

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Caldwell Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 210 Cleveland Boulevard Caldwell, ID 83605	

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)
<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40733</p> <p>Based on record review and interview, it was determined the facility failed to ensure residents received a written notice prior to a change in their room for 1 of 1 resident (Resident #110) who was reviewed for a room change. This resulted in a lack of information being provided to a resident necessary to make an informed decision. Findings include:</p> <p>Resident #110 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including schizoaffective disorder, borderline personality disorder, COPD (lung diseases that block airflow and make it difficult to breathe), and diabetes.</p> <p>Resident #110's record included documentation that on 1/3/24, she was transferred from her single-bed room to a 4-bed room. Resident #110's record did not include documentation she was provided with written notice prior to the room change.</p> <p>During an interview on 10/11/24 at 9:30 AM, the CRN reviewed Resident #110's record and confirmed there was no documentation to confirm Resident #110 had been notified in advance of her room change.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>51121</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure residents were provided with a safe, clean, comfortable, and homelike environment. This was true for 1 of 3 shower rooms observed. This deficient practice created the potential for diminished quality of life for all residents that use the east shower room. Findings include:</p> <p>On 10/8/24 at 9:22 AM, observed paint peeling away from the ceiling in various areas in the east shower room.</p> <p>On 10/8/24 at 9:25 AM, CNA #2 stated she noticed the paint had started peeling a few months ago.</p> <p>The facility maintenance work orders were reviewed for the last 6 months. There was no work order for the peeling paint found.</p> <p>On 10/8/24 at 3:30 PM, the Maintenance Director stated he was not aware of the paint peeling in the east hall shower room and that it needed to be fixed.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121</p> <p>Based on review of medical records, the State Survey Agency's Long-Term Care Reporting Portal, and staff interviews, it was determined the facility failed to ensure residents' rights were protected to be free from abuse. This was true for 1 of 6 residents (Resident #32) reviewed for abuse. This failure placed all residents at risk of ongoing abuse, potential physical, and psychosocial harm. Findings include:</p> <p>Resident #32 was admitted to the facility on [DATE] with multiple diagnoses including, hemiplegia (paralysis of one side of the body) and end stage renal disease (a chronic kidney disease that has reached its final, permanent stage).</p> <p>Resident #111 was admitted to the facility on [DATE] with multiple diagnoses including dementia and hypertension.</p> <p>A facility reported incident investigation, initiated 3/9/24, documented Resident #111 walked up behind Resident #32 and put him in a choke hold, stating he was going to kill him. Resident #111 was pulled away from Resident #32 by nursing staff. Resident #32 stated he did not suffer any injuries and refused to be assessed.</p> <p>The facility administrator documented in the 3/9/24 incident investigation that it was his opinion that Resident #111's intent was to harm Resident #32 during this incident.</p> <p>The facility investigation documented two additional incidents Resident #111 was involved in.</p> <p>On 2/23/24, Resident #111 yelled at another resident and then lunged at the resident's neck, making contact.</p> <p>On 3/4/24, Resident #111 pushed Resident #32 in his wheelchair into the nurses station, bumping Resident #32's knee into a cabinet.</p> <p>On 10/11/24 at 9:58 AM, the facility administrator stated the incident on 3/9/24 seemed to be a rapid change in behavior for Resident #111.</p> <p>The facility documented that the following actions were taken to protect residents and prevent a possible reoccurrence:</p> <ul style="list-style-type: none"> - Resident #32 was evacuated from his room. - Staff had 1:1 supervision with Resident #111 until police arrived. - Emergency Medical Services was called to evaluate Resident #32. Resident #32 refused to be evaluated and stated he was not injured. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Resident #111 was taken by police to the hospital for psychological evaluation. He was discharged and not readmitted to the skilled nursing facility.</p> <p>- All staff were re-educated about abuse and abuse prevention by 9/15/24.</p> <p>These findings represent past noncompliance with this regulatory requirement. There was sufficient evidence the facility corrected the noncompliance as of 9/15/24 and there were no other occurrences of alleged abuse or neglect. At the time of this survey, the facility was in substantial compliance for this regulatory requirement and, therefore, does not require a plan of correction.</p>

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40733</p> <p>Based on record review and staff interview, 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 1 of 4 residents (Resident #110) reviewed for hospitalization s. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed at the facility within a specified time. Findings include:</p> <p>Resident #110 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including schizoaffective disorder, borderline personality disorder, COPD (lung diseases that block airflow and make it difficult to breathe), and diabetes.</p> <p>Resident #110's record included documentation she was transferred to the hospital on 1/21/24, for evaluation and treatment of worsening respiratory symptoms. Her record did not include documentation she was provided with a bed-hold notice.</p> <p>During an interview on 10/11/24 at 10:24 AM, the DON confirmed there was no documentation Resident #110 received a bed-hold notice.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983</p> <p>Based on policy review, record review, and staff interview, it was determined the facility failed to refer residents for further evaluation when residents were diagnosed with a major mental illness. This was true for 2 of 4 residents (#42 and #46) reviewed for Pre-Admission Screening and Resident Review (PASARR) level 2 evaluations. This deficient practice had the potential to cause harm if residents' specialized services for mental health needs were not evaluated by an appropriate state-designated authority. Findings include:</p> <p>The facility's Pre-Admission Screening and Resident Review policy, dated 11/28/17, documents positive level 1 PASARR's (a major mental illness has been identified) are forwarded to the state-designated authority for a level 2 PASARR evaluation.</p> <p>The State Operation Manual, Appendix PP revised on 8/8/24, documents if a PASARR level 1 identifies a major mental illness, an in-depth evaluation, known as a PASARR level 2 evaluation is completed by the state-designated authority, which must be completed prior to admission to a nursing facility.</p> <p>1. Resident #42 was admitted to the facility on [DATE], with multiple diagnoses which included amputation, malnutrition, and bipolar disease.</p> <p>Resident #42's care plan, created on 12/14/22, documented Resident #42 was prescribed antianxiety and antipsychotic medications related to his diagnosis of bipolar disease.</p> <p>Resident #42's admission MDS (Minimum Data Set - an assessment used to identify the resident's clinical condition, cognitive and functional status, and use of services), completed on 12/27/22, documented his diagnosis of bipolar disease.</p> <p>Resident #42's medical record documented he had a diagnosis of bipolar disease (a major mental illness) but the record did not include a completed PASARR level 1 screening or PASARR level 2 evaluation from the state-designated authority.</p> <p>2. Resident #46 was admitted to the facility on [DATE], with multiple diagnoses including schizophrenia and non-Alzheimer's dementia.</p> <p>Resident #46's care plan dated 3/8/24, documented she takes antipsychotic medication related to her diagnosis of schizophrenia.</p> <p>Resident #46's admission MDS completed on 3/13/23, documented she had a severe mental disorder and a diagnosis of schizophrenia.</p> <p>Resident #46's medical record documented a PASARR level 1 screening was completed on 4/5/23 (36 days after admission). The PASARR level 1 screening documented Resident #46 had a major mental illness of schizophrenia and instructed that the PASARR level 1 be forwarded to the states-designated authority for a PASARR level 2 evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #46's medical record did not document a PASARR level 2 evaluation had been completed.</p> <p>On 10/10/24 at 10:58 AM, the CRN stated the facility did not have a PASARR level 2 for Resident #42 or Resident #46.</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983</p> <p>Based on policy review, record review, and staff interview, it was determined the facility failed to ensure a Pre-Admission Screening and Resident Review (PASARR), was completed within the required timeframe for 2 of 4 residents (#42 and #46) reviewed for PASARR screenings. This failure created the potential for harm if residents required, but did not receive, specialized services for mental health while residing in the facility. Findings include:</p> <p>The facility's Pre-Admission Screening and Resident Review policy, dated 11/28/17, documented a PASARR level 1 will be completed prior to admission and is included in the required paperwork from the referring agency, hospital, or physician.</p> <p>The State Operation Manual, Appendix PP revised on 8/8/24, documents all applicants to Medicaid-certified nursing facilities are to be screened for possible serious mental disorders or intellectual disabilities and related conditions. This initial pre-screening is referred to as PASARR Level 1 and should be completed prior to admission to a nursing facility.</p> <p>1. Resident #42 was admitted to the facility on [DATE], with multiple diagnoses which included amputation, malnutrition, and bipolar disease.</p> <p>Resident #42's care plan, created on 12/14/22, documented Resident #42 was prescribed antianxiety and antipsychotic medications related to his bipolar disease.</p> <p>Resident #42's admission MDS, completed on 12/27/22, documented a diagnosis of his bipolar disease.</p> <p>Resident #42's medical record did not document a PASARR level 1 was completed.</p> <p>2. Resident #46 was admitted to the facility on [DATE], with multiple diagnoses including schizophrenia and non-Alzheimer's dementia.</p> <p>Resident #46's care plan dated 3/8/24, documented Resident #46 was prescribed antipsychotic medication related to her diagnosis of schizophrenia.</p> <p>Resident #46's admission MDS completed on 3/13/23, documented she had a severe mental disorder and a diagnosis of schizophrenia.</p> <p>Resident #46's medical record documented a PASARR level 1 screening was completed on 4/5/23 (36 days after admission). The PASARR level 1 screening documented Resident #46 had a major mental illness of schizophrenia and instructed the PASARR level 1 to be forwarded to the states-designated authority for a PASARR level 2 evaluation.</p> <p>Resident #46's medical record did not document a PASARR level 1 was completed prior to admission.</p> <p>On 10/10/24 at 10:58 AM, the CRN stated the facility did not have a PASARR level 1 for Resident #42 or a PASARR level 1, prior to admission, for Resident #46.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121</p> <p>Based on interview and record review, the facility failed to revise a comprehensive person-centered care plan related to a fall intervention of 30-minute checks for 1 of 22 Residents (#52). This deficient practice had the potential to affect residents health and wellbeing. Findings include:</p> <p>Resident #52 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including Parkinson's disease (a progressive brain disorder that causes movement problems, stiffness, and other issues) and bipolar disorder.</p> <p>Resident #52's care plan documented 30-minute checks due to a fall on 6/9/24.</p> <p>Resident #52's Interdisciplinary Team progress note dated 6/15/24, documented, The plan is to have Resident #52 be on 30-min checks at all times for increased safety.</p> <p>Resident #52's CNA task Kardex, dated 6/18/24, directed CNA staff to perform 30-minute checks for safety and falls.</p> <p>Resident #52's medical record did not document 30-minute checks were performed.</p> <p>On 10/10/24 at 2:50 PM, the DON stated the care plan should have been updated and the 30-minute checks should have been removed.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121</p> <p>Based on observation, interview, policy and record review, the facility failed to follow standard of practice during resident transfers for 1 of 2 residents (Resident #8), and follow a comprehensive person-centered care plan to maintain resident body weight for 1 of 22 residents (Resident #26). This deficient practice created the potential for harm or adverse outcomes. Findings include:</p> <p>Facility Resident Mobility - Safety policy, revised 4/16/24, documented, Gait belts are used with resident requiring hands-on assistance unless contraindicated, for the primary purpose of staff and resident safety. Gait belts are considered part of a direct care staff's uniform.</p> <p>1. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including major depressive disorder (a serious mental health condition that involves a persistent low mood and a loss of interest in activities that were once enjoyable) and dementia.</p> <p>Resident #8's care plan revised 4/27/23, stated Transfer: Limited/Extensive assistance with transfers with assist of 1 staff.</p> <p>On 10/7/24 at 4:31 PM, observed CNA #5 use Resident #8's belt loop to assist during a bed to wheelchair transfer.</p> <p>On 10/7/24 at 4:40 PM, CNA #5 stated she should have used a gait belt during the bed to wheelchair transfer, not Resident #8's belt loop.</p> <p>2. Resident #26 was admitted to the facility on [DATE],with multiple diagnoses including dementia and diabetes.</p> <p>Resident #26's medical record documented a 5.84% weight loss between 5/1/24 and 6/1/24.</p> <p>Resident #26's care plan documented interventions to monitor resident weight and report significant weight changes to the medical director (MD).</p> <p>Resident #26 medical record did not have documentation the MD had been notified of the 5.84% weight loss.</p> <p>On 10/10/24 at 10:00 AM, the CRN stated the MD should have been notified of Resident #26's weight loss and was not.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121</p> <p>Based on observation, interview, record review, and policy review, the facility failed to ensure 2 of 5 resident's (#32 and #47) records reviewed for oxygen use had complete orders, and 2 of 2 residents (#5 and #47) were using oxygen per physician orders. This created the potential for residents to experience harm, respiratory difficulties, and adverse outcomes. Findings include:</p> <p>Facility Oxygen Therapy policy, revised 8/4/23, directed staff to verify physician orders prior to initiating oxygen therapy.</p> <p>1. Resident #5 was admitted to the facility on [DATE], with multiple diagnoses including panic disorder and dementia.</p> <p>On 10/8/24 at 2:34 PM, it was observed Resident #5 had been transferred into bed without his oxygen nasal cannula in place.</p> <p>On 10/8/24 at 3:01 PM, CNA #4 stated Resident #5 should be using the oxygen at all times, but CNA #3 had forgot to put it back on him.</p> <p>A physician's order, dated 8/4/23, for oxygen at 2 liters per minute, via nasal cannula, to help maintain Resident #5 adequate oxygen saturation.</p> <p>2. Resident #32 was admitted to the facility on [DATE], with multiple diagnoses including hemiplegia (paralysis of one side of the body) and end stage renal disease (a chronic kidney disease that has reached its final, permanent stage).</p> <p>Resident #32's medical record included an incomplete order for oxygen usage (oxygen at 2 liters via nasal cannula). The oxygen order did not include the duration of use.</p> <p>On 10/11/24 at 9:24 AM, CRN confirmed Resident #32's oxygen order was incomplete and should have stated duration of use.</p> <p>3. Resident #47 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including acute respiratory failure with hypoxia (a serious medical condition that occurs when the lungs have difficulty loading the blood with enough oxygen), and chronic obstructive pulmonary disease (a chronic lung disease that makes it difficult to breathe).</p> <p>On 10/8/24 at 4:29 PM, observed Resident #47 wearing a nasal cannula that was attached to his oxygen portable unit but the oxygen liter flow had been set at zero.</p> <p>On 10/8/24 at 5:30 PM, observed Resident #47 in the dining room with his oxygen portable unit set at zero.</p> <p>Resident #47's medical record had an incomplete order for oxygen usage (oxygen at 2 liters via nasal cannula). The oxygen order did not include the duration of use.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/8/24 at 5:34 PM, LPN #1 stated Resident #47's portable oxygen unit should have been set at 2 liter per minute.</p> <p>On 10/11/24 at 9:25 AM, CRN stated that the oxygen order was incomplete and should have stated duration of use.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>50983</p> <p>Based on review of facility staffing records and staff interview, it was determined the facility failed to ensure an RN was on duty at least 8 consecutive hours per day, 7 days a week. This was true for 1 of 38 days reviewed for RN staffing coverage. The failure created the potential for harm if routine and/or emergency nursing needs went unmet and had the potential to affect all residents living in the facility. Findings include:</p> <p>Licensed Nurse time punches for 9/1/24 to 10/8/24, documented the facility did not have an RN on duty for 8 consecutive hours on 9/1/24.</p> <p>On 10/10/24 at 5:15 PM, the CRN and DON stated on 9/1/24, the RN was covered by an LPN and confirmed there was not an RN for 8 consecutive hours that day.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>51121</p> <p>Based on observation, interview, policy review, and review of the Idaho Food Code, the facility failed to appropriately store, label, and serve foods. This deficient practice had the potential to affect the 59 residents who received meals in the dining room and eat snacks that had been stored in the snack refrigerators. This placed residents at risk for the potential for consuming contaminated and spoiled foods, and adverse health outcomes related to food-borne illnesses. Findings include:</p> <p>Review of the Idaho Food Code, revised February 2021, stated,. 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking . refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.</p> <p>Facility Food and Supply Storage policy dated 11/28/17, documented, For food products that are opened and not completely used or prepared at facility and stored, the product should be labeled as to it contents and use by dates.</p> <p>On 10/7/24 at 11:40 AM, 3 outdated yogurts (10/2/24) were observed in the walk-in refrigerator.</p> <p>On 10/7/24 at 11:42 AM, the CDM stated the outdated yogurts should have been removed from the walk-in refrigerator on 10/2/24.</p> <p>On 10/9/24 at 1:30 PM, an ice cream container with open date of 9/2/24 and used by date of 10/2/24, was observed in the resident snack freezer.</p> <p>On 10/9/24 at 1:35 PM, the CDM stated the ice cream container should have been removed on 10/2/24.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Caldwell Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 210 Cleveland Boulevard Caldwell, ID 83605	
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)		
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121</p> <p>Based on observation and interviews, it was determined the facility failed to ensure all residents had access to their call lights while in their beds. This issue was observed in 1 of 22 resident's (Resident #5) observed for call light access. This failure had the potential for harm if residents were not able to summon staff assistance by activating the call light. Findings include:</p> <p>Resident #5 was admitted to the facility on [DATE], with multiple diagnoses including panic disorder and dementia.</p> <p>Resident #5's care plan initiated 3/17/23, directed staff to keep his call light button within reach.</p> <p>On 10/8/24 at 2:34 PM, Resident #5 was observed in his bed without the call light button which was across the room, on his dresser.</p> <p>On 10/8/24 at 2:36 PM, Resident #5 stated he had been yelling for help because he was in pain but no one heard him.</p> <p>On 10/8/24 at 2:48 PM, CNA #3 stated she forgot to give Resident #5 his call light.</p> <p>On 10/10/24 at 10:53, the DON stated staff should ensure all residents have access to their call lights while in bed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Caldwell Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 210 Cleveland Boulevard Caldwell, ID 83605	

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)
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121</p> <p>Based on observation and interview, the facility failed to provide safe shower floors for all residents that use the east shower room. This deficient practice had the potential to cause harm due to slips or falls and distress for residents that use the east side shower. Findings include:</p> <p>Resident #51 was admitted to the facility on [DATE], with multiple diagnoses including stroke and diabetes.</p> <p>On 10/7/24 at 2:38 PM, Resident #51 stated the shower floor had been very slippery and he had almost fallen in the shower room because the floor anti-slip pads were missing.</p> <p>On 10/8/24 at 9:22 AM, observed the non-slip strips had peeled up and were missing in the east hall shower room.</p> <p>On 10/8/24 at 9:28 AM, CNA #2 stated the non-slip strips had peeled up about two months ago and a work order was submitted but nothing had been done yet.</p> <p>On 10/8/24 at 3:30 PM, the Maintenance Director stated the missing shower floor non-slip strips needed to be replaced.</p> <p>A facility work order #2674 (for the non-slip strips) in the east hall shower was created on 8/15/24. The east hall shower non-slip strips were not replaced until 10/8/24.</p>