapy. * Successful functional maintenance programs helped to prevent pressure ulcers and contractures, prevent physical and/or cognitive deterioration, and enhanced the resident's well-being. This policy was not followed. 1. Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including chronic respiratory failure (when the airways in the lungs become narrow and damaged), quadriplegia (paralysis of all four limbs), and [NAME] Nile virus infection with encephalitis (inflammation of the brain). Resident #14's MDS assessment, dated 10/10/19, documented his functional status was total dependence with two or more staff physical assistance for all ADLs, and he was not receiving restorative nursing care. Resident #14's physician orders, dated 11/26/19, documented an active order for Resident #14 to receive restorative nursing care. Resident #14's care plan, dated 9/30/19, documented staff was to monitor the need for consultation, and provide or screen Resident #14 as needed for physical therapy. On 12/8/19 at 10:17 AM, Resident #14's wife stated the facility no longer offered physical or restorative therapy for him. A review of Resident #14's record, included documentation he was not receiving physical or occupational therapy. The record documented he was removed from physical and occupational therapy on 8/16/19. On 12/12/19 at 9:02 AM, RN #4 stated Resident #14's restorative care was provided by RNA #2. RN #4 stated Resident #14 was receiving massage therapy and passive range of motion restorative therapy. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/19 at 9:30 AM, RNA #1 stated Resident #14 was not receiving restorative care. RNA #1 stated Resident #14 was taken off restorative care because he was so stiff it hurt him too much to move. He stated Resident #14's wife was not notified why Resident #14 was removed from restorative therapy. The facility failed to implement a restorative therapy program for Resident #14 as ordered by his physician. 2. Resident #62 was admitted on [DATE], and readmitted on [DATE], with multiple diagnoses including acute respiratory failure (fluid buildup in the air sacs of the lungs), quadriplegia (paralysis of all four limbs), congestive heart failure (a weakness of the heart that leads to buildup of fluid in the lungs and surrounding body tissues) and colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon). Resident #62's MDS assessment, dated 10/16/19, documented Resident #62 needed extensive to total assistance with activities of daily living with one to two-person assistance for completing tasks. Resident #62's physician orders, dated 11/12/19, documented Resident #62's rehabilitation potential was fair. Resident #62's care plan, dated 11/12/19, documented physical therapy and occupational therapy were to evaluate and treat Resident #62 as indicated. On 12/8/19, at 10:33 AM, Resident #62's daughter stated the facility was cutting back on his physical therapy and he was declining. Resident #62's daughter stated she saw a decline in her father's ability to move. Resident #62's physical therapy treatment encounter notes, dated 11/21/19, documented an RNA was instructed on range of motion for Resident #62 to include bilateral lower extremities, 10 to 15 times for each extremity to increase and maintain his range of motion. On 12/12/19 at 9:33 RNA #1 stated Resident #62 was put into the restorative program on 12/9/19 but had not yet received a restorative therapy session, 21 days after the recommended resorative therapy was made by physical therapy. The facility failed to implement a restorative program for Resident #62 as recommended by physical therapy.

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	135146	A. Building B. Wing	12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascadia of Boise	6000 W Denton St Boise, ID 83704

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42346 Based on observation, Incident and Accident (I&A) report review, policy review, record review, and staff interview, it was determined the facility failed to ensure residents were protected from falls and did not sustain injuries due to incorrect use of sit-to-stand lifts (STS - used to assist people with limited mobility when they are unable to transition from a sitting position to a standing position on their own). This was true for 1 of 3 residents (Resident #55) reviewed for falls and 1 of 5 residents (Resident #10) reviewed for abuse and neglect. Resident #10 was harmed when she sustained extensive bruising and experienced intense fear and anxiety due to dangling from the sling of a STS lift. These failures also placed Resident #55 at risk of bone fractures or other serious injuries from from repeated falls. Findings include: 1. Resident #10 was admitted to the facility on [DATE], with multiple diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following a cerebral infarction (stroke) and anxiety. Resident #10 annual MDS assessment, dated 10/1/19, documented she was severely cognitively impaired and required extensive assistance of 1-2 staff members for her ADLs. Resident #10's physician's orders included Aspirin (may interfere with blood clotting at low doses) 81 mg (milligrams) one tablet one time a day for cardiac (heart) precautions, ordered on 12/4/18. Resident #10's care plan included the following: - She was at risk for abnormal bleeding or hemorrhage due to anticoagulant use related to use of Aspirin and staff were directed to monitor for signs and symptoms of bleeding such as bruising. - She had mood problems related to anxiety and staff were directed to provide 1:1 reassurance, offer two staff members to assist during these times, offer repositioning, offer warm blankets and soothing music. A Nursing Note, dated 1/17/19 at 9:13 AM, documented Resident #10 had an order for a physical therapy (PT) evaluation for ROM and evaluation of options to help assist with pain in her right leg/knee. A PT Evaluation and Plan of Treatment, dated 1/8/19, documented Resident #10 was severely deconditioned and would benefit from increased postural stability for eating and ADLs. The short and long term goals for Resident #10 were for her to safely perform bed mobility, sit at side of bed up to 30 minutes to increase socialization and to improve postural stability, and to safely propel herself in a wheelchair. A Nursing Note, dated 1/27/19 at 5:30 PM, documented the nurse was called by a CNA to check on the bruise found on Resident #10's arm. The bruise measured 11 cm (centimeter) x (by) 9 cm extending down to her right breast measuring 8 cm x 5 cm. Resident #10 denied pain and did not know how it happened. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Weekly Skin Alteration Report, dated 1/30/19, documented Resident #10 had an 11 cm x 9 cm bruise on her right inner arm and an 8 cm x 5 cm bruise on her right lateral breast. A Weekly Skin Check Report, dated 2/5/19, documented Resident #10 had a 15 cm x 4 cm bruise on her right arm and 15 cm x 5 cm bruise on her right breast. An I&A report documented Resident #10's bruise was found on 1/27/19 and her representatives were notified. The I&A documented during witness statement collection Staff A went and looked at Resident #10's bruise and reported to the nurse she thought the bruise could have happened during her therapy session on 1/26/19 with the STS lift. The I&A report documented the Administrator and DON were notified and Staff F was put on suspension pending investigation. Staff A's written statement, dated 1/27/19 at 5:15 PM, documented on 1/26/19 she went to Resident #10's room to provide pericare and Staff F was in the room working with Resident #10 with the STS lift, and told her to wait. Staff A said on her report she left the room and when she came back she saw Resident #10 dangling from the STS lift and was crying. Staff A asked Staff F if she was done with Resident #10 and was told Not yet. Staff A said she left the room to answer another call light. When Staff A came back to Resident #10's room she saw Staff F still trying to get her to stand using the STS lift. Staff A said on her report Resident #10 was dangling and crying and saying she could not breathe. Staff A said Staff F attempted one more time and Resident #10 was saying she could not do it and she could not breathe. Staff F then put Resident #10 down on the bed and Staff A provided pericare to Resident #10. Staff A's report said Staff F assisted her in providing pericare to Resident #10. A Sit to Stand Lift Criteria - Interior Health Website, accessed on 12/19/19, documented the patient should be able to hold onto both handles on the machine to avoid too much pressure in patient's armpit and should be able to keep both feet flat on the footplate of the lift throughout the transfer. An undated and unsigned statement of Staff F, with handwritten note sometime around 9:30-10ish per [Staff F's name] on the right top corner, documented on 1/26/19 she was with Resident #10 and asked if she was ready to stand up. Resident #10 said No as she had with every other treatment they had. Staff F explained to Resident #10 the benefits of getting out of bed and returning to her prior level of function (PLOF), and that they would just practice standing up. Staff F said on her report that she could tell Resident #10 was not comfortable and resisting too much to achieve standing using the STS lift so she returned her back to a sitting position immediately. Staff F's report documented Resident #10 told Staff F she could not breath and Staff F recognized Resident #10's shortness of breath. Staff F documented she asked Resident #10 to take a deep breath, relax and gave her time to calm down. Staff F's report documented she initiated Resident #10 to stand up again using the STS lift but noticed she had quicker resistance and fear with standing and was much quicker to return to sitting position. Staff F's report documented Resident #10 continued to report difficulty of breathing. Staff F told Resident #10 it was perfectly normal to be scared and it was her job to safely show and encourage residents to return to their PLOF. Staff F then put Resident #10 to bed and assisted Staff A with completing pericare to Resident #10. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The I&A report further documented the interdisciplinary team (IDT) determined abuse did not occur to Resident #10 and the bruise was caused by the sling from the STS lift. Staff F was working with her scope of practice and with proper plan of treatment. Staff A did not feel Resident #10 was harmed or abused but had questioned in her head why STS lift was being used and it may have gone on too long without stopping the session. Both Staff A and Staff F were given education regarding customer service and abuse training. There was no documentation Staff F was evaluated for proper use of the STS lift or provided additional training related to its use. On 12/10/19 at 9:31 AM, the Director of Therapy said Staff F choose to leave the facility about six weeks ago. On 12/11/19 at 10:25 AM, the Administrator said Resident #10's bruise was caused by the sling from the STS lift. 2. The facility's Fall Response and Management policy, dated 11/28/17, documented staff were to: * Revise the plan of care, as appropriate * Document in the patient medical record: - Review post fall evaluation and fall investigation - Determine causal factors, if possible - Revise the care plan with interventions Resident #55 was admitted to the facility on [DATE], with multiple diagnoses, which included Parkinson's Disease (a progressive disease of the nervous system that affects movement) and Lewy Body Dementia (progressive brain disorder triggered by abnormal deposits of protein in the brain). A quarterly MDS assessment, dated 11/11/19, documented Resident #55 was cognitively intact and was totally dependent on two or more staff members with bathing, bed transfers and bed mobility. The assessment also documented Resident #55 was not steady and required stabilization with assistance when moving from a seated to standing position and walking. A Fall Risk assessment, dated 11/1/19, documented Resident #55 had a prior history of falls within the last 3 months and scored at risk for falls. A Bed Safety Evaluation, dated 11/1/19, documented Resident #55's bed was to be in the low position. Resident #55's care plan did not document an intervention for his bed to be in the low position, until 11/25/19, 24 days after his Bed Safety Evaluation on 11/1/19 assessed his bed was to be in the low position. A Post Fall Investigation documented Resident #55 fell on [DATE] at 12:40 AM. The investigation documented Resident #55 rolled out of bed and fell on to the floor. The investigation documented Resident #55's bed was not in the low position as directed by his Bed Safety Evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #55's care plan documented staff were to use a bedside impact absorbing floor mat next to Resident #55's bed when he was in bed, initiated on 11/15/19. A Post Fall Investigation documented Resident #55 had an unwitnessed fall on 11/22/19 at 7:00 AM. There were no new documented interventions on Resident #55's care plan to prevent further falls. A Post Fall Investigation documented Resident #55 had an unwitnessed fall on 11/24/19 at 7:20 PM, while transferring out of the wheelchair and into the bed. No new interventions were documented on Resident #55's care plan. A physician's order, dated 11/25/19, documented Resident #55 was to have a fall mat to the right side of his bed. A physician's order, dated 12/2/19, documented Resident #55 was to have his bed in the lowest position. On 12/10/19 at 10:07 AM, Resident #55 was observed lying in bed. There was no fall mat on the floor by his bed and the bed was not in the lowest position as directed by his care plan and physician orders. On 12/10/19 at 10:56 AM, UM #2 stated there was no floor mat in Resident #55's room and he should have one. On 12/10/19 at 10:58 AM, UM #2 stated Resident #55's fall risk score indicated he was a high fall risk. UM #2 stated care plan interventions should be completed after each fall. The facility did not follow its policy to reassess and revise the care plan after each fall. The facility did not follow the interventions that were documented on Resident #55's care plan and subsequently ordered by his physician, for his bed to be in low position and a floor mat next to his bed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37263 Based on record review, review of facility protocol for treatment, and resident, family and staff interview, it was determined the facility failed to ensure the bowel protocol was followed and implemented for 1 of 5 residents (Resident #55) reviewed for bowel and bladder care. This had the potential to place residents at risk for fecal impaction. Findings include: The facility's Bowel Care Protocol, updated 1/27/11, documented the bowel regime if a resident had no bowel movement for 48 hours was to administer 30 ml of Milk of Magnesia (MOM). If the resident had no bowel movement for 72 hours, administer 10 mg Dulcolax suppository. If the resident did not have a bowel movement documented by the following morning, administer a Fleets enema rectally. If no bowel movement within 2 hours, notify the physician for additional orders. This protocol was not followed. Resident #55 was admitted to the facility on [DATE], with multiple diagnoses including Parkinson's disease (a progressive disease of the nervous system that affects movement) with Lewy body dementia (abnormal protein deposits in the brain). The admission MDS assessment, dated 11/11/19, documented Resident #55 was cognitively intact, required extensive assistance of 2 staff members with toileting, and was occasionally incontinent of bowel. Resident #55's physician's orders, dated 11/1/19, directed staff to provide Senna-Docusate (a stool softener and laxative) 8.6-50 mg 1 tablet twice a day and Miralax powder 17 gram mixed with 8 ounces of liquid daily as needed for bowel care. Resident #55's physician's orders also included the facility's bowel protocol for MOM if no bowel movement for 2 days, Dulcolax Suppository 10 mg if no results from MOM, and if no results in 12 hours, a Fleets Enema, if no results after the Fleets enema in 4 hours, notify the physician for further instructions. Resident #55's Bowel Function Monitoring for November 2019, documented he did not have a bowel movement from 11/3/19 to 11/8/19, 6 days. The November 2019 MAR documented Resident #55 was administered 30 ml of MOM on 11/7/19 at 9:11 AM, four days after no bowel movement, and the results were unknown. The MAR documented Resident #55 was administered a Fleets Enema on 11/8/19 at 5:48 PM, and the results were effective. There was no documentation Resident #55 received a Dulcolax suppository prior to receiving a Fleets enema per the facility's protocol and his physician orders. Resident #55's Bowel Function Monitoring for November 2019, documented he did not have a bowel movement from 11/12/19 to 11/18/19, 7 days. The November 2019 MAR documented Resident #55 was administered 30 ml of MOM on 11/14/19 at 11:48 AM, and the results were ineffective. Resident #55's record did not include documentation he was administered the Dulcolax and the Fleets Enema per the facility's protocol and his physician orders. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #55's Bowel Function Monitoring for November 2019 and December 2019, documented he did not have a bowel movement from 11/24/19 to 12/2/19, 9 days. The November 2019 MAR documented Resident #55 was administered 30 ml of MOM on 11/26/19 at 5:05 PM, and the results were ineffective. The MAR documented Resident #55 received a Dulcolax suppository on 11/27/19 at 5:48 AM, and the results were ineffective. The December 2019 MAR documented Resident #55 received a Dulcolax suppository on 12/1/19 at 5:19 AM, and the results were ineffective. There was no documentation Resident #55 received a Fleets enema per the facility's protocol and his physician orders. On 12/10/19 at 11:50 AM, Resident #55's spouse stated he has had constipation since he was admitted to the facility. Resident #55 and his spouse stated if he received the Miralax daily that seemed to keep him regular and the facility would not administer it to him. The spouse stated she had talked with the facility staff and the hospice agency and they do not seem to want to listen. On 12/10/19 at 1:23 PM, UM #2 stated he reviewed residents' bowel function and if a resident had not had a bowel movement for 2 days or longer, he added the resident to the bowel list for the floor nurse to follow the facility's bowel protocol. UM #2 stated Resident #55 should not have gone more than 3 days without having a bowel movement. UM #2 stated the nurses were not following the bowel protocol for Resident #55. Resident #55 did not receive bowel care per the facility's protocol or his physician's orders.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31923 Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure a feeding tube was checked for placement and residuals before medication administration. This was true for 1 of 3 residents (Resident #18) reviewed for medication administration through a feeding tube. This deficient practice placed the resident at risk of complication due to improper feeding tube management. Findings include: The facility's Administration of Medication through an Enteral Feeding Tube, dated 1/1/18, documented: * If not using a pump, use a 60 ml syringe, check the tube for placement and patency, and flush the tube with 15-30 ml of warm fresh water. * Mix medication with warm tap water. * Administer medication. * After medication administration, flush the tube with 15-30 mls of tap water either using a 60 ml syringe or pushing the flush option on the pump. Resident #18 was admitted to the facility on [DATE], with multiple diagnosis including traumatic brain injury and dysphagia (difficulty swallowing). She had a PEG tub (percutaneous endoscopic gastrostomy tube used to supply nutrition or fluids). Resident #18's admission MDS assessment, dated 10/15/19, documented she received more than 51% of her total nutrition through a feeding tube. Resident #18's physician's orders documented the following: * On 10/9/19: Check feeding placement every shift by auscultation and aspiration before initiation of formula, medication administration, and flushing tube or at least every 8 hours. Record residual [amount of gastric contents aspirated]. If greater than 100 mls notify the physician. * On 11/14/19: Propranolol (medication for high blood pressure) HCl (hydrochloride), 10 mg give one tablet via PEG tube three times a day for hypertension, hold for HR (heart rate) less than 60 and SBP (systolic blood pressure) less than 100. * On 12/4/19: Flush feeding tube with 30 mls of water before and after medication administration and 5 mls between each individual medication. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/19 at 9:45 AM, RN #4 was observed as he administered Resident #18's propranolol through her PEG tube. RN #4 mixed the propranolol to about 30 - 60 mls of water. RN #4 then attached a 60 cc syringe to the end of Resident #18's PEG-tube and poured the medication into the 60 ml syringe, followed it with water filling the syringe up to the 60 ml mark. The syringe did not drain for 3 - 5 minutes, then began to flow slowly. When the syringe was almost empty, RN #4 poured another 60 mls of water into the syringe after it had emptied. RN #4 was not observed to check the placement of Resident #18's PEG tube or to check her residuals. RN #4 was also not observed to flush Resident #18's PEG-tube prior to administering her Propranolol. After RN #4 administered Resident #18's medication, RN #4 said she could receive about 200 mls of water every four hours. RN #4 said Resident #18's total water for this medication was 20 mls of free water and about 30 - 60 mls of water that was used to mix her medication. When asked if he checked Resident #18's PEG tube placement. RN #4 said he did not check Resident #18's PEG tube placement and he did not check her residuals or flush her PEG tube with water before he administered her medication. RN #4 said I probably should have done that. On 12/12/19 at 1:35 PM, the Clinical Resource Nurse said PEG tube placement should be checked and flushed with water before administering medications.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on observation, record review, and staff and resident interviews, it was determined the facility failed to ensure residents received respiratory care as ordered by a physician. This was true for 1 of 6 residents (Resident #15) reviewed for oxygen therapy. This failure created the potential for harm if residents did not receive oxygen therapy to maintain oxygen levels. Findings include: Resident #15 was readmitted to the facility on [DATE], with multiple diagnoses including acute respiratory failure with hypoxia (decreased oxygen supply to the body tissues) and hypercapnia (excessive carbon dioxide in the bloodstream caused by inadequate respiration). An admission MDS, dated [DATE], documented Resident #15 received oxygen. A physician order, dated 9/6/19, documented Oxygen at 2 liters/minute (LPM) via nasal cannula continuously as needed and every shift. On 12/8/19 at 11:17 AM, Resident #15 was observed sitting at the table in his power wheelchair in the dining room. He had oxygen in place by nasal cannula connected to a portable oxygen tank. On 12/8/19 at 12:34 PM, Resident #15 said his portable oxygen tank was filled by a CNA before he went to the dining room. Resident #15 said while he was at the dining room waiting for his lunch he felt dizzy and UM #1 found his oxygen tank was empty. Resident #15 said this was not the first time he found his portable oxygen tank empty. On 12/8/19 at 12:35 PM, UM #1 came back with the portable oxygen tank. UM #1 said Resident #15 complained of feeling dizzy and when he checked the portable oxygen tank it was empty. UM #1 then checked Resident #15's oxygen saturation and it was 88 to 90 percent. UM #1 said Resident #15 was on continuous oxygen at 2 LPM and staff should make sure his portable oxygen tank was not empty whenever he was out of his room.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18639 Based on observation, record review, policy review, Facility Assessment review, review of Resident Council meeting minutes, resident and resident representative interview, and staff interview, it was determined the facility failed to ensure there were sufficient numbers of staff to meet ADL needs, answer call lights in a timely manner, and deliver food in a timely manner for residents. This was true for 13 of 74 residents (#9, #12, #20, #24, #25, #27, #30, #44, #47, #55, #70, #120, and #569) reviewed for staffing concerns. These systemic deficient practices placed residents at risk of adverse events due to delayed call light response times, skin breakdown, and embarrassment or decrease in feelings of self-worth due to lack of cares. Findings include: The facility's policy Sufficient Qualified Nurse Staffing, dated 11/28/17, stated the facility provided licensed nurses and other nursing personnel to provide nursing care to all residents in accordance with resident care plans. The policy stated nursing and related services were provided to ensure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by their assessments and individual plans of care. The policy also stated these services were provided with consideration to the number, acuity, and diagnoses of the facility's resident population in accordance with the required facility assessment. This policy was not followed. Facility staffing was insufficient to meet the care and needs of the residents and to respond to resident concerns. Examples include: a. Residents and their representatives were interviewed and stated the facility did not have sufficient staff to meet their needs. - On 12/8/19 at 10:22 AM, Resident #9 said her roommate was put to bed in her pants but had sat in her wheelchair prior to transfer and had peed and wet her pants. Resident #9 said she called staff to come and change her roommate's pants. Resident #9 said her roommate is unable to advocate for herself, had sat wet for an hour, and the staff had not checked on her. Resident #9 said when she moved here in February of 2019, there were 50 residents. She said the census went up to 75 residents, but they did not hire more people. Resident #9 said there were 2 CNAs most of the time on day shift, with 1 CNA at night. She said they needed an extra CNA in the morning and afternoon, and 2 CNAs at night, and they were not provided. - On 12/8/19 at 11:33 AM, Resident #120 said there were not enough staff to administer her medications on time, give her showers when she was scheduled, and said on the weekends call lights were not answered timely. - On 12/8/19 at 5:20 PM, Resident #569 stated he came to the facility from an acute care hospital on 12/6/19, and he was admitted for physical therapy and to gain strength in his legs prior to hip surgery. Resident #569 said since he was admitted to the facility, the service had been very slow. He said sometimes when he put on his call light it took 10 to 15 minutes to get a response, and sometimes no one came at all. Resident #569 stated, I believe they are under-staffed here. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- On 12/9/19 at 10:54 AM, Resident #25's spouse said there were not enough staff on the weekends to assist with residents with their meals, meals are generally late, and there are not enough staff to take care of residents' hygiene needs. - On 12/10/19 at 12:25, Resident #12's daughter stated hospice has helped her with addressing her problems with the facility staff. She stated last Thursday evening the staffing board documented there were 3 nurses and they had to get someone from another hall to assist Resident #12 to bed. Resident #12's daughter stated she has been sent to appointments without her hair being brushed. - On 12/10/19 at 2:35 PM, during the Resident Group interview, Residents #9, #20, #27, #30, and #44 said showers were not being completed, especially on Saturdays. - On 12/10/19 at 3:02 PM, the co-guardians for Resident #70 stated when they went in to visit or take him to an appointment he often had a wet adult brief and the staff were not changing him. One of the guardians stated they had taken Resident #70 to an appointment and at the appointment a wound was found on his leg. The guardian stated the nurse at the appointment stated the wound should have been identified by the facility it had been there for a while. The guardian stated the staff at the facility should have been performing weekly skin checks to identify these types of issues. b. Staff were interviewed and stated there was not sufficient staff to provide the cares required and to meet the needs of the residents. - On 12/8/19 at 10:22 AM, CNA #9 said there were not always enough staff to meet the needs of the residents. - On 12/8/19 at 10:42 AM, LPN #1 said there are not enough staff because there were several residents who required 2-person assistance with transfers. - On 12/9/19 at 1:57 PM, CNA #18 said she started working as Shower Aide about 3 months ago. CNA #18 said she was asked about 3 times to work on the floor because of staff call offs. CNA #18 said showers were not completed on those days she was asked to work on the floor as a CNA. - On 12/10/19 at 9:10 AM, RNA #1 said he was working as a CNA and said would not be able to do the RNA program today. When asked who would be doing the RNA program for the residents. RNA #1 said Nobody. RNA #1 said he was pulled out to work as a CNA about four to five times since he started working as an RNA six months ago. - On 12/11/19 at 2:04 PM, CNA #6 stated they don't have enough care givers. CNA #6 said residents who were using mechanical lifts received their showers on Wednesdays and Saturdays and there was not enough staff scheduled on Saturdays. CNA #6 said there was no shower aides on Saturdays. CNA #6 also said the razor blade got dull and one resident had not been shaved for a week, and he got shaved only during his shower days. CNA #6 said she had requested to have the Saturday's showers changed because of there was no shower aide but she got no response. -On 12/11/19 at 3:45 PM, CNA #7 was asked if the facility staffing was adequate to assist residents with meals. CNA #7 said there was not enough staff to assist residents during meals or anything else unless the survey team was in the building. Then all personnel from the office would come on the floor and help. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- On 12/12/19 at 9:04 AM, CNA #10 said there were only two CNAs over here and sometimes when we ask for help, we just get ignored. Some of the resident can take up to an hour to help, leaving only one CNA on the floor and that is not enough. It leaves us rushing around trying to get things done. On 12/13/19 at 9:45 AM, RN #5 said there was staffing problem in the facility that was why she worked as a CNA on 12/8/19. c. The Resident Council expressed concerns regarding lengthy call light response times, showers, and dining which were not addressed by the facility. The facility's Grievance policy, dated 11/28/17, documented the facility would make prompt efforts to resolve grievances, including Resident Council concerns, and to keep residents notified of progress toward resolution. Resident Council Meeting minutes, dated 9/4/19, documented concerns with call light response times up to 30 minutes and very slow response times during meals. Resident Council Meeting minutes, dated 10/2/19, documented concerns with call light response times up to one and a half hours, not enough staff, staff saying they would come back to help residents and did not, and breakfast served in resident rooms were late. There was no documentation what actions were taken to resolve the concerns identified in the 9/4/19 meeting. Resident Council Meeting minutes, dated 11/6/19, documented concerns with call light response times up to two hours, long response times during shift change, staff saying they would come back to help residents and did not come back, and room trays were late due to not enough staff to pass out trays. There was no documentation what actions were taken to resolve the concerns identified in the 9/4/19 or 10/2/19 meetings. Resident Council Meeting minutes, dated 12/4/19, documented concerns with not enough staff on the weekends and not all the residents were getting showers as scheduled. There was no documentation what actions were taken to resolve the concerns identified in the 9/4/19, 10/2/19, and 11/6/19 meetings. On 12/10/19 at 2:35 PM, during the Resident Group interview, Residents #9, #30, and #44 said there were still issues with slow call light response times, not enough staff, low food temperatures, and late delivery of trays. They stated these concerns were not addressed by the facility. On 12/11/19 at 9:36 AM, the Activity Director said she emailed the Resident Council meeting notes to the department heads. She said she had not been given direction to readdress the old complaints during the Resident Council meetings. The Activity Director said the Administrator met individually with the Resident Council President to address the Resident Council concerns. On 12/11/19 at 1:10 PM, the Administrator said he met with the Resident Council President and relied on the council's President to report back to the Resident Council. The Administrator provided minutes for meetings with the council's President for 11/11/19 and 11/27/19. The minutes did not document a discussion of not enough staff, staff saying they will come back to help residents and then not coming back, and late meal trays. The Administrator said he did not see where concerns were readdressed in the Resident Council minutes. The Administrator said he expected Resident Council concerns to be addressed. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	d. Residents did not receive bathing and showers consistent with their needs. - Resident #47 was readmitted to the facility on [DATE], with multiple diagnoses including amyotrophic lateral sclerosis (a progressive degenerative nervous system disease that affects nerve cells in the brain and the spinal cord). A quarterly MDS assessment, dated 11/11/19, documented Resident #47 was cognitively intact and required extensive, 2-person assistance for bathing. The ADL Care Plan, undated, documented Resident #47 was dependent on staff for bathing. He was to be assisted with bathing twice per week and PRN. Resident #47's ADL Reports for October, November, and December 2019 documented he did not receive a bath/shower from 10/5/19 to 10/11/19 (6 days), from 10/16/19 to 10/22/19 (6 days), from 10/23/19 to 11/4/19 (11 days), from 11/5/19 to 11/25/19 (20 days), and from 12/7/19 to 12/11/19 (5 days). On 12/8/19 at 10:25 AM, Resident #47 stated the time between showers/baths had gotten longer. On 12/12/19 at 8:57 AM, Resident #47 said his regular scheduled shower days were Wednesdays and Saturdays and he said the facility wanted to change his Saturday schedule to a different day and he told them no. On 12/12/19 at 3:56 PM, the Clinical Resource Nurse said Resident #47's record did not include additional baths/showers received in October, November, and December. - Resident #24, whose age was in the mid-30s, was admitted to the facility on [DATE], with multiple diagnoses including cerebral palsy (brain injury which most often happens before or during a baby's birth, or during the first 3-5 years of a child's life, that affects muscle tone, movement, and motor skills, and may also cause sight, hearing, and learning problems) and intellectual disability. Resident #24's annual MDS assessment, dated 10/21/19, documented she required extensive, 2-person assistance with personal hygiene and was totally dependent, requiring 2-person assistance with bathing. Resident #24's care plan, dated 11/21/19, documented she was dependent on staff and directed staff to provide assistance with her bathing and personal hygiene. Resident #24's ADL Reports for November and December 2019, documented her bathing days were Tuesday and Friday and PRN. The reports documented she was not bathed from 11/20/19 to 11/26/19 (7 days) and from 11/27/19 to 12/3/19 (7 days). On 12/8/19 at 11:52 AM, Resident #24 was in her wheelchair in the Alpine unit day room watching TV. Her hair was matted and appeared unkempt. She had a non-stained clothing protector around her neck and chest area. She had on a sweater that was stained with streaks of food and excessive oral secretions underneath the clothing protector. The top left of her pants was soiled with food stains, near her hip. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/8/19 at 11:59 AM, RN #8 assisted Resident #24 to her room and changed her sweater with a new shirt and a new clothing protector. RN #8 said the stain to Resident #24's shirt was probably pudding she had eaten earlier in the day. RN #8 then assisted Resident #24 out of her room. RN #8 did not attempt to change Resident #24's pants or brush her matted hair. On 12/9/19 at 9:56 AM, CNA #2 assisted Resident #24 to her room to change her wet and stained shirt. After placing the new shirt on her, CNA #2 began to take Resident #24 from the room. CNA #2 said Resident #24's chest had been wet from oral secretions and CNA #2 had not attempted to clean Resident #24's chest before placing the new shirt on. On 12/10/19 at 8:13 AM, CNA #12 said Resident #24 received 2 showers a week. She said as long as staff wiped off her excessive oral secretions and groomed her hair, then 2 showers a week was fine for Resident #24. CNA #12 said if showers were not completed during the day shift then the evening shift was to complete them. On 12/11/19 at 3:53 PM and 4:19 PM and on 12/12/19 at 11:09 AM, the DON, with the Clinical Resource Nurse present, said she expected staff to provide Resident #24 with showers as scheduled, to wipe her oral secretions off, provide grooming, and to change her clothes when soiled. The Clinical Resource Nurse said due to Resident #24's age she might need to be reassessed to see if 2 showers a week was adequate. - Resident #55 was admitted to the facility on [DATE], with multiple diagnoses, which included Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors) and Lewy Body Dementia (progressive brain disorder triggered by abnormal deposits of protein in the brain). An admission MDS assessment, dated 11/11/19, documented Resident #55 was cognitively intact and was totally dependent on two staff members with bathing, bed transfers and bed mobility. The facility's shower schedule documented Resident #55's shower schedule was Mondays and Thursdays in the morning. Resident #55's care plan, revised on 11/18/19, documented he required extensive assistance of 1-2 staff for bathing. Resident #55's ADL report for November 2019 documented there were no showers given or offered from 11/6/19 through 11/10/19 (5 days), and 11/12/19 through 11/17/19 (6 days). Resident #55's ADL report for December 2019 documented there were no showers given or offered from 12/6/19 through 12/10/19 (5 days). On 12/10/19 at 2:15 PM, Resident #55 stated his last shower was on 12/5/19. On 12/10/19 at 2:22 PM, UM #2 stated that Resident #55 refused his shower on 12/9/19, and he was scheduled to receive a makeup shower. UM #2 said hospice services did most of Resident #55's showers. UM #2 was unable to find documentation that Resident #55 refused his shower on 12/9/19. On 12/13/19 at 9:19 AM, UM #2 stated Resident #55 did not receive showers as scheduled. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Resident #120 was admitted to the facility on [DATE], with multiple diagnoses including muscle weakness and Parkinson's disease. Resident #120's admission MDS assessment, dated 12/2/19, documented she required 1-person assistance with bathing. Resident #120's care plan, dated 11/26/19, directed staff to provide 1-person assistance with bathing. Resident #120's ADL Reports for November and December 2019, documented her bathing days were Wednesday and Saturday and PRN. The reports documented she was not bathed from 11/28/19 to 12/2/19 (5 days) and from 12/5/19 to 12/9/19 (5 days). On 12/8/19 at 11:33 AM, Resident #120 said since she had been admitted to the facility, she had not received her showers as scheduled. On 12/12/19 at 11:10 AM, the DON said Resident #120's showers were missed on 11/30/19 and 12/7/19. She said if staff did not complete the residents' showers she expected staff to offer the shower the next day. e. The facility's policy Facility Assessment, dated 11/28/17, documented the following: * The facility evaluated its resident population and identified the resources needed to provide the necessary care and services to its residents competently during daily operations and during emergencies. * The facility reviewed and updated the assessment whenever there was, or the facility planned for, any changes that required a substantial modification to any part of the assessment. The facility assessment addressed or included the following: - The facility's resident population, including but not limited to the number of residents and the facility's resident capacity. - The care required by the resident population with consideration of the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other relevant facts that were present within that population. - The facility's resources, including but not limited to all personnel, including managers and staff (facility employees and those who provided services under contract). The Facility Assessment Tool, dated 7/1/19, was compared to the Resident Census and Conditions of Residents form completed during the survey on 12/9/19. The Facility Assessment Tool had not been updated to reflect the facility's population. Examples included, but were not limited to, the following: - The Facility Assessment Tool documented the average daily census was 58 residents. However, the Resident Census and Conditions of Residents form documented the facility's census was 74 residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/13/19 at 8:40 AM, the Administrator was shown the Facility Assessment Tool, dated 7/1/19. The Administrator stated the average daily census was 58 at the time the assessment was completed, and the current average daily census was 72. - The Facility Assessment Tool documented the number of residents in the facility who required the specified treatment/services which included: Respiratory Treatments: Oxygen therapy: 16-18 residents Suctioning: 10-12 residents Tracheostomy care: 2-3 Mental Health: Behavioral Health Needs: 15-20 residents Other: Injections: 3-4 residents Dialysis: 3 residents Ostomy care: 2-3 residents However, the Resident Census and Conditions of Residents form documented the following current resident needs: Respiratory Treatments: Respiratory treatment: 27 residents Suctioning: 13 residents Tracheostomy care: 13 residents Mental Health Behavioral Health Needs: 58 residents Other Injections: 17 residents Dialysis: 4 residents (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ostomy care: 5 residents The Facility Assessment Tool documented the facility's staffing plan for nursing care, which included RNs, LPNs, CNAs, NAs, and hospitality aides (non-skilled care), was to be at 4.5 to 5.5 hours per resident per day. Hospitality aides are not allowed to provide nursing care and should not be reflected in the nursing care hours. The direct care nursing hours worked from 11/17/19 through 12/7/19 were reviewed. The staffing levels did not meet the 4.5 to 5.5 hours planned in the Facility Assessment Tool. The days for which the hours did not meet nursing care were as follows: Sunday, 11/17/19 - 4.01 Saturday, 11/23/19 - 4.3 Sunday, 11/24/19 - 3.82 Saturday, 11/30/19 - 4.32 Sunday, 12/1/19 - 3.90 Saturday, 12/7/19 - 4.09 On 12/12/19 at 4:38 PM, the DON together with the Clinical Resource Nurse was asked if the Facility Assessment included a determination of the level and competency of staff needed to meet each residents' needs each day and during emergencies. The DON said Yes. Both the DON and the Clinical Resource Nurse said the planned nursing hours per resident per day was 4.5 hours to 5.5 hours. The DON and the Clinical Resource Nurse stated they were not aware the staffing levels for the past three weekends did not meet the planned staffing levels according to the Facility Assessment. On 12/13/19 at 8:40 AM, the Administrator stated the assessment was a fluid document, which could be updated and changed. The Administrator stated it was not indicative of the current staffing because the average daily census was 58 at the time the assessment was completed, and the current average daily census was 72. (This represented an increase of 24% in the average daily census since the Facility Assessment Tool was completed). 31867 31923 36193 38350 41819

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 18639 Based on review of staff training and performance review records, facility policy review, and staff interview, it was determined the facility failed to ensure all CNAs received the required competency evaluations and completed the required hours of yearly training. This was true for 5 of 5 CNAs (Staff G, H, I, J, and K) reviewed for competency evaluations and annual training. This failed practice had the potential to affect all 74 residents in the facility and created the potential for harm if residents received incompetent care from CNAs. Findings include: The facility's policy for Sufficient Qualified Nurse Staffing, dated 11/28/17, stated Sufficient qualified nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the required facility assessment. The facility's policy for Nurse Aide Staffing, dated 11/28/17, documented the following: * At least 12 hours of in-service training was provided to nurse aides each employment year based on the outcome of the annual performance review and special needs of the resident population. * Nurse aides must demonstrate competency in areas such as communication and personal skills, basic nursing skills, personal care skills, mental health and social service needs, basic restorative services, and Resident Rights. These policies were not followed. The following information regarding the training and performance evaluations for Staff G, H, I, J, and K was provided by the facility's SDC: 1. Staff G, a CNA whose hire date was 9/10/18, received a total of 0.5 hours of training/in-service since 12/1/18. Staff G did not have a performance evaluation after 9/20/18. 2. Staff K, a CNA whose hire date was 9/25/18, received 8 hours of training/in-service since 12/1/18. Staff K did not have a performance evaluation after 9/28/18. 3. Staff I, a CNA whose hire date was 11/5/18, received a total of 8.25 hours of training/in-service since 12/1/18. Staff I did not have a performance evaluation after 11/19/18. 4. Staff J, a CNA whose hire date was 6/14/18, received a total of 2.25 hours of training/in-service since 12/1/18. Staff J did not have a performance evaluation after 6/26/18. 5. Staff H, a CNA whose hire date was 5/3/18, did not have a performance evaluation after 6/18/18. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/12/19 at 3:11 PM, the above findings were reviewed with the SDC. When asked if the CNAs identified above had received 12 hours of training/in-services since 12/1/18, she stated Staff G, I, J and K did not. When asked whose responsibility it was to ensure the CNAs received the required training/in-services, she stated, I don't know. I'm going to assume it's me. The SDC was asked if there were additional performance evaluations for the 5 CNAs, she stated, I don't know. What you have is what I had. On 12/12/19 at 4:38 PM, the DON stated the SDC was responsible for overseeing nursing competencies. The DON stated nursing staff should be evaluated to assess their competencies, skills, and knowledge Yearly or if there is a change. The facility failed to complete annual performance evaluations and develop a training program based on the review.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 31867 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure nurse staffing information was posted daily and at the beginning of each shift, only included the licensed and unlicensed nursing staff directly responsible for residents' care, and was accurate based on actual staff working for 74 of 74 residents in the facility. This failed practice had the potential to affect all residents in the facility and their representatives, visitors, and those who wanted to be informed of the facility's staffing levels. Findings include: The facility's Posting Licensed and Unlicensed Direct Care Staff policy, dated 11/28/17, documented the facility posted the following information daily: total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for residents' care per shift. This policy was not followed. On 12/8/19 from 10:22 AM to 11:10 AM, the daily nurse staff posting was not observed in the facility. At 11:20 AM, the DON said the postings were not at the nurse's stations. She said she expected the nurses to post the daily staffing at each nurse's station. On 12/9/19 at 12:00 AM, the staff postings were on the nurse's station counter. The information was for 24 hours, not the current night shift. The staff posting documented there were 10 CNAs working from 2:00 PM to 10:00 PM for a total of 88 hours. Under the section with the number of CNAs working RSA, which stood for a hospitality aide, was handwritten. The hospitality aide's hours were included with the nursing hours of the CNAs. It was also not clear how many hospitality aides were scheduled and included as CNAs for the 2:00 PM to 10:00 PM shift. Hospitality aides are not allowed to provide nursing care and should not be reflected in the nursing care hours. On 12/9/19 at 12:00 AM, the staff postings also documented there were to be 6 LPNs and no RNs for a total of 72 hours for the 6:00 PM to 6:00 AM shift. There were 2 LPNs and 1 RN in the facility. At 12:00 AM, RN #6 said she was the only RN in the facility. At 12:15 AM, LPN #3 said there were 2 LPNs in the facility. The staff postings did not accurately reflect the nursing staff working at the facility for the shift. On 12/9/19 at 9:30 AM, the Administrator said the hospitality aide should not have been posted and counted in the CNA total hours. He said the staff posting for the evening shift was inaccurate and should have been corrected to reflect staffing as worked.

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	135146	A. Building B. Wing	12/13/2019

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Cascadia of Boise	6000 W Denton St Boise, ID 83704

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31923 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents were free of both significant and non-significant medication errors. This was true for 2 of 5 residents (#70 and #569) whose medications were reviewed. This failure placed residents at risk for harm when symptoms related to adverse side effects from the medications given in error are not recognized and acted upon promptly and if their condition worsened due to not receiving their prescribed medications as ordered by their physician. Findings include: 1. The facility's policy for Medication Errors, dated [DATE], documented the following: * Medications are managed and safely administered to residents with a minimum of medication errors (not 5% or greater) and residents are free of any significant medication errors. * A significant medication error is one which causes the resident discomfort or places the resident's health and safety in jeopardy. * Facility staff monitor the resident for possible medication-related adverse consequences, including mental status and level of consciousness, when the following conditions occur: A clinically significant change in condition/status, unexplained decline in function or cognition, worsening of an existing problem or condition, new or worsening psychiatric manifestation or distressed behavior, acute onset of signs or symptoms or worsening or a chronic problem or condition, .medication error e.g. wrong or expired medication . * In the event of a significant medication error or adverse drug reaction, immediate action is taken, as necessary, to protect the resident's safety and welfare . The prescriber is notified promptly of any significant error or adverse medication reaction . Any new prescribed orders are implemented, and the resident is monitored closely for 24 to 72 hours or as directed. This policy was not followed. The Nursing 2019 Drug Handbook documented the eight rights of medication administration were: 1. The right drug. 2. The right patient. 3. The right dose. 4. The right time. 5. The right route. 6. The right reason. 7. The right response. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0760 Level of Harm - Actual harm Residents Affected - Few	8. The right documentation. Resident #70 was admitted to the facility on [DATE], with diagnoses including atrial fibrillation (irregular heart rhythm), hypertension (high blood pressure), chronic kidney disease, Type 2 diabetes mellitus, and stroke. Resident #70 had two guardians appointed to him through the courts. Resident #70's record included physician orders for the following medications: - Apixaban 5 mg twice a day for atrial fibrillation - Atorvastatin 40 mg once a day for high cholesterol - Digoxin 62.5 mcg (microgram) once a day for high heart rate - Famotidine 20 mg once a day for gastroesophageal reflux disease (causes heartburn or indigestion) - Finasteride 5 mg once a day for prostate disorder - Humulin (insulin) 10 units injected before meals for diabetes - Glargine Insulin 10 units injected before bedtime for diabetes - Lasix 20 mg one time a day (for water retention) - Lisinopril 40 mg once a day for high blood pressure - Metoprolol 50 mg twice a day for high blood pressure - Potassium Chloride 10 mEq (milliequivalent) once a day for low potassium - Terazosin 4 mg once a day for enlarged prostrate - Cholecalciferol 1000 unit once a day for supplement - Melatonin 3 mg at bedtime for insomnia A nurse's progress note, dated [DATE] at 5:28 AM, documented Patient is sleeping soundly in bed, no complaints at this time. Water and call light are within reach. At approximately 1900 [7:00 PM], patient was given Ranitidine, Lithium, morphine IR, Soma, Lyrica, gabapentin, simvastatin, and trazadone [sic]. MD [Medical Doctor] notified and orders to monitor patient q [every] 30 min[utes] then to increase to 1 hr [hour] checks of pulse and oxygen. Patient [oxygen saturation] ranged from ,d+[DATE]% on RA [room air], and pulse of ,d+[DATE], normal for patients [sic] baseline. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The next nurse's progress note was 25 hours later at 6:39 AM on [DATE]. The note documented report was given by the day shift nurse about the medication error and that Resident #70 was being monitored. The nurse documented after receiving report from the day shift nurse she checked on Resident #70 at 6:30 PM on [DATE], and he was sitting up in bed sleeping. The nurse documented she performed a sternal rub (using the knuckles of the hand to rub the chest to elicit a response due to pain) and Resident #70 was aroused from his sleep. The nurse documented Resident #70 was checked on by staff at 10:15 PM and at 12:30 AM. At 2:15 AM on [DATE], the nurse documented Resident #70 stated he was feeling slightly dizzy and she encouraged fluids since .dayshift staff had stated that Res [Resident #70] did not take in any PO [oral] fluids all day. The nurse documented at 4:40 AM on [DATE], staff went to check on Resident #70 and he was found face down on the floor next to his bed and he told a CNA he fell out of bed. The nurse documented she stayed in the room with Resident #70 while the CNA went to get the Hoyer lift (a mechanical lift) and when she attempted to roll him over his face was red and she felt for a pulse and Resident #70 did not have one. The nurse documented the CNA came into the room and she instructed her to call 911 and to call a code (an alert to staff for an emergency to begin cardiopulmonary resuscitation efforts). The nurse documented Emergency Medical Services arrived a short time later and pronounced Resident #70 dead after they attempted resuscitation for 30 minutes. The note stated the police and coroner were called. The medications Resident #70 received had the following significant side effects according to Drugs.com a nationally recognized resource for medication information, website accessed [DATE]: - Lithium: lithium toxicity which may cause tremors, trouble walking, kidney problems, and an altered level of consciousness; confusion, fainting, irregular heartbeat, increased thirst, unusual tiredness or weakness - Morphine IR: respiratory depression, confusion, dizziness, faintness, lightheadedness, irregular heartbeat, drowsiness - Soma: difficult or troubled breathing, shakiness, unsteady walk - Lyrica: dizziness, fast heartbeat, weakness, drowsiness, confusion - Gabapentin: clumsiness, unsteadiness, tiredness or weakness - Trazodone: confusion, dizziness, faintness, tiredness or weakness, irregular heartbeat - Simvastatin: dizziness, fainting, irregular heartbeat A Medication Error report, dated [DATE], documented the wrong medication was given to the wrong patient, Resident #70, at 7:15 PM on [DATE]. The report documented the reason for the error was because the medication was pre-poured. Pre-pouring of medication was removing the medication from the packaging and setting it aside for administration at a later time. The report documented the Medical Director was notified at 8:10 PM on [DATE], and the DON was notified at 8:15 PM on [DATE]. The report also documented the Medical Director ordered for Resident #70 to have his oxygen saturation and heart rate monitored every 30 minutes for two hours and then every hour until the end of the shift. The report documented the outcome to Resident #70 was lethargy (abnormal drowsiness) and his vital signs were stable. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Resident #70's record did not include documentation of vital signs or assessments after the medication error as ordered by the Medical Director. An untitled document signed by UM #1, dated [DATE], documented he was called to Resident #70's room and when he entered the medication nurse was taking vital signs for Resident #70. UM #1 stated the nurse at the bedside demonstrated Resident #70 was not responsive to painful stimuli. UM #1 stated he observed Resident #70 for two minutes then in a loud voice called Resident #70 by his name and requested he open his eyes. UM #1 stated Resident #70 promptly opened his eyes. UM #1 stated he asked Resident #70 several questions which he answered accurately. UM #1 stated Resident #70 said he was dizzy and stated that someone had given him something. UM #1 stated he was at the bed side for about 10 minutes. UM #1 stated Resident #70 told him it was not necessary for him to go to the Emergency Department. UM #1 stated he requested the medication nurse continue closely monitoring Resident #70, which was put in place earlier that day. An untitled document dated [DATE] and signed by CNA #13 on [DATE], documented Resident #70 was very drowsy during the day and it .took 20 minutes to get up with sternal rubs. CNA #13 documented Resident #70 was lethargic during the times she provided care. An untitled and undated document signed by CNA #2, documented Resident #70 was pretty drowsy during the day and was hard to wake up. CNA #2 also stated Resident #70 was lethargic but was able to be roused. A police report, dated [DATE], documented RN #3 stated Resident #70 was given the wrong medications between 7:00 PM and 8:30 PM on [DATE], he was given his roommate's medications, and stated Resident #70 was lethargic most of the day, was sleeping a lot, and was dizzy. RN #3 stated this was not normal behavior for Resident #70. An untitled document signed by RN #2, dated [DATE], stated it was a late entry for Resident #70. The note documented at 6:00 AM on [DATE] RN #2 received report from the night nurse that a medication error occurred for Resident #70 at 8:00 PM on [DATE]. RN #2 stated the night nurse told her she received orders from the on-call physician to monitor Resident #70 throughout the night and the observation was to end with the day shift. RN #2 stated the night nurse told her the on-call physician told her Resident #70 would sleep it off the next day. RN #2 stated at 7:30 AM she instructed the CNAs to continue hourly monitoring of Resident #70 by taking vital signs hourly and to leave the pulse oximeter (for monitoring oxygen saturation) on him and to report to her if his oxygen level dropped below 92% or his blood pressure dropped below ,d+[DATE] (Normal oxygen saturation levels are 90 to 100%). RN #2 stated Resident #70 had stable vital signs and was easily roused when spoken to from 8:00 AM to 3:30 PM on [DATE]. RN #2 stated between 3:30 PM and 4:00 PM on [DATE] Resident #70 was more difficult to rouse and mumbled um-hmm when asked questions. RN #2 stated around 4:30 PM to 5:00 PM on [DATE], a CNA informed her Resident #70's oxygen saturation was in the high 70s. RN #2 stated she went into his room to rouse him and he was deep asleep and she repositioned him and took his vital signs and his oxygen saturation went up to 93%. RN #2 stated she radioed for the Unit Manager to come to Resident #70's room for further assessment. RN #2 stated when the Unit Manager entered the room he spoke to Resident #70 in a loud voice asking him to wake up, Resident #70 opened his eyes and sat up and told the Unit Manager he was sleeping and asked what the Unit Manager wanted. RN #2 stated Resident #70 was awake and stable when nursing staff left the room. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 9:28 AM, the case worker from the Veteran's Administration stated they were called by Resident #70's sister to say he had died . The case worker stated they had called Resident #70's daughter to see if there was anything of concern and she told them she was concerned about the medication error. The case worker stated she did not know how Resident #70's daughter and sister found out about the medication error. She stated Resident #70 was doing well at the last visit she had with him. On [DATE] at 1:05 PM, the Medical Director said he generally expected the nurses to call if there were abnormal vital signs or symptoms that were concerning. He said he would rely on the nurse's assessment of these situations. The Medical Director said he reviewed some of the documentation related to this situation, and some words used in the documentation could have been used inappropriately. He said for example, when the resident responded to voice, but did not respond to painful stimuli, he would then question what was meant by painful stimuli. The Medical Director said Resident #70's medication and the medications he was given in error were reviewed. The Medical Director said the medication given to Resident #70 in error was a big dose of a centrally acting medication, and he would have expected him to be sleepy. On [DATE] at 1:52 PM, UM #1 said the incident regarding the medication error for Resident #70 happened at about 5:00 PM. UM #1 said he was getting ready to leave for the day when the nurse asked him to come down and look at Resident #70. UM #1 said the nurse was giving Resident #70 a sternal rub, and after watching the nurse apply the sternal rub he used a low, slow, loud voice and Resident #70 woke right up. UM #1 said the nurse used her knuckles to apply the sternal rub, and he thought the sternal rub was appropriate. UM #1 said, Honestly, I think that conversation was one of the more honest conversation I have had with this resident. He knew where he was and what was going on. I know I wasn't aware of what the doctor had recommended. When we walked out of the room the nurse told me that they were doing enhanced monitoring of the resident. In the conversation that I had with the nurse the vitals we were monitoring were within parameters. She said the blood pressure and pulse were fine she just couldn't get the resident to respond to her. UM #1 said nursing would generally contact the doctor for change of condition, vital signs out of parameter, and any sort of acute condition. UM #1 said he could not remember what Resident #70 said that made him think he was disoriented, but when he attempted to orient him, he responded quickly that he knew where he was and what happened to him. UM #1 said Resident #70 told him he was given something that he should not have been given. UM #1 said he did not have any idea where the vital signs were documented throughout the day. UM #1 said [Resident #70] had a tendency to play possum a lot. On [DATE] at 3:02 PM, the co-guardians for Resident #70 stated they were not notified of the medication error by the facility, it was his sister who informed them. The co-guardians stated the facility notified them of his death but did not mention the medication error. The co-guardians stated they notified his providers, including the Veteran's Administration, about his death. The co-guardians stated a case worker from the Veteran's Administration called them back and stated they were unaware of the medication error also and the case worker told them she was concerned because they oversaw the care of Resident #70 as well. On [DATE] at 4:19 PM, the Clinical Resource Nurse said she found a note that documented nursing would continue to monitor Resident #70 after the medication error, but she did not find documentation they were going to continue taking vital signs. The Clinical Resource Nurse said she was unable to find documented vital signs after the night shift on the evening of the medication error. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 7:23 PM, RN #2 said her shift on [DATE] was from 6:00 AM to 6:00 PM, and The entire situation was very bizarre. RN #2 said when she arrived at the facility and took over for the night shift nurse, she asked whether Resident #70 was transferred to the Emergency Department (ED) and RN #1 told her the Medical Director had given orders which ended with her shift at 6:00 AM. RN #2 said RN #1 told her she talked to the Medical Director at length, and if Resident #70 did not have any trouble by that time, he would be fine. RN #2 said she was not comfortable with not following up with someone who had taken that many medications in error. RN #2 said she told the CNAs they would continue to monitor Resident #70, the vitals machine was in his room all day, and the pulse oximeter was on him continuously. RN #2 said Resident #70 woke up a few times and mumbled a few words, but other than that he slept all day. RN #2 said she told UM #2 that she was not comfortable with that and she thought he needed to be sent to the ED for fluids or the facility could provide IV (intravenous) fluids onsite for him. RN #2 said UM #2 was very confused about what to do, and he asked the other Unit Manager what to do. UM #1 came over and said not to do any more charting on Resident #70 than we usually do, and if he just sleeps just let him sleep it off. RN #2 said UM# 1 said something like don't chart anything out of the usual and he said if everything was stable or fine, the extra monitoring should not be documented and to keep it at a minimum. RN #2 said Resident #70 then just slept for the rest of the day. He had no bowel movement or urine and he just kept sleeping. RN #2 said between lunch and dinner, the aide came to her and said he was unable to rouse Resident #70. The CNA said he tried to rouse Resident #70 and he would moan, but he would not rouse. RN #2 said when Resident #70 could not be roused, the pulse oximeter was on him and vital signs were being taken, but staff could not rouse him. RN #2 said she called for UM #1 on the radio and he came right away. RN #2 said she thought Resident #70 needed to be sent to the ED, and UM #1 yelled out Resident #70's name and wake up in a loud, deep, baritone voice and Resident #70 opened his eyes and was rousable at that point. RN #2 said UM #1 said, It's just like I thought he was playing possum. RN #2 said, I don't think he is playing possum we couldn't rouse him. RN #2 said UM #1 said Resident #70 did not need to be sent to the ED, RN #2 said she kept asking UM #1 if he was sure and he kept saying Resident #70 did not need to go to the ED. She said Resident #70 woke up and made a short/brief comment like What do you want? I'm sleeping. RN #2 said UM #1 said staff were to make sure Resident #70 ate dinner. RN #2 said Resident #70 did not really get up and eat or drink, and later on the aides brought a meal into his room. RN #2 said she was told by UM #1 and UM #2 throughout the day just to follow the order, and the drug half-life (an estimate of the period of time that it takes for the concentration or amount in the body of that drug to be reduced by exactly one half) had passed through his system, and he was just sleeping as the Medical Director said he would. RN #2 said Resident #70's vital signs were stable, so she did not call the physician. RN #2 said she remembered charting the incident on Resident #70, but she stepped away and the note did not get saved. RN #2 said she was contacted the next morning and was told she needed to write a progress note, and she told the facility she did write a progress note. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 8:31 AM, RN #3 said she worked on [DATE] during the 6:00 PM to 6:00 AM shift. RN #3 said the day shift nurse told her that the night nurse had administered several incorrect medications to Resident #70. RN #3 said she went to Resident #70's room first after she received shift report. RN #3 said Resident #70 was awake, still lethargic, groggy, and sitting up. RN #3 said Resident #70's blood sugar and vital signs were checked, his pulse oximeter reading was in the low 90s at the beginning of the shift, and he could answer questions appropriately. RN #3 said staff checked Resident #70 approximately every hour throughout the night. RN #3 said Resident #70 kept saying he was okay, but he was still lethargic. RN #3 said when he fell , he was able to tell her that he rolled out of bed, and when she tried to get him to roll him over he had a red face. RN #3 said she did not receive any instructions regarding documentation of the incident, and she did not think she needed to contact the physician because Resident #70 was up and answering questions appropriately prior to going to bed. RN #3 said she felt Resident #70 was okay, and he was just lethargic. RN #3 said she initially thought he should have been sent out to the ED. RN #3 said when Resident #70 coded, she asked the physician why he was not sent out to the ED. RN #3 said the physician told her he was not informed of all of the medications that were included in the medication error, and she could not remember which medications the physician was aware of. On [DATE] at 10:35 AM, when asked about what should be documented when monitoring and assessing a resident after a significant medication error, UM #1 said I don't know that. He said, All I really know was I wasn't working on that unit, but as I recall they were monitoring his BP [blood pressure] and pulse for that shift, and level of consciousness. UM #1 said he did not know what was ordered regarding documentation for Resident #70. On [DATE] at 8:18 AM, Resident #70's sister said the facility had called her and told her about her brother passing, but she was not aware of the medication error. She said it surprised her that he died because he seemed to be doing really well. Resident #70's sister stated it may have been his daughters that brought the medication error to the attention of his case managers. On [DATE] at 1:12 PM, the DON said there was no documentation of vital signs that were taken after the time frame that was ordered by the Medical Director. She stated the nurse working the day shift on [DATE] did not write a progress note. The DON stated she could not answer why the assessments conducted by the nurse were not documented in Resident #70's record but stated they should have documented the assessments. 2. The facility's policy for Pharmacy Services, dated [DATE], documented the facility provided pharmaceutical services including assuring the accurate acquiring, receiving, dispensing, and administering of drugs and biologicals to meet the needs of each resident. The policy stated the pharmacy worked with the facility to ensure that medications were requested, received, and administered in a timely manner and as ordered by the prescriber. This policy was not followed. Resident #569 was admitted to the facility on [DATE], with multiple diagnoses including end stage renal disease, chronic obstructive pulmonary disease (COPD - a progressive lung disease that results in increasing breathlessness), and diarrhea. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Resident #569's record included physician orders, dated [DATE], for Symbicort (an inhaled medication to treat COPD),d+[DATE].5 mcg inhale 2 puffs orally two times a day for COPD, sodium bicarbonate (antacid) 650 mg 2 tablets by mouth two times a day for heartburn, and Creon capsule (a pancreatic enzyme replacement) delayed release particles 6000 Units 1 capsule by mouth three times a day for diarrhea. Resident #569's record included progress notes dated [DATE] at 5:09 PM and 5:17 PM, respectively, which documented the facility was awaiting delivery from the pharmacy to administer the Symbicort, sodium bicarbonate, and Creon. A packing list from the pharmacy documented medications were delivered to the facility on [DATE] at 6:46 PM. The packing list included the 3 medications ordered for administration to Resident #569 that evening. The medications were not administered as ordered. Resident #569's [DATE] MAR documented he had not received the sodium bicarbonate tablets, the Symbicort inhaler, or the Creon capsule on the evening of [DATE]. On [DATE] at 1:30 PM, the DON was interviewed regarding Resident #569 not receiving the 3 ordered medications on [DATE]. The DON said she did not know why the LPN did not administer the medications as ordered to Resident #569.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31867 Based on observation, policy review, review of Resident Council minutes, resident interview, Resident Group interview, test tray evaluation, and staff interview, it was determined the facility failed to ensure palatable food was served. This was true for 5 of 9 residents (#8, #34, #47, #120, and #420) reviewed for food and nutrition who ate in the Alpine and [NAME] dining rooms and/or in their rooms, and 6 of 8 residents (#9, #20, #27, #30, #44, and #67) in the Resident Group interview. This failed practice had the potential to negatively affect residents' nutritional status and psychosocial well-being. Findings include: The facility's food preparation and timely meal service policy, dated 11/28/17 and 02/2017; respectively, documented food was to be kept at appropriate levels to maintain flavor and palatability, and food would be delivered promptly. These policies were not followed. 1. On 12/8/19 at 10:22 AM, CNA #9 said there was not always enough staff to meet the needs of the residents. On 12/8/19 at 10:26 AM, CNA #6 said not all of the residents' needs were met due to low staffing levels. Resident Council Meeting minutes, dated 10/2/19, documented concerns of late breakfast room trays and Resident Council Meeting minutes, dated 11/6/19, documented concerns of late room trays. On 12/11/19 at 9:46 AM, the CDM said when the hall carts were ready, dietary staff called over the facility's radio to each unit and the CNAs on those units were expected to come to the kitchen to retrieve them and distribute the trays to the residents. She said there were times when staff would not come to retrieve the carts and dietary staff had to radio again to have unit staff deliver the carts. The facility's meal times were posted on the walls near the dining room of the [NAME] and Alpine units. The meals times documented breakfast was from 8:00 AM to 9:00 AM and lunch was from 12:00 PM to 1:00 PM. On 12/11/19 at 1:10 PM, the Administrator said he expected all residents to receive their breakfast by 9:00 AM and lunch by 1:00 PM. Observations of meal service were conducted. Meals were not served to all residents in a timely manner or at an appropriate temperature, as follows: a. Resident #47 was readmitted to the facility on [DATE], with multiple diagnoses including amyotrophic lateral sclerosis (ALS- a progressive neurodegenerative disease that affects nerve cells in the brain and the spinal cord). Resident #47's quarterly MDS assessment, dated 11/11/19, documented he was dependent on staff for all of his ADLs, including eating. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135146	A. Building B. Wing	12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascadia of Boise	6000 W Denton St Boise, ID 83704

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/8/19 at 1:08 PM, Resident #47's lunch tray had not been delivered or set up for him. No staff member was available to deliver the tray from the food cart, which was stationed in the hall near Resident #47's room. Other residents had received their meal trays, but a tray had not been provided to Resident #47 at that time. At 1:22 PM, an aide was in the hall cleaning a Hoyer mechanical lift (a device to help transfer residents), and she was returning dishes to the meal cart from resident rooms. A Regional staff member was in the hall walking past resident rooms and asking residents if they needed anything. No staff members went to Resident #47's room. At 1:29 PM, CNA #10 arrived at the meal cart, picked up a meal tray, and delivered it to Resident #47's room. CNA #10 began to set up the meal tray for Resident #47. The surveyor requested to check the temperature of the food on the tray. All the food was pureed or soft in texture. At 1:32 PM, the food temperatures were measured as follows: mashed potatoes were 115.3 degrees Fahrenheit, roast beef was 94.6 degrees Fahrenheit, carrots were 83.3 degrees Fahrenheit, and cottage cheese was 49.8 degrees Fahrenheit. CNA #10 left the room and talked to a nurse in the hall. The nurse told her to warm the food on Resident #47's tray. CNA #10 returned to the room and took the tray out of the room. On 12/9/19 at 9:40 AM, Resident #47 said his food was a little cooler, but staff warmed it up if he asked them to. Resident #47 said staff was often busy, and he received his lunch meal anywhere from before 1:00 PM to 1:30 PM. On 12/12/19 at 9:04 AM, CNA #10 said on 12/8/19 she was giving care in another room, and called for help about three times, and no one came to help and that was why I was late to deliver that tray. CNA #10 said a nurse called over the radio and asked if she was going to assist Resident #47, and CNA #10 said she was in another room providing assistance and asked if someone else would be able to assist Resident #47. CNA #10 said she did not receive a response to her request for someone else to assist Resident #47. CNA #10 said Resident #47 told her a nurse came to his room and asked him if he was ready to eat, and he said yes. Resident #47 told CNA #10 the nurse left the room and never came back, so he didn't get to eat until I got to him. CNA #10 said there were only two CNAs over here and sometimes when we ask for help, we just get ignored. Some of the residents can take up to an hour to help, leaving only one CNA on the floor and that is not enough. It leaves us rushing around trying to get things done. On 12/11/19 at 2:25 PM, the CDM said the kitchen staff started dishing up the hall trays at about 12:20 PM. The CDM said the aides then picked up the carts from the kitchen and took them out to the nursing unit at about 12:50 PM to deliver the meal trays to the residents. b. On 12/8/19 at 1:13 PM, lunch meal hall trays in the Alpine unit were observed to be delivered by UM #2 and he said hall trays were delivered after the dining rooms were served. At 1:18 PM, he delivered a hall tray to Resident #120. UM #2 came out of the room and said Resident #120 only wanted the cake from her meal tray. At 3:23 PM, Resident #120 said she refused her lunch tray because her tray was late again. She said because she could not wait for her tray, she ate snacks and was no longer hungry when her tray arrived. Resident #120 said her breakfast tray usually arrived late and her eggs were always cold. She said her lunch tray usually arrived between 1:30 PM and 2:30 PM. c. On 12/9/19 at 2:49 PM, Resident #9 said the good cooks went elsewhere so the facility hired from within, promoted other kitchen staff, and the quality dropped. She said the flavor, variety, and temperatures could be improved. Resident #9 reviewed the menu for the week and said potatoes were planned for 5 of 7 days that week. She said the facility offered a few options, but she was getting tired of those. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 12/10/19 at 8:30 AM, Resident #420, who normally ate in the Alpine dining room, said his fried eggs were cold and tasted like they were left in the refrigerator for the past year. e. On 12/10/19 at 8:36 AM, Resident #8, who normally ate in the Alpine dining room, said his fried eggs and the plate were cold. f. On 12/10/19 at 9:23 AM, Resident #120 was in her room and said she did not receive her breakfast hall tray. She said she was concerned she had not received her tray yet because she had therapy scheduled at 10:00 AM and needed the food for energy. At 9:32 AM, the hall tray cart arrived on the Alpine unit and the first breakfast hall tray was delivered to room A-6. At 9:41 AM, PTA #1 was near the nurses' station engaged in a conversation with Resident #120. PTA #1 asked Resident #120 if she was ready for therapy and Resident #120 told PTA #1 she needed to eat breakfast before therapy. At that time the meal tray cart passed by both of them toward Resident #120's room and Resident #120 followed the cart back to her room. At 9:43 AM, PTA #1 said she did not want Resident #120 to start her therapy session until after she ate and would come back later. At 9:55 AM, Resident #120 was in her room eating scrambled eggs and bacon and said her breakfast was barely lukewarm. g. On 12/10/19 at 2:35 PM, during the Resident Group interview, Resident #9, #20, #27, #30, #44, and #67 said meals were always served late and the food was lukewarm. h. On 12/12/19 at 9:22 AM, breakfast hall trays on the [NAME] unit were delivered by two staff from separate sister facilities. On 12/13/19 at 8:56 AM, one of the staff members who was a DON, said she and the other staff member were at the facility the previous day to help support the facility staff. She said they helped pass out hall trays the previous day and said they did not do that on a regular basis at the facility. i. On 12/11/19 at 3:00 PM, the RD provided a dining policy and said, Our policy is hot-things-hot, cold-things-cold. It is resident preference. On 12/12/19 at 9:15 AM, Cook #1 had five plates on the counter in front of the kitchen steam table. She plated breakfast meals and placed them on a warming pellet and were covered and placed on the hall cart. At 9:19 AM, one of the plates on the counter was used for a requested test tray, which included scrambled eggs, an over easy fried egg, sausage links, and french toast. At 9:24 AM, the test tray was evaluated by two surveyors along with the CDM. The french toast was 118 degrees Fahrenheit and the fried egg was 120 degrees Fahrenheit. The CDM said the fried egg and french toast could have been warmer. The surveyors determined the fried egg and french toast were not palatable due to the low temperature. The CDM said dietary staff normally kept plates warm in the steam table compartment prior to plating the food. The facility failed to ensure meals were served to all residents in a timely manner and at an appropriate temperature. 31923 37263 41819

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	135146	A. Building B. Wing	12/13/2019

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39184 Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with a diet that was consistent with physician orders. This was true for 1 of 4 residents (Resident #19) whose diet orders were reviewed. This failed practice created the potential for harm if residents experienced choking or adverse effects from ingesting a diet that was not in accordance with physician orders. Findings include: The facility's policy for Therapeutic Diets and Meal Plans, dated 11/28/17, documented the following: * The facility provided therapeutic diets when a resident's medical/nutrition diagnosis identified the need to modify the resident's meal plan. * The registered dietician assessed residents for the necessity of a therapeutic meal plan at the initial nutrition assessment, throughout the resident's admission, and as necessary. * A diet order was obtained for the appropriate therapeutic meal plan. * The resident's therapeutic meal plan was documented in the medical record and on the meal tray ticket, as a method of communicating the prescribed diet to staff. The facility's policy for Aspiration (when food or liquid becomes inhaled into the lungs) Risk with Dysphagia (a swallowing disorder), dated 2/28/18, documented the following: * A trained dysphagia clinician performed assessment of the resident and assisted with determining the best approach and interventions on a person-centered basis. * The primary methods to prevent aspiration included texture modification of food/liquids. These policies were not followed. Resident #19 was admitted to the facility on [DATE], with multiple diagnoses including stroke, hemiplegia and hemiparesis (weakness and paralysis on one side), and dysphagia. Resident #19's care plan documented she had a nutritional problem or potential nutritional problem related to stroke and altered textures, initiated on 2/12/19 and revised on 12/3/19. The care plan directed staff to provide and serve the diet as ordered: Regular mechanical soft, nectar thick, fortified, puree vegetables. The intervention was initiated on 2/12/19 and revised on 12/3/19. Resident #19 had an order dated 4/5/19 for a regular diet, mechanical soft texture, nectar thick consistency, fortified meals, and pureed vegetables were okay. The diet was order was revised on 12/9/19 to regular diet, pureed texture, nectar thick consistency, and Resident #19 could have thin liquids between meals. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/9/19 at 2:45 PM, Resident #19 was lying awake in bed turned slightly towards her right side, and the head of the bed was elevated at approximately 20 to 30 degrees. An overbed table was in place over Resident #19's lap, and a box of Cheeze-It crackers and chocolate-covered peanut butter balls were on the table and were open in front of her. On 12/9/19 at 2:50 PM, UM #1 said Resident #19 should not eat unattended, and he was not sure of her diet order or if the items in front of her were consistent with her ordered diet but he would check. UM #1 said perhaps Resident #19's family brought the food in for her. On 12/10/19 at 8:29 AM, Resident #19 was at the dining table for breakfast. The food items in front of her included toast, a Danish pastry, ground sausage and gravy, and a bowl of Fruit Loops cereal partially covered in thickened milk. Resident #19's meal ticket documented her diet order was mechanical soft/pureed vegetables, and nectar thick fluids. Resident #19's physician orders at that time documented a regular diet, pureed texture, nectar thick consistency, and she could have thin liquids between meals, which started on 12/9/19. CNA #11 was present at the table with Resident #19, and he fed her a total of 4 bites of the Danish pastry. CNA #11 said the cereal in front of Resident #19 was probably not mechanical soft, and he was not aware of any changes to her diet orders. CNA #11 said he would find out about changes to residents' diet orders by looking at their meal ticket, or he could ask the Speech Therapist. On 12/10/19 at 8:38 AM, UM #1 observed Resident #19's breakfast meal on the table in front of her, and he said her diet order was mechanical soft and thickened liquids. UM #1 then reviewed Resident #19's physician orders and said Resident #19's diet order was for pureed food. UM #1 said the food on the table in front of Resident #19 did not look pureed, and he was not aware of the new diet order. On 12/10/19 at 8:50 AM, the CDM said Resident #19's diet was changed to pureed, and the order came in the previous night. The CDM said when a resident's diet order was changed, the UM was given a diet slip and there was diet information for staff to refer to. The CDM said Resident #19's diet slip was not correct. On 12/10/19 at 10:18 AM, the Speech Therapist said when she had diet recommendations for a resident, she completed a diet order form, then she provided a copy to the nurse and to the kitchen. The Speech Therapist said if a diet order was completed right before a meal, she provided it to the kitchen in writing and verbally. The Speech Therapist said she recommended pureed solids and nectar thick liquids for Resident #19, and the diet change was ordered on 12/9/19 due to increased coughing in the dining room. The Speech Therapist said she was informed Resident #19's son was bringing in outside food to her, so it was time to reassess her. The Speech Therapist said the Cheeze-It crackers and chocolate covered peanut butter balls were not appropriate for Resident #19, and the food provided to her at breakfast that morning was absolutely not appropriate. I recommended pureed. The Speech Therapist said Resident #19 had a long-term swallowing problem and a history of stroke. On 12/10/19 at 4:28 PM, the RD said the Cheeze-It crackers and chocolate covered peanut butter balls were not on Resident #19's diet, and her family brought them into the facility.

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	135146	A. Building B. Wing	12/13/2019

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37263 Based on observation, resident and staff interview, and record review, it was determined the facility failed to follow a resident's meal preference. This was true for 1 of 4 residents (Resident #420) reviewed for food preferences. This failure created the potential for harm if residents experienced hunger or weight loss for not having complete meals served. Findings include: Resident #420 was admitted to the facility on [DATE], with multiple diagnoses including failure to thrive. Resident #420's breakfast ticket documented his standing orders for breakfast were oatmeal with raisins. On 12/10/19 at 8:36 AM, Resident #420 did not have raisins for his oatmeal. Resident #420 stated he received oatmeal with raisins every day for breakfast per his preferences. Resident #420 picked up his breakfast ticket and pointed at the preferences for oatmeal and in parentheses the ticket documented, W/Raisins. Resident #420 stated he would only eat his oatmeal with raisins and he refused to eat his oatmeal until he received raisins to put in his oatmeal. Resident #420 requested raisins to the Director of Rehabilitation and she delivered a cup full of raisins to him at 8:42 AM. Resident #420 stated his oatmeal was cold and did not want to eat it now. On 12/10/19 at 8:43 AM, CNA #12 stated Resident #420's breakfast ticket was specific on his preferences. CNA #12 stated Resident #420's raisins should be delivered to him in a small cup with his whole meal and he should not have to wait for them. On 12/10/19 at 8:45 AM, UM #2 stated the meal tickets included resident preferences to notify the staff member delivering the tray what specific requests residents wanted to avoid a delay in waiting for the completed meal. UM #2 stated Resident #420's meal ticket documented he wanted oatmeal with raisins and the raisins should have been delivered at the same time with his oatmeal.

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	135146	A. Building B. Wing	12/13/2019

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 31867 Based on record review, policy review, review of Resident Council minutes, review of staffing schedules, review of the Facility Assessment, review of the Resident Census and Conditions, and resident, resident representative, and staff interview, it was determined the facility failed to ensure services were provided which maintained residents' highest practicable level of well-being for 26 of 26 residents (#4, #6, #9, #10, #12, #13, #14, #15, #19, #20, #24, #30, #33, #34, #39, #44, #47, #52, #55, #56, #57, #62, #65, #66, #120, #420, and #569) who were reviewed, and had the potential to affect the other 48 residents in the facility. This administration failed to act when they had knowledge of issues and concerns pertaining to the receipt of appropriate care and services and lack of sufficient staff. Findings include: The facility's Facility Administration policy, dated 11/28/17, documented the Administrator was responsible for establishing and implementing policies regarding the management and operation of the facility. The policy stated the facility operates and provides services that follow accepted professional standards and principles of practice. The policy also stated the facility has a governing body consisting of the Administrator, Director of Nursing Services, and Medical Director that is legally responsible for establishing and implementing policies regarding the management and operation of the facility. This policy was not followed. Administration was aware of the issues and concerns with resident care and did not act to ensure residents attained and/or maintained physical, mental, and psychosocial well-being. Examples include: 1. The facility's policy Facility Assessment, dated 11/28/17, documented the following: * The facility evaluated its resident population and identified the resources needed to provide the necessary care and services to its residents competently during daily operations and during emergencies. * The facility reviewed and updated the assessment whenever there was, or the facility planned for, any changes that required a substantial modification to any part of the assessment. The facility assessment addressed or included the following: - The facility's resident population, including but not limited to the number of residents and the facility's resident capacity. - The care required by the resident population with consideration of the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other relevant facts that were present within that population. - The facility's resources, including but not limited to all personnel, including managers and staff (facility employees and those who provided services under contract). (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. The Facility Assessment Tool, dated 7/1/19, documented the average daily census was 58 residents. The tool documented the number of residents in the facility who required the specified treatment/services listed, but did not account for all 58 residents. Examples included, but were not limited to, the following: - The Assistance with Activities of Daily Living section of the tool documented the assistance residents required for dressing which stated 1 resident was independent, 15-20 residents required assistance of 1-2 staff, and 5-7 residents were dependent upon staff, for a maximum total of 28 residents' needs being accounted for (i.e. 1 independent, plus 20 requiring 1-2 staff, plus 7 dependent on staff, equaling 28 total residents accounted for). The Assessment Tool did not include information related to the dressing needs of the 30 other residents required to account for the facility's average daily census of 58 residents (58 total residents, minus 28 residents accounted for, equaling 30 residents not accounted for). - The Assistance with Activities of Daily Living section of the tool documented the assistance residents required for bathing which stated 1 resident was independent, 15-20 residents required assistance of 1-2 staff, and 10-15 residents were dependent upon staff, for a maximum total of 36 residents' needs being accounted for (i.e. 1 independent, plus 20 requiring 1-2 staff, plus 15 dependent on staff, equaling 36 total residents accounted for). The Assessment Tool did not include information related to the bathing needs of the 22 other residents required to account for the facility's average daily census of 58 residents (58 total residents, minus 36 residents accounted for, equaling 22 residents not accounted for). - The Assistance with Activities of Daily Living section of the tool documented the assistance residents required for transfers which stated 2 residents were independent, 15-20 residents required assistance of 1-2 staff, and 10-15 residents were dependent upon staff, for a maximum total of 37 residents' needs being accounted for (i.e. 2 independent, plus 20 requiring 1-2 staff, plus 15 dependent on staff, equaling 37 total residents accounted for). The Assessment Tool did not include information related to the transfer needs of the 21 other residents required to account for the facility's average daily census of 58 residents (58 total residents, minus 37 residents accounted for, equaling 21 residents not accounted for). - The Assistance with Activities of Daily Living section of the tool documented the assistance residents required for eating which stated 15-20 residents were independent, 5-10 residents required assistance of 1-2 staff, and 4-7 residents were dependent upon staff, for a maximum total of 37 residents' needs being accounted for (i.e. 20 independent, plus 10 requiring 1-2 staff, plus 7 dependent on staff, equaling 37 total residents accounted for). The Assessment Tool did not include information related to the eating needs of the 21 other residents required to account for the facility's average daily census of 58 residents (58 total residents, minus 37 residents accounted for, equaling 21 residents not accounted for). The facility failed to ensure the Assessment Tool accounted for all resident needs based on the facility's average daily census. b. The Facility Assessment Tool, dated 7/1/19, was compared to the Resident Census and Conditions of Residents form completed during the survey on 12/9/19. The Facility Assessment Tool had not been updated to reflect the facility's population. Examples included, but were not limited to, the following: (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- The Facility Assessment Tool documented the average daily census was 58 residents. However, the Resident Census and Conditions of Residents form documented the facility's census was 74 residents. On 12/13/19 at 8:40 AM, the Administrator was shown the Facility Assessment Tool, dated 7/1/19. The Administrator stated the average daily census was 58 at the time the assessment was completed, and the current average daily census was 72. - The Facility Assessment Tool documented the number of residents in the facility who required the specified treatment/services which included: Respiratory Treatments: Oxygen therapy: 16-18 residents Suctioning: 10-12 residents Tracheostomy care: 2-3 Mental Health: Behavioral Health Needs: 15-20 residents Other: Injections: 3-4 residents Dialysis: 3 residents Ostomy care: 2-3 residents However, the Resident Census and Conditions of Residents form documented the following current resident needs: Respiratory Treatments: Respiratory treatment: 27 residents Suctioning: 13 residents Tracheostomy care: 13 residents Mental Health Behavioral Health Needs: 58 residents Other Injections: 17 residents (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dialysis: 4 residents Ostomy care: 5 residents The facility failed to ensure the Assessment Tool was updated to account for the increased number of residents and their increased needs. c. The Facility Assessment Tool documented the facility's staffing plan included providing a total of 4.5 to 5.5 hours of nursing care per resident per day, which included RNs, LPNs, CNAs, NAs, and hospitality aides (non-skilled care). Hospitality aides are not allowed to provide nursing care and should not be reflected in the nursing care hours. The direct care nursing hours worked from 11/17/19 through 12/7/19 were reviewed. The staffing levels did not meet the 4.5 to 5.5 hours planned in the Facility Assessment Tool. The days for which the hours did not meet nursing care were as follows: Sunday, 11/17/19 - 4.01 Saturday, 11/23/19 - 4.3 Sunday, 11/24/19 - 3.82 Saturday, 11/30/19 - 4.32 Sunday, 12/1/19 - 3.90 Saturday, 12/7/19 - 4.09 On 12/12/19 at 4:38 PM, the DON together with the Clinical Resource Nurse was asked if the Facility Assessment included a determination of the level and competency of staff needed to meet each residents' needs each day and during emergencies. The DON said Yes. Both the DON and the Clinical Resource Nurse said the planned nursing hours per resident per day was 4.5 hours to 5.5 hours. The DON and the Clinical Resource Nurse stated they were not aware the staffing levels for the past three weekends did not meet the planned staffing levels according to the Facility Assessment. The staffing plan was not updated to include additional staff based on the facility's increased number of residents and their increased needs, as documented on the Resident Census and Conditions of Residents form. On 12/12/19 at 5:15 PM, the Administrator and the Director of Operations were interviewed regarding the facility's staffing and the nursing hours per resident per day documented in the Facility Assessment Tool. The Administrator stated the nursing hours per resident per day in the assessment would have changed because the census was now higher than when the assessment was completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135146	A. Building B. Wing	12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascadia of Boise	6000 W Denton St Boise, ID 83704

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/13/19 at 8:40 AM, the Administrator stated the assessment was a fluid document, which could be updated and changed. When asked if the per resident per day staffing referenced in the assessment was current and valid, the Administrator stated it was not indicative of the current staffing because the average daily census was 58 at the time the assessment was completed, and the current average daily census was 72. (This represented an increase of 24% in the average daily census since the Facility Assessment Tool was completed). The facility failed to ensure the Assessment Tool was updated to account for the facility's increased staffing needs. 2. The facility's Grievance policy, dated 11/28/17, documented the facility would make prompt efforts to resolve grievances, including Resident Council concerns, and to keep residents notified of progress toward resolution. Resident Council Meeting minutes, dated 9/4/19, documented concerns with call light response times up to 30 minutes and very slow response times during meals. Resident Council Meeting minutes, dated 10/2/19, documented concerns with call light response times up to one and a half hours, not enough staff, staff saying they would come back to help residents and did not, and breakfast served in resident rooms were late. There was no documentation what actions were taken to resolve the concerns identified in the 9/4/19 meeting. Resident Council Meeting minutes, dated 11/6/19, documented concerns with call light response times up to two hours, long response times during shift change, staff saying they would come back to help residents and did not come back, and room trays were late due to not enough staff to pass out trays. There was no documentation what actions were taken to resolve the concerns identified in the 9/4/19 or 10/2/19 meetings. Resident Council Meeting minutes, dated 12/4/19, documented concerns with not enough staff on the weekends and not all the residents were getting showers as scheduled. There was no documentation what actions were taken to resolve the concerns identified in the 9/4/19, 10/2/19, and 11/6/19 meetings. On 12/10/19 at 2:35 PM, during the Resident Group interview, Residents #9, #30, and #44 said there were still issues with slow call light response times, not enough staff, low food temperatures, and late delivery of trays. They stated these concerns were not addressed by the facility. On 12/11/19 at 9:36 AM, the Activity Director said she emailed the Resident Council meeting notes to the department heads. She said she had not been given direction to readdress the old complaints during the Resident Council meetings. The Activity Director said the Administrator met individually with the Resident Council President to address the Resident Council concerns. On 12/11/19 at 1:10 PM, the Administrator said he met with the Resident Council President and relied on the council's President to report back to the Resident Council. The Administrator provided minutes for meetings with the council's President for 11/11/19 and 11/27/19. The minutes did not document a discussion of not enough staff, staff saying they will come back to help residents and then not coming back, and late meal trays. The Administrator said he did not see where concerns were readdressed in the Resident Council minutes. The Administrator said he expected Resident Council concerns to be addressed. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Facility staffing was insufficient to meet the care and needs of the residents and to respond to resident concerns. Examples include: a. Residents and their representatives were interviewed and stated the facility did not have sufficient staff to meet their needs. - On 12/8/19 at 10:22 AM, Resident #9 said her roommate was put to bed in her pants but had sat in her wheelchair prior to transfer and had peed and wet her pants. Resident #9 said she called staff to come and change her roommate's pants. Resident #9 said her roommate is unable to advocate for herself, had sat wet for an hour, and the staff had not checked on her. Resident #9 said when she moved here in February of 2019, there were 50 residents. She said the census went up to 75 residents, but they did not hire more people. Resident #9 said there were 2 CNAs most of the time on day shift, with 1 CNA at night. She said they needed an extra CNA in the morning and afternoon, and 2 CNAs at night, and they were not provided. - On 12/8/19 at 11:33 AM, Resident #120 said there were not enough staff to administer her medications on time, give her showers when she was scheduled, and said on the weekends call lights were not answered timely. - On 12/8/19 at 5:20 PM, Resident #569 stated he came to the facility from an acute care hospital on 12/6/19, and he was admitted for physical therapy and to gain strength in his legs prior to hip surgery. Resident #569 said since he was admitted to the facility, the service had been very slow. He said sometimes when he put on his call light it took 10 to 15 minutes to get a response, and sometimes no one came at all. Resident #569 stated, I believe they are under-staffed here. - On 12/9/19 at 10:54 AM, Resident #25's spouse said there were not enough staff on the weekends to assist with residents with their meals, meals are generally late, and there are not enough staff to take care of residents' hygiene needs. - On 12/10/19 at 12:25, Resident #12's daughter stated hospice has helped her with addressing her problems with the facility staff. She stated last Thursday evening the staffing board documented there were 3 nurses and they had to get someone from another hall to assist Resident #12 to bed. Resident #12's daughter stated she has been sent to appointments without her hair being brushed. - On 12/10/19 at 2:35 PM, during the Resident Group interview, Residents #9, #20, #27, #30, and #44 said showers were not being completed, especially on Saturdays. - On 12/10/19 at 3:02 PM, the co-guardians for Resident #70 stated when they went in to visit or take him to an appointment he often had a wet adult brief and the staff were not changing him. One of the guardians stated they had taken Resident #70 to an appointment and at the appointment a wound was found on his leg. The guardian stated the nurse at the appointment stated the wound should have been identified by the facility it had been there for a while. The guardian stated the staff at the facility should have been performing weekly skin checks to identify these types of issues. b. Staff were interviewed and stated there was not sufficient staff to provide the cares required and to meet the needs of the residents. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- On 12/8/19 at 10:22 AM, CNA #9 said there were not always enough staff to meet the needs of the residents. - On 12/8/19 at 10:42 AM, LPN #1 said there are not enough staff because there were several residents who required 2-person assistance with transfers. - On 12/9/19 at 1:57 PM, CNA #18 said she started working as Shower Aide about 3 months ago. CNA #18 said she was asked about 3 times to work on the floor because of staff call offs. CNA #18 said showers were not completed on those days she was asked to work on the floor as a CNA. - On 12/10/19 at 9:10 AM, RNA #1 said he was working as a CNA and said would not be able to do the RNA program today. When asked who would be doing the RNA program for the residents. RNA #1 said Nobody. RNA #1 said he was pulled out to work as a CNA about four to five times since he started working as an RNA six months ago. - On 12/11/19 at 2:04 PM, CNA #6 stated they don't have enough care givers. CNA #6 said residents who were using mechanical lifts received their showers on Wednesdays and Saturdays and there was not enough staff scheduled on Saturdays. CNA #6 said there was no shower aides on Saturdays. CNA #6 also said the razor blade got dull and one resident had not been shaved for a week, and he got shaved only during his shower days. CNA #6 said she had requested to have the Saturday's showers changed because of there was no shower aide but she got no response. -On 12/11/19 at 3:45 PM, CNA #7 was asked if the facility staffing was adequate to assist residents with meals. CNA #7 said there was not enough staff to assist residents during meals or anything else unless the survey team was in the building. Then all personnel from the office would come on the floor and help. - On 12/12/19 at 9:04 AM, CNA #10 said there were only two CNAs over here and sometimes when we ask for help, we just get ignored. Some of the resident can take up to an hour to help, leaving only one CNA on the floor and that is not enough. It leaves us rushing around trying to get things done. On 12/13/19 at 9:45 AM, RN #5 said there was staffing problem in the facility that was why she worked as a CNA on 12/8/19. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. On 12/13/19 at 9:53 AM, the Administrator, with the President Cascadia South present, said the Quality Assessment Performance Improvement (QAPI) committee had identified treatment of pressure ulcers was an issue and had addressed it by sending the Wound Nurse through specialized training. The Administrator said the facility was not perfect yet and was still trying to work on prevention of facility acquired pressure ulcers. The President Cascadia South said the facility admitted complex residents with lots of care needs and staff were still adjusting to the increase in the number of residents that were being admitted . The Administrator and the President Cascadia South said the staffing levels of 4.5 to 5.5 hours per resident per day, documented in the Facility Assessment, was the goal for the facility. The Administrator said the facility did not always have the staff to meet that level. He said the facility was still working on trying to provide resident meals on time, which was generally 50% of the time. The Administrator presented a QAPI meal service monitoring document, he said it was used for staff to be able to better monitor tray delivery. The Administrator said as part of QAPI, the facility had added a shower aide but still had issues completing all of the necessary showers. He said the previous day a DON from a sister facility was working with the facility staff to help modify the residents' shower schedule to make sure showers were not being missed. The President Cascadia South said the facility was still trying to build the core group of staff who could turn the facility in the right direction. The Administrator said during the last survey, the facility was cited for lack of hand hygiene during wound care. He was informed of the infection control observations during the current survey and he said he expected the SDC and the DON to monitor infection control practices. The Administrator said during the last survey, the facility was also cited for dignity for not offering residents clothing protectors prior to placing them on and it was part of QAPI. He was informed of the dignity concerns and the dignity with dining experiences and he said the facility did not do a good job at complying with that regulation. 5. Please refer to F550 as it related to the facility's failure to ensure residents were not harmed due to a lack of respect and dignity. 6. Please refer to F552 as it related to the facility's failure to ensure appropriate consent was obtained. 7. Please refer to F677 as it related to the facility's failure to provide bathing and showers to meet the residents' needs. 8. Please refer to F684 as it related to the facility's failure to provide care and services which were provided following professional standards of practice. 9. Please refer to F686 as it related to the facility's failure ensure residents were not harmed due to lack of treatment and services to prevent and heal pressure ulcers. 10. Please refer to F689 as it related to the facility's failure to ensure residents were not harmed due to improper use of equipment and residents were protected from falls and injuries. 11. Please refer to F725 as it related to lack of sufficient staff to meet residents' needs. 12. Please refer to F760 as it related to the facility's failure to ensure residents were not harmed due to lack of identifying adverse effects of medications and acted upon promptly and were free of both significant and non-significant medication errors.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 18639 Based on review of the Facility Assessment Tool, policy review, and staff interview, it was determined the facility failed to ensure the Facility Assessment was updated to reflect the current levels of staffing required to meet the needs of all 74 residents residing at the facility. This had the potential to result in insufficient staffing to meet the needs of the residents. Findings include: The facility's policy Facility Assessment, dated 11/28/17, documented the following: * The facility evaluated its resident population and identified the resources needed to provide the necessary care and services to its residents competently during daily operations and during emergencies. * The facility reviewed and updated the assessment whenever there was, or the facility planned for, any changes that required a substantial modification to any part of the assessment. The facility assessment addressed or included the following: - The facility's resident population, including but not limited to the number of residents and the facility's resident capacity. - The care required by the resident population with consideration of the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other relevant facts that were present within that population. - The facility's resources, including but not limited to all personnel, including managers and staff (facility employees and those who provided services under contract). a. The Facility Assessment Tool, dated 7/1/19, documented the average daily census was 58 residents. The tool documented the number of residents in the facility who required the specified treatment/services listed, but did not account for all 58 residents. Examples included, but were not limited to, the following: - The Assistance with Activities of Daily Living section of the tool documented the assistance residents required for dressing which stated 1 resident was independent, 15-20 residents required assistance of 1-2 staff, and 5-7 residents were dependent upon staff, for a maximum total of 28 residents' needs being accounted for (i.e. 1 independent, plus 20 requiring 1-2 staff, plus 7 dependent on staff, equaling 28 total residents accounted for). The Assessment Tool did not include information related to the dressing needs of the 30 other residents required to account for the facility's average daily census of 58 residents (58 total residents, minus 28 residents accounted for, equaling 30 residents not accounted for). (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- The Assistance with Activities of Daily Living section of the tool documented the assistance residents required for bathing which stated 1 resident was independent, 15-20 residents required assistance of 1-2 staff, and 10-15 residents were dependent upon staff, for a maximum total of 36 residents' needs being accounted for (i.e. 1 independent, plus 20 requiring 1-2 staff, plus 15 dependent on staff, equaling 36 total residents accounted for). The Assessment Tool did not include information related to the bathing needs of the 22 other residents required to account for the facility's average daily census of 58 residents (58 total residents, minus 36 residents accounted for, equaling 22 residents not accounted for). - The Assistance with Activities of Daily Living section of the tool documented the assistance residents required for transfers which stated 2 residents were independent, 15-20 residents required assistance of 1-2 staff, and 10-15 residents were dependent upon staff, for a maximum total of 37 residents' needs being accounted for (i.e. 2 independent, plus 20 requiring 1-2 staff, plus 15 dependent on staff, equaling 37 total residents accounted for). The Assessment Tool did not include information related to the transfer needs of the 21 other residents required to account for the facility's average daily census of 58 residents (58 total residents, minus 37 residents accounted for, equaling 21 residents not accounted for). - The Assistance with Activities of Daily Living section of the tool documented the assistance residents required for eating which stated 15-20 residents were independent, 5-10 residents required assistance of 1-2 staff, and 4-7 residents were dependent upon staff, for a maximum total of 37 residents' needs being accounted for (i.e. 20 independent, plus 10 requiring 1-2 staff, plus 7 dependent on staff, equaling 37 total residents accounted for). The Assessment Tool did not include information related to the eating needs of the 21 other residents required to account for the facility's average daily census of 58 residents (58 total residents, minus 37 residents accounted for, equaling 21 residents not accounted for). The facility failed to ensure the Assessment Tool accounted for all resident needs based on the facility's average daily census. b. The Facility Assessment Tool, dated 7/1/19, was compared to the Resident Census and Conditions of Residents form completed during the survey on 12/9/19. The Facility Assessment Tool had not been updated to reflect the facility's population. Examples included, but were not limited to, the following: - The Facility Assessment Tool documented the average daily census was 58 residents. However, the Resident Census and Conditions of Residents form documented the facility's census was 74 residents. On 12/13/19 at 8:40 AM, the Administrator was shown the Facility Assessment Tool, dated 7/1/19. The Administrator stated the average daily census was 58 at the time the assessment was completed, and the current average daily census was 72. - The Facility Assessment Tool documented the number of residents in the facility who required the specified treatment/services which included: Respiratory Treatments: Oxygen therapy: 16-18 residents (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Suctioning: 10-12 residents Tracheostomy care: 2-3 Mental Health: Behavioral Health Needs: 15-20 residents Other: Injections: 3-4 residents Dialysis: 3 residents Ostomy care: 2-3 residents However, the Resident Census and Conditions of Residents form documented the following current resident needs: Respiratory Treatments: Respiratory treatment: 27 residents Suctioning: 13 residents Tracheostomy care: 13 residents Mental Health Behavioral Health Needs: 58 residents Other Injections: 17 residents Dialysis: 4 residents Ostomy care: 5 residents The facility failed to ensure the Assessment Tool was updated to account for the increased number of residents and their increased needs. c. The Facility Assessment Tool documented the facility's staffing plan included providing a total of 4.5 to 5.5 hours of nursing care per resident per day, which included RNs, LPNs, CNAs, NAs, and hospitality aides (non-skilled care). Hospitality aides are not allowed to provide nursing care and should not be reflected in the nursing care hours. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The direct care nursing hours worked from 11/17/19 through 12/7/19 were reviewed. The staffing levels did not meet the 4.5 to 5.5 hours planned in the Facility Assessment Tool. The days for which the hours did not meet nursing care were as follows: Sunday, 11/17/19 - 4.01 Saturday, 11/23/19 - 4.3 Sunday, 11/24/19 - 3.82 Saturday, 11/30/19 - 4.32 Sunday, 12/1/19 - 3.90 Saturday, 12/7/19 - 4.09 On 12/12/19 at 4:38 PM, the DON together with the Clinical Resource Nurse was asked if the Facility Assessment included a determination of the level and competency of staff needed to meet each residents' needs each day and during emergencies. The DON said Yes. Both the DON and the Clinical Resource Nurse said the planned nursing hours per resident per day was 4.5 hours to 5.5 hours. The DON and the Clinical Resource Nurse stated they were not aware the staffing levels for the past three weekends did not meet the planned staffing levels according to the Facility Assessment. The staffing plan was not updated to include additional staff based on the facility's increased number of residents and their increased needs, as documented on the Resident Census and Conditions of Residents form. On 12/12/19 at 5:15 PM, the Administrator and the Director of Operations were interviewed regarding the facility's staffing and the nursing hours per resident per day documented in the Facility Assessment Tool. The Administrator stated the nursing hours per resident per day in the assessment would have changed because the census was now higher than when the assessment was completed. On 12/13/19 at 8:40 AM, the Administrator stated the assessment was a fluid document, which could be updated and changed. When asked if the per resident per day staffing referenced in the assessment was current and valid, the Administrator stated it was not indicative of the current staffing because the average daily census was 58 at the time the assessment was completed, and the current average daily census was 72. (This represented an increase of 24% in the average daily census since the Facility Assessment Tool was completed). The facility failed to ensure the Assessment Tool was updated to account for the facility's increased staffing needs.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42346 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure care was coordinated with hospice services to meet resident needs. This was true for 1 of 2 residents (Resident #55) reviewed for hospice services. This failure had the potential for harm if residents received inadequate care from the facility and/or hospice agency due to a lack of care coordination. Findings include: The facility's policy for hospice services, dated 11/29/17, documented the facility had a written agreement with hospice services which included delineation of hospice responsibilities, including nursing and all other necessary care of the resident. The policy documented the facility had the responsibility to meet the residents' personal cares or nursing needs and coordinated these with the hospice representative. This policy was not followed. Resident #55 was admitted to the facility on [DATE], with multiple diagnoses, which included Parkinson's Disease (a progressive disease of the central nervous system that affects movement) and Lewy Body Dementia (progressive brain disorder triggered by abnormal deposits of protein in the brain). Resident #55's MDS assessment initiated on 11/11/19, documented Resident #55 was admitted for hospice services. Resident #55's hospice delineation of duties dated 11/1/19, documented the facility was responsible for 24-hour room and board, personal care and nursing needs of residents. The delineation of duties did not include details of what cares or tasks each nursing home or hospice discipline was responsible for completing. The delineation of duties document also did not include how communication would be documented between the facility and hospice agency. Resident #55's care plan, initiated 11/18/19, documented Resident #55 implemented end of life care with a hospice agency with an intervention to coordinate aspects of his care with the hospice agency. The care plan did not include documentation of the detailed responsibilities or care provided between the facility and the hospice agency. On 12/12/19 at 8:27 AM, CNA #12, who was a shower aide for the facility, stated she did not know what cares the hospice agency was responsible for. CNA #12 said she did not know when the hospice agency gave showers to Resident #55. CNA #12 said if she did not know if Resident #55 received a shower, she gave him one. On 12/10/19 at 2:36 PM, the DON stated care plans should include documentation of delineation of care with a hospice agency. The DON stated hospice coordinated with nursing staff and then provided a note that was scanned into the record. The DON was unable to find delineation of cares for Resident #55 in the care plan. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/13/19 at 9:19 AM, UM #2 stated he was unable to locate the delineation of cares in Resident #55's care plan which documented what services hospice, or the facility personnel, performed. The facility failed to incorporate Resident #55's delineation of care, how communication was documented, or details of what tasks each discipline completed between the facility and hospice on his care plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37263 Based on observation, staff interview, and policy review, it was determined the facility failed to ensure staff performed hand hygiene and followed professional standards of practices for infection prevention. This was true for 3 of 21 residents (#15, #24, and #57) who were observed for infection prevention. These failures placed residents at risk for infection due to cross contamination and potential exposure to bacteria and other pathogens. Findings include: The facility's policy Transmission-Based Precautions, dated 10/1/17, documented the facility's staff were to notify the designated Infection Prevention Nurse of suspected infectious or communicable disease, place the resident on appropriate transmission-based precautions, post precaution signage outside the resident room, and educate the staff on the importance of hand hygiene and using appropriate personal protective equipment (PPE). The appropriate PPE included hand hygiene, gloves, gowns, and masks. The facility's Hand Hygiene/Handwashing policy, dated 11/28/19, documented hand hygiene was to be performed after removal of medical/surgical or utility gloves, intermittently after gloves were removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients of environments and during moving from a contaminated body site to a clean body site during patient care. These policies were not followed. 1. On 12/11/19 at 8:00 AM, when entering the facility there were signs posted on the front door and at the lobby desk to warn visitors the facility was experiencing a viral gastrointestinal virus and requested visitors come back later to avoid exposure. On 12/11/19 at 8:20 AM, the DON stated there were five residents who were identified as having gastrointestinal symptoms and they resided on one hall. The DON stated all the residents on the one hall were instructed to stay in their rooms for meals. The DON stated one staff member was identified as having the gastrointestinal symptoms and was not at work. The DON stated the five residents who were identified had an isolation caddy hung on their door to alert staff to follow the appropriate PPE precautions. On 12/11/19 at 8:38 AM, an isolation caddy was observed hanging on the backside of Resident #57's open door. There was no sign or direction of what precautions were to be taken. On 12/11/19 at 8:40 AM, the DON was observed entering Resident #57's room with a breakfast tray without applying a gown, gloves, or a mask. The DON exited Resident #57's room and applied hand sanitizer to both hands. On 12/11/19 at 8:46 AM, the DON was observed re-entering Resident #57's room without applying a gown, gloves, or a mask. The DON exited the room applying hand sanitizer to both hands. On 12/11/19 at 8:47 AM, the DON was observed re-entering Resident #57's room without applying a gown, gloves, or mask. The DON exited the room applying hand sanitizer to both hands. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135146	A. Building B. Wing	12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascadia of Boise	6000 W Denton St Boise, ID 83704

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/19 at 8:48 AM, the DON stated she did not see the isolation caddy on the back of the door. The DON stated there should have been a sign to warn the staff of isolation precautions and the isolation caddy should have been hung up on the front side of the door. 2. Resident #24 was admitted to the facility on [DATE], with multiple diagnoses including muscle weakness and cerebral palsy. On 12/9/19 from 1:08 PM to 1:23 PM, Resident #24 was in the Alpine day room watching TV. An oven mitt, with a detachable strap, was on the floor next to her wheelchair. LPN #2 picked up the oven mitt off the floor with her gloved right hand and placed it in Resident #24's lap. LPN #2 did not remove her gloves or perform hand hygiene after picking up the mitt from the floor. LPN #2 and CNA #2 assisted Resident #24 into her room to perform cares. In the room, LPN #2 removed the oven mitt strap with her gloved hands and set the strap on the bedside stand and the oven mitt on the dresser. LPN #2 then picked up a clean mitt from the dresser drawer and set it on the dresser. At 1:14 PM, LPN #2 then assisted CNA #2 to transfer Resident #24 with a Hoyer lift (a mechanical lift) into her bed. LPN #2 assisted CNA #2 to remove and replace Resident #24's incontinent brief. LPN #2 then removed her original gloves and washed her hands in the bathroom sink. LPN #2 then donned new gloves and retrieved a new strap from the dresser and the clean oven mitt off the dresser and placed the mitt on Resident #24's right hand and the strap around her elbow. LPN #2 then lowered the bed with the bed controls, positioned the call light on Resident #24, placed a mat on the floor, moved the Hoyer lift out of the room, then removed her gloves and used hand sanitizer. On 12/9/19 at 1:24 PM, LPN #2 said she should have placed Resident #24's dirty mitt into a bag to be washed and should have removed her gloves and sanitized her hands. LPN #2 said she should not have touched clean items after she touched dirty items without sanitizing her hands. On 12/11/19 at 3:47 PM, the DON said she expected LPN #2 to not place the dirty oven mitt onto her lap, she expected her to place the dirty mitt into the laundry bag for cleaning. The DON said LPN #2 should have removed her gloves and washed her hands after each encounter with an item that was suspected to be dirty and before she touched a clean item. 3. Resident #15 was readmitted to the facility on [DATE], with multiple diagnoses including morbid (severe) obesity and rectal fistula (an abnormal connection between the end of the bowel and the rectum). On 12/8/19 at 10:52 AM, RN #7 and CNA #16 were observed as they provided peri-care to Resident #15. RN #7 and CNA #16 were wearing gloves, RN #7 wiped Resident #15's genitalia and CNA #16 wiped Resident #15's buttocks. RN #7 then removed her gloves and applied new gloves without performing hand hygiene. RN #7 then used wipes to clean Resident #15's body and applied deodorant under his arms. RN #7 then removed her gloves and looked for Resident #15's socks in his drawer. She did not perform hand hygiene after removing her gloves. RN #7 applied new gloves and put the nonskid socks on Resident #15. When RN #7 and CNA #16 finished performing cares to Resident #15, they assisted him to transfer to his power wheelchair using the ceiling Hoyer (a stationary lifting device mounted on a rail system and transfers patients between a bed and a chair or toilet). RN #7 and CNA #16 removed their gloves then performed hand hygiene before leaving Resident #15's room. (continued on next page)

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	135146	A. Building B. Wing	12/13/2019

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/19 at 10:38 AM, the Wound Nurse was observed as she changed Resident #15's wound dressing. The Wound Nurse wore gloves and removed Resident #15's old dressing and said it was wet. She then wet a 4 x 4 gauze with normal saline and cleansed Resident #15's wound with the same gloves she used to remove the dirty dressing. The Wound Nurse then removed her gloves, performed hand hygiene and applied new gloves. The WCC nurse then covered Resident #15's wound with border dressing and dated it. On 12/10/19 at 10:42 AM, the WCC nurse said she should have change her gloves and performed hand hygiene after she removed Resident #15's old dressing and before cleansing the wound with wet gauze. 31867 36193