



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER - Governor
RICHARD M. ARMSTRONG - Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

January 30, 2015

FILE COPY

Robin J. Leary, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Ms. Leary:

On **January 14, 2015**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. In addition, a complaint investigation was conducted in conjunction with the on-site follow-up revisit. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **November 14, 2014**. However, based on our on-site follow-up revisit conducted **January 14, 2015**, we found that your facility is not in substantial compliance with the following participation requirements:

- F164 -- S/S: D -- 42 CFR §483.10(e), 483.75(l)(4) -- Personal Privacy/Confidentiality of Records**
- F242 -- S/S: D -- 42 CFR §483.15(b) -- Self-Determination - Right to Make Choices**
- F309 -- S/S: D -- 42 CFR §483.25 -- Provide Care/Services for Highest Well Being**
- F514 -- S/S: D -- 42 CFR §483.75(l)(1) -- Resident Records-Complete/Accurate/Accessible**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each federal and state tag in column X5 Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your copy of the Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed. The findings for the Complaint Investigation is being processed and will be sent to your facility under separate cover.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 12, 2015**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567, and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

As noted in the letter of **October 29, 2014**, following the **Recertification, Complaint Investigation and State Licensure** survey of **October 14, 2014**, we made recommendations to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **April 14, 2015**, if substantial compliance is not achieved by that time.

Our records indicate that on October 31, 2014, CMS notified the facility of an intent to impose the following remedies:

- A 'per instance' civil money penalty of **\$5000.00**.
- Denial of payment for new admissions effective **November 15, 2014**.

Robin J. Leary, Administrator
January 30, 2015
Page 3 of 3

- Loss of Nurse Aide Training and Competency Evaluation Program.

If you believe the deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, Option #2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

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

This request must be received by **February 12, 2015**. If your request for informal dispute resolution is received after **February 12, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the on-site follow-up revisit. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626, Option #2.

Sincerely,



LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor
Long Term Care

LKK/dmj
Enclosures

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

PRINTED: 01/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/14/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF POST FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint investigation and follow-up to the annual recertification survey.</p> <p>The surveyors conducting the survey were: Arnold Rosling, RN, BSN, QIDP Lauren Hoard, RN, BSN</p> <p>The survey team entered the facility on January 13, 2015 and exited the facility on January 14, 2015.</p> <p>Survey definitions included:</p> <p>BIMS = Brief Interview of Mental Status DON = Director of Nursing LN = Licensed Nurse MD = Medical Doctor MDS = Minimum Data Set</p>	{F 000}	<p>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p>	
{F 164} SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p>	{F 164}	<p>DATE OF COMPLIANCE:</p> <p>F 164:</p> <p>SPECIFIC RESIDENTS</p> <p>Resident #14 was interviewed to assure that the resident was not affected by staff members' failure to knock and identify themselves prior to entering resident's room and</p>	2-5-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Robert Leary* TITLE *Administrator* (X6) DATE *2-5-15*

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

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{F 164}	<p>Continued From page 1</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and resident interview, it was determined that the facility failed to ensure a resident was provided an opportunity for a private conversation. This affected 1 of 3 (#14) residents interviewed. Staff's failure to knock and identify themselves prior to entering a resident's room created an opportunity for them to overhear and repeat a conversation that the resident thought was being shared in confidence. Findings include:</p> <p>During an interview with the surveyor on 1/14/15 at 2:15 PM, Resident #14 was positioned in his bed next to the window of the room while the surveyor was seated in a chair at the end of the bed. The resident's privacy curtain was pulled down to the end of the bed and a second resident's bed was between the curtain and the door to the hallway. During the conversation, the resident stated he was not happy with the way the facility's administrator handled a situation with a family member. While the resident was describing his discontent to the surveyor, a facility staff member walked about 5 feet into the room. The</p>	{F 164}	<p>potentially overhearing a private conversation.</p> <p>OTHER RESIDENTS Residents have the potential to be affected by this practice and staff will knock and announce prior to entering rooms.</p> <p>SYSTEMIC CHANGES Root cause indicated this is a staff education and execution of process on resident rights including announcing yourself or knocking on the door prior to entry to a resident's room and the right to private personal conversation. Staff have been in serviced on ensuring residents are provided the opportunity for private conversations. This includes ensuring they knock and announce themselves prior to entry of residents' room.</p> <p>Weekly the residents will be invited to meet with the Administrator or designee. Administrator or designee will ask residents if they have had any issues with staff not knocking or announcing themselves before going</p>	

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{F 164}	Continued From page 2 staff member did not knock or announce herself before entering the room. The staff member then made a remark about being "sorry" and walked out of the room. On 1/14/15 at 5:30 PM, during the exit conference, the administrator commented on information that the resident had shared with the surveyor in confidence. The information that was reported to the administrator and told to the surveyors did not accurately describe the conversation that took place between the resident and the surveyor.	{F 164}	into residents room. Administrator or designee will follow up as needed. MONITOR: Department heads and/or designee will perform direct observations of staff with unit rounds to ensure compliance with knocking on doors and announcing themselves prior to entry. The results of the observations will be taken to the monthly QAPI meetings for three months for review and action taken as indicated.		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and record review, it was determined the facility failed to allow residents to make choices about aspects of their life in the facility that were significant as it related to dining. This was true for 2 of 13 (#s 10 & 14) sampled residents. Not allowing residents to make choices about aspects of their life they enjoyed resulted in distress to residents and had the potential to cause psychosocial harm. Findings include:	F 242	F 242: SPECIFIC RESIDENTS Resident # 10 and #14 were visited by social services for follow up. Both residents reported continued satisfaction with their current dining room location.	2-5-15	

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F 242	<p>Continued From page 3</p> <p>A complaint from the public identified that three residents who had previously lived on the 300 hall of the facility and a family member were told, shortly before the noon meal on 10/30/14, starting that day those three residents would no longer be allowed to eat their meals in the 300 hall dining room. Instead, they would be required to eat in the main dining room of the facility.</p> <p>NOTE: The entire facility is certified for Medicare and Medicaid and does not have a "distinct part."</p> <p>The 300 hall dining room was observed during the noon meal on 1/13/15. The dining room was set up with four tables on one side and three tables on the other side of the room. These tables were joined together to make one long table on each side of the room. There were three additional round tables in the room. During the observation most of the residents were on the side of the room where the four tables were joined together. One resident was seated with family at the other long table. The room was not crowded and no one was seated at any of the three round tables in the room.</p> <p>Resident #10's Progress Notes, between 10/15/14 and 10/29/14, documented the resident's room location on the 200 hall, and he took his meals in the dining room on the 300 hall.</p> <p>Resident #10's record included a note, dated 10/30/14 (no time noted), from the administrator/executive director (ED). It documented, "Spoke [with] [family member name] about [Resident #10] eating in the main dining room. SS [Social Services] arranged for him and 3 others to have their own table in the main dining room. We are not allowing 200/100</p>	F 242	<p>OTHER RESIDENTS</p> <p>An audit was completed on room changes that occurred since 12/5/14 that may have resulted in subsequent dining room change with no findings.</p> <p>SYSTEMIC CHANGES</p> <p>Root cause indicated that the IDT misunderstand resident rights to make choices on dining room preference and understand that there are no distinct areas in the facility regarding pay type. IDT team in serviced to ensure the appropriate understanding of residents rights of choice and to ensure appropriate execution of process in allowing residents to make choices about aspects of their life as it relates to dining. Residents admitting to facility will be shown dining room locations specific to the units. As residents choose to move rooms, Social Services or designee will communicate timely to the resident and family as appropriate any potential dining room locations and will allow the resident to choose where they wish to dine.</p>	
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F 242	<p>Continued From page 4</p> <p>hall residents to have meals in the 300 hall. Comments and concerns from staff and resident on 300 hallway for over crowding from these residents and extra cares needed to support them there...."</p> <p>The ED further documented on 11/4/14 that the ombudsman came to the facility to investigate the issue with the resident dining room move.</p> <p>An ED note on 11/5/14 (no time specified) documented, "It was brought to EDs attention that [Resident Family Member name] and table mates were still going to 300 hall for coffee. ED met with [Resident #10] and explained again that he could not be there during 300 hall meal time even for coffee. He shook his head yes at request to not go there during meals. ED offered a private coffee time for him and his friends in the 200 day room before meals but he declined..."</p>	F 242	<p>Weekly the residents will be invited to meet with the Administrator or Designee. Administrator or designee will ask the residents if there are any concerns with the choice of dining room and ensure that resident's rights and choices are upheld.</p> <p>MONITOR:</p> <p>DON and/or designee will review all room moves to ensure residents who changed dining rooms have been provided the right to make a choice on where they eat. The results will be taken to the monthly QAPI meeting for three months for review and action taken as indicated</p>		
	<p>Resident #10, who had a diagnosis of cerebral vascular accident with expressive aphasia and was able to make his interests known, was interviewed at 10:00 AM on 1/13/15. The resident had lived on the 300 hall and ate in the 300 hall dining room previously but, after being moved to another hall, was told he could no longer eat in that dining room. The resident made it known that he still preferred to have meals and coffee in the 300 hall dining room.</p> <p>The Administrator and DON were interviewed on 1/14/15 at 10:30 AM. They stated that the social service person talked with the residents prior to the move from the 300 hall dining room to the main dining room. They stated there were three residents and a family member who were eating in the 300 hall dining room when they were asked</p>				

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F 242	<p>Continued From page 5</p> <p>to move to the main dining room. Staff on the 300 hall voiced concerns about the crowding and care needs for residents who ate in that dining room. Residents who resided on the 300 hall wanted additional space for family and loved ones to utilize during meals. The Administrator and DON thought the residents were O.K. with the move.</p> <p>The Administrator and social worker were interviewed on 1/14/15 at 10:45 AM regarding the residents' preference to eat in a smaller dining room. The social worker indicated the 300 hall dining room was smaller and the 300 hall was for residents who were being rehabilitated and whose payor source was either private pay or Medicare. The social worker stated she talked with the three residents before the move occurred. She stated she was told to talk to them because the facility had numerous grievances about these residents continuing to eat in the 300 hall dining room. However, when asked for the grievances, none were made available to review. The Administrator said the three residents had not resided on the 300 hall for many weeks prior to the move and a sudden decision was made when another resident was moved to the 300 hall from the 200 hall. The food trays of the three residents and a family member had been delivered to them that day on the 300 hall via food cart. The Administrator further stated the residents were informed they could eat their meals in the day room of the 200 hall but they refused.</p> <p>Resident #14, who was alert and oriented to time, place and person, was interviewed on 1/14/15 at 2:15 PM. The resident had lived on the 300 hall and ate in the 300 hall dining room previously, but after being moved to another hall was told he</p>	F 242		

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F 242	Continued From page 6 could no longer eat in that dining room. The resident indicated during the interview that he was more upset with the way the move was handled than moving to the main dining room for meals. The resident stated the staff, "never said a word. They just came into the 300 dining room and moved us out." The Administrator, DON and Regional staff were informed of this concern on 1/14/15 at 5:30 PM. On 1/16/15 the Ombudsman provided the Bureau of Facility Standards a copy of notes from the 11/14/14 meeting regarding this issue; however, it did not resolve the facility's issue of requiring residents to eat in certain dining rooms based on the payor source for their care.	F 242	F 309: SPECIFIC RESIDENTS Resident #17 has Tubigrips/wraps to bilateral lower extremities as ordered. The wound was assessed and clarification of orders were received from physician. Resident #17's care plan was reviewed and updated to include history of refusals, goals to increase her acceptance of treatments and approaches for staff to use if she refuses treatments.	2-5-15
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure physician orders were followed when a resident was observed without tubigrips or wraps to the bilateral lower extremities. This was true for 1 of 13 (#17) sampled residents. This deficient practice created the potential for more than minimal harm should	F 309	OTHER RESIDENTS: Residents with orders for Tubigrips/wraps were reviewed to ensure physician orders are followed. SYSTEMIC CHANGES Root cause indicates staff education and execution of process to ensure physician orders are followed, treatments are not documented prior to being completed, and that resident refusals are documented per policy.	

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F 309	<p>Continued From page 7</p> <p>the resident have increased edema, skin breakdown, pain, infection or functional decline when treatments were not provided as ordered. Findings included:</p> <p>Resident #17 was readmitted to the facility on 3/17/13 with multiple diagnoses, which included diabetes, Congestive Heart Failure (CHF) and edema.</p> <p>The quarterly MDS assessment, dated 9/27/14, documented Resident #17 was cognitively intact with a BIMS of 13, had no refusals of care and had one venous and arterial ulcer.</p> <p>NOTE: The Nursing Progress Notes and Physician Progress Notes documented the resident was ill at the time of the annual MDS assessment, dated 12/28/14, and the interview to determine cognitive status was not completed.</p> <p>Resident #17's Activities of Daily Living Care Plan, dated 3/17/13, documented the approach, "Apply tubigrip, size F, daily on in AM and off PM." The approach did not include a date of initiation.</p> <p>Resident #17's Risk for Pressure Ulcers Care Plan, dated 5/16/14, documented a potential for skin breakdown. Approaches included, "Encourage elevating legs to decrease edema. continue with lower extremity wraps or TED hose as tolerated. 9/16/14."</p> <p>On 10/31/14, a Physician's Order documented, "Tx [Treatment]: Lower legs: Cleanse with NS [Normal Saline]; apply telfa to open areas, wrap with gauze then wrap with ace wrap. On in AM; off at HS [bedtime] daily (Stasis lesions.)"</p> <p>On 11/6/14 a Physician's Order documented, "pt</p>	F 309	<p>Education provided to nursing staff to apply Tubigrips/wraps as ordered, not document prior to delivery of care, ensure refusals are documented and that residents who have a history of refusals have interventions care planned.</p> <p>MONITOR: DON or designee will audit residents with Tubigrips/wraps to ensure they are in place as ordered and that residents who refuse such orders have appropriate documentation and care plan revisions.</p> <p>The results of audits will be taken to the monthly QAPI meeting for three months for review and action taken as indicated</p>	

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F 309	<p>Continued From page 8</p> <p>[patient] needs bilat[eral] LE's [Lower Extremities] wrapped every day daily" for edema.</p> <p>The November 2014 Treatment Administration Record (TAR) documented the aforementioned order from 10/31/14 with refusals by Resident #17 to take the wraps off on 11/20 and 11/24/14. The TAR did not include any additional documentation related to those refusals. The TAR did not include the new order from 11/6/14 to wrap the LE's daily.</p> <p>Physician's progress notes dated 11/14/14, 11/20/14, and 12/1/14 documented the resident continued with daily dressing changes to her lower extremities. There was no documentation in these notes regarding resident refusals. There was no documentation in the resident's care plan regarding a history of refusals regarding her tubigrips, wraps, or TED hose; goals to increase her acceptance of those treatments; or how the facility had identified and attempted to overcome barriers to her acceptance. There were no identified approaches for staff to use if the resident refused the application of these treatments.</p> <p>On 12/1/14 a Physician's Order documented, "once lower legs are heal [sic] dc [discontinue] wraps and gauze, then start tubigrip size F daily twice daily on in AM off in PM."</p> <p>The resident's December 2014 TAR documented several blanks of the physician-ordered dressing and wraps. Please see F 514 for details. There was a refusal documented on 12/1/14 to have the dressing/wraps removed, with no explanation offered. On 12/6 the resident refused application of the dressing/wraps and the explanation</p>	F 309			

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F 309	<p>Continued From page 9 documented, "Resident refused to let nurse wrap legs."</p> <p>On 12/30/14 a Physician's Telephone Order documented, "DC order for dressing to lower legs. Continue to wrap legs daily as res[ident] allows." The indication column of the order documented, "wound healed." The resident's TAR documented the aforementioned order from 10/31/14 was discontinued on 12/30/14.</p> <p>On 12/31/14, a Physician's SOAP note [Progress Note] documented, "[complains of] bilateral [lower extremity] 'itching', requesting [as needed medication], recent [significant] weight gain (15 pounds in past 2 [weeks]) [with] accompanying increase in [lower extremity] edema..." The physician's assessment of the resident's extremities documented, "[Three plus bilateral lower extremity] edema, exam limited by tight pant legs [with] inability to raise pants up to knees for adequate visualization." The assessment of the resident's skin was documented as, "[Bilateral lower extremities with] erythema distally." The plan was documented as, "Chronic [lower extremity] edema [with] recent worsening [due to] diuretic [discontinuation] in setting of acute renal failure..." It could not be determined, from the physician's progress note, how the determination had been made the resident's open area was healed.</p> <p>The January 2015 TAR from 1/1/15 through 1/13/15 documented all application and removal of the resident's tubigrips had been completed as ordered, with no refusals noted. The resident's nursing progress notes between 1/1/15 and 1/13/14 did not document any refusals, unplanned removal, or other concerns with the</p>	F 309			

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F 309	<p>Continued From page 10 resident's tubigrips.</p> <p>On 1/8/15, a Physician's Progress note documented, "remains non-compliant [with] compressions stockings [and] recently cut off for the [second] time..." On the same date, the TAR documented the tubigrips were applied with no resident refusal noted, and no entry was made in the resident's Nursing Progress notes regarding this event.</p> <p>On 1/12/15, a Physician's Progress Note documented, "[Two plus] edema LE's, calves non-tender." There was no documentation as to whether the resident was experiencing drainage or had an open area related to the edema.</p> <p>On 1/13/15 at 10:05 AM, while visiting with Resident #17, she pulled up her pant leg to show the surveyor her left leg. The resident said her legs had not been wrapped, she did not know why and it bothered her. The resident was wearing shoes with white socks and no dressing or wrap was observed in place. The sock was observed to have drainage on it from an open area just above the sock on the anterior shin.</p> <p>On 1/13/15 at 11:50 AM and 3:15 PM, Resident #17 showed the surveyor her legs were still not wrapped.</p> <p>On 1/13/15 at 3:50 PM, the surveyor asked Resident #17 to observe both legs. The resident's right leg was red with dry flaky skin from the shin to the ankle. The left leg was red with dry flaky skin and an open area on the anterior aspect of the leg which was draining onto her white sock. The resident said the open area had healed at one point, but had started again.</p>	F 309			

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F 309	<p>Continued From page 11</p> <p>On 1/14/15 at 3:20 PM, LN #1 said Resident #17 had tubigrips on her LE's. The LN said the resident sometimes refused and had been refusing the last few days, which would be written on the back of the TAR. At 3:36 PM, the LN was shown the back of the January 2015 TAR which documented the resident allowed the application of tubigrips from 1/1/15 through 1/13/15. The LN apologized for not documenting the refusal. The LN stated she had not made an entry in the resident's Progress Notes regarding the refusal. Please see F 514 for details.</p> <p>On 1/14/15 at 3:53 PM, the DON provided a Progress Note, dated 1/14/15 at 3:36 PM, made by LN #1 which documented, "Late entry for 1/13/14 [year incorrect] Day shift: Approached resident x3 regarding application of tubigrips, resident refused and did not allowed [sic] this nurse to apply. Resident educated on importance of tubigrip application to manage her edema however resident did not allow this nurse to perform. Resident did allow this nurse to assist her to rest in bed and elevate her legs and apply lotion before breakfast. Noted LE with less edema after legs were elevated. Continue to encourage resident to wear tubigrips as ordered by MD." The Progress Note did not mention there was a draining open area to the left anterior shin.</p> <p>On 1/14/15 at 4:10 PM, Resident #17 was observed sitting in the wheelchair. When asked about her legs, she pulled up both pant legs which had tubigrips in place. There was drainage observed on the left tubigrip from the open area on the left anterior shin. No dressing was observed underneath the tubigrip. The resident said her legs hurt "so bad" the previous night.</p>	F 309			

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F 309	<p>Continued From page 12</p> <p>She had reported the pain and received pain medication. The resident said she had a pair of tubigrips before but they were too short. Some time went by and a new longer pair of tubigrips were provided.</p> <p>Resident #17 had orders for tubigrips to bilateral lower extremities daily. On 1/13/15 the tubigrips were observed not in place and an open area on the resident's leg, which had not been covered with a dressing, was draining directly onto the resident's white sock. On 1/14/15, the resident was observed with the tubigrip in place, however the open area was not covered in a dressing and drainage from the wound was observed on the tubigrip, which had been put in place only after the facility was notified of their [tubigrips] absence.</p> <p>On 1/14/15 at 5:30 PM, the DON, with the Administrator present, was asked if the facility had been aware of the open area to the resident's left shin prior to the observation made by the surveyor on 1/13/15. The DON stated the resident had a history of weeping edema that came and went, but did not elaborate further on whether the facility had a previous awareness of this particular episode.</p> <p>On 1/14/15 at 5:30 PM, the Administrator and DON were informed of the issues related to following physician orders. No further information or documentation was provided regarding the resident's tubigrips.</p>	F 309			
{F 514} SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	{F 514}	<p>F 514:</p> <p>SPECIFIC RESIDENTS Resident #17's Treatment administration record (TAR) was corrected to be accurate and any modifications made are clearly identified and documented.</p> <p>OTHER RESIDENTS Residents with Tubigrips/wraps were audited to ensure that the TAR was accurate and any modifications made were clearly identified and documented.</p>	2-5-15	

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{F 514}	<p>Continued From page 13</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, Policy and Procedure review, and resident and staff interview, it was determined the facility failed to ensure documentation on the Treatment Administration Records (TAR) was accurate, and any modifications made were clearly identified and documented. This was true for 1 of 13 (#17) sampled residents. This deficient practice increased the risk for medical decisions to be based on incomplete or inaccurate information and increased the risk for complications due to inappropriate care or interventions. Findings included:</p> <p>The facility's Policy and Procedure for Correction of Medical Record Errors and Omissions, dated 1/18/08 included: * "If a mistake is made while manually recording information in the medical record, a single line should be drawn through the entry containing the error. The individual making the correction initials and dates it..." * "The correct information is then recorded</p>	{F 514}	<p>SYSTEMIC CHANGES</p> <p>Root cause indicated staff execution and education with licensed nurses on proper medical record documentation including not signing for treatments before they are done, documentation of resident refusals and late entries.</p> <p>Licensed Nurses were in serviced on proper medical record documentation, late entries, refusals and subsequent follow through.</p> <p>MONITOR:</p> <p>Unit Managers and/or designee will audit treatment administration records to ensure documentation is accurate and that any late entries are documented correctly. Results will be taken to QAPI monthly for three months for review and follow up as indicated.</p>		

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{F 514}	<p>Continued From page 14</p> <p>directly above the corrected area, or in the next available space, with the signature, date, and title of the person making the entry...;"</p> <p>* "Retractions may not be done for typographical, or factual errors, or undesirable notes. Retractions made...for these and other improper reasons will be considered false documentation and, therefore, subject to disciplinary action, up to and including termination of employment..."</p> <p>* "Late entry notes are discouraged because they tend to reduce credibility of the record. However, authorized personnel may make late entry notes in the medical record, which must be done within 48 hours and appropriately labeled as a 'late entry,' dated, and signed. When noting late entries, always indicate the date on which the information should have been recorded in addition to the current date;" and,</p> <p>* "All additions, corrections, and other changes must be initialed and dated by the person making the entry."</p> <p>Resident #17 was readmitted to the facility on 3/17/13 with multiple diagnoses which included diabetes, Congestive Heart Failure and edema.</p> <p>Resident #17's Activities of Daily Living Care Plan, dated 3/17/13, documented the approach, "Apply tubigrip, size F, daily on in AM and off PM." The approach did not include a date of initiation.</p> <p>The January 2015 Physician's Orders for Resident #17 included:</p> <p>* 10/31/14, "Tx [Treatment]: Lower legs: Cleanse with NS [Normal Saline]; apply telfa to open areas, wrap with gauze then wrap with ace wrap. On in AM; off at HS daily.(Stasis lesions);"</p> <p>* 11/6/14, "pt [patient] needs bilat[eral] LE's [Lower Extremities] wrapped every day daily" for</p>	{F 514}			

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{F 514}	<p>Continued From page 15</p> <p>edema; * 12/1/14, "once lower legs are heal [sic] dc [discontinue] wraps and gauze, then start tubigrip size F daily twice daily on in AM off in PM;" and, * 12/30/14 (Telephone Orders), "DC order for dressing to lower legs. Continue to wrap legs daily as res[ident] allows." The indication was documented as, "wound healed."</p> <p>The December 2014 TAR included the 10/31/14 order which had a line through it. The section of the TAR where LNs initial the treatment as performed had handwritten, "[Change] to size F." The TAR included on a separate page the order for size F tubigrips to be applied daily in the AM and off at bedtime. From 12/1 through 12/3, and on 12/28, the spaces for documenting the application of tubigrips in the AM were blank. On 12/4, 12/11, 12/13 and 12/23/14 the spaces for documenting the removal of the tubigrips at bedtime were blank. On 12/1/14 the TAR documented the resident refused to allow removal of the tubigrips with no explanation of the refusal.</p> <p>NOTE: It was unclear how it was determined the resident had refused the removal of the tubgrips, when it had not been documented the tubgrips were applied.</p> <p>The January 2015 TAR included the 11/6/14 order for wrapping Resident #17's legs daily with a handwritten addition, "[Change] to Tubigrip," which required LN initials, and the 12/1/14 order to apply tubigrips once the lower extremities were healed. On 1/13/15, the LN documented the resident's tubgrips were applied with no refusal, and the 12/1/14 order was documented as performed on 1/13/15 with no refusal.</p>	{F 514}			

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{F 514}	<p>Continued From page 16</p> <p>On 1/13/15 at 10:05 AM, 11:50 AM, 3:15 PM and 3:50 PM, Resident #17's lower extremities were observed without tubigrips in place. Refer to F309 for additional information.</p> <p>On 1/14/15 at 3:26 PM, LN #1 said on 1/13/15 she attempted to don the tubigrips but Resident #17 refused them. When asked if the LN documented the resident's refusal, the LN said she charted it on the back of the TAR. The surveyor showed the LN the TAR, which documented the tubigrips were applied on 1/13/15, and the LN apologized for not documenting the refusal. The LN was asked if she wrote a Progress Note regarding the refusal and she stated she had not.</p> <p>On 1/14/15 at 3:31 PM, the surveyor approached LN #1 who was talking to the DON. The front of the January 2015 TAR now had a circle around the LN's initials (indicating the treatment had not been completed) for 1/13/15. The back of the TAR documented the resident had refused the tubigrips, but the time of the refusal was not documented. The refusal explanation did not document it was a late entry written on 1/14/15. The LN confirmed she went back and documented the refusal from the previous day, and the DON said it was their policy to allow 48 hours to perform documentation. The policy was requested.</p> <p>On 1/14/15 at 3:53 PM, the DON provided a Nursing Progress Note, dated 1/14/15 at 3:36 PM, made by LN #1 which documented, "Late entry for 1/13/14 [year incorrect] Day shift: Approached resident x3 regarding application of tubigrips, resident refused and did not allowed [sic] this nurse to apply. Resident educated on</p>	{F 514}			

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{F 514}	<p>Continued From page 17</p> <p>importance of tubigrip application to manage her edema however resident did not allow this nurse to perform. Resident did allow this nurse to assist her to rest in bed and elevate her legs and apply lotion before breakfast. Noted LE with less edema after legs were elevated. Continue to encourage resident to wear tubigrips as ordered by MD."</p> <p>The LN initially documented the tubigrips were in place on 1/13/15, although on four occasions they were not observed to be in place. The following day, 1/14/15, after the incorrect documentation was brought to the LN and DON's attention, the LN amended the documentation on the TAR from 1/13/15 by circling her initials and wrote a refusal on the back of the TAR. The documentation on the back of the TAR had the date of 1/13/15 and did not include "late entry" or the date the entry was made. There was no documentation on the TAR to inform readers the initial documentation was incorrect and had been amended. In addition, the January 2015 TAR had a similar order for tubigrips daily which was not amended to reflect the resident had refused them.</p> <p>On 1/14/15 at 5:30 PM, the Administrator and DON were informed of the issues related to inaccurate and incomplete documentation.</p> <p>On 1/22/15, additional information was received from the facility regarding Resident #17, which included another copy of the January 2015 TAR. This TAR documented, for 1/13/15, a date the alteration was made and the LN's initials. The back of the TAR had the date of 1/13/15 crossed out with the LN's initials and, "1/14/15 (Late entry for 1/13/15) See Above entry." The similar order for tubigrips daily, which originally documented</p>	{F 514}			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 01/14/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF POST FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 514}	Continued From page 18 the tubigrips were applied on 1/13/15 without alteration, contained a circle around the LN's initials with the explanation, "1/14/15 (late entry for 1/13/15) Resident Refused tubigrip. [Elevated] legs/Lotioned." The three TARs provided during and post survey were not corrected as required by facility policy and procedure.	{F 514}			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001415	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/14/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF POST FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(C 000)	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the State Licensure and Complaint survey followup of your facility. The surveyors conducting the survey were: Arnold Rosling, RN, BSN, QIDP Lauren Hoard, RN, BSN The Survey team entered the facility on January 13, 2015 and exited the facility on January 14, 2015.	(C 000)		
C 127	02.100,03,c,xi Private Association/Communication xi. May associate and communicate privately with persons of his choice, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician in his medical record); This Rule is not met as evidenced by: Please see F 164 as it pertains to pivity with visitors.	C 127	C 127 See Plan of Correction for F 164 as it pertains to privacy with visitors.	2-5-15
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please see F 309 as it pertains to following physician's orders.	C 784	C 784 See Plan of Correction for F 309 as it pertains to following physicians orders.	2-5-15

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FACILITY STANDARDS

Bureau of Facility Standards

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

TITLE

(X6) DATE

Robert Leary

Administrator

2-5-15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001415	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/14/2015
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF POST FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854
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{C 881}	Continued From page 1	{C 881}		
{C 881}	02.203,02 Individual Medical Record 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Please see F 514 as it pertains to medical records.	{C 881}	C881 See Plan of Correction for F514 As it pertains to medical Records.	2-5-15



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- Governor
RICHARD M. ARMSTRONG -- Director

FILE COPY

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

February 10, 2015

Robin J. Leary, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Ms. Leary:

On **January 14, 2015**, an unannounced on-site complaint survey was conducted at Life Care Center of Post Falls. The complaint allegations, findings and conclusions are as follows:

Complaint #6738

ALLEGATION:

The complainant stated the facility told four residents who resided on the 200 hall but who ate their meals in the 300 dining room, they had to eat in the main dining room from now on. They were told this an hour prior to lunch time. The reporting party was not sure who spoke to the residents. The reporting party further stated that no one from the facility talked with the group prior to the change, they were just told this was what was going to happen.

A family member of one of the residents spoke with the Administrator, at 12:00 p.m. because staff on the 300 hall could not tell her who made this decision. The lady assigned to assist the resident's table in the main dining room didn't know either; everybody had just been informed. The Administrator told the family member the management staff made the decision because it was the short stay unit and they didn't belong over there. The family member told the Administrator the resident had eaten there since May, and three of the residents used to reside on the 300 hall but had been moved to the 200 hall. It had been fine for them to eat there up until

Robin J. Leary, Administrator
February 10, 2015
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October 30, 2014, when the change occurred. The Administrator told the family member the 300 dining room was too full. Family members of residents that live on the 300 hall couldn't come in and visit them. The family member was told by the Administrator that people in the 300 dining room had complained because there wasn't enough room for everyone and their families.

The interaction with the family member took place on the 200 hall and could be heard by residents and staff that were in the area.

FINDINGS:

The complaint was investigated in conjunction with an on-site follow-up, conducted January 13 and 14, 2015. In addition to observations of the 200 and 300 hallway and main dining room, the following documentation was reviewed:

Grievance files requested but none existed; and
Residents' medical records.

The following interviews were conducted with:

Administrator;
Director of Nursing;
Social Worker;
Unit Manager of 200 hallway; and
Residents that still reside in the facility.

The information reviewed shows the facility made changes with the dining arrangements of the four residents. The residents had eaten in the 300 hall dining area for more than two weeks after they were moved to the 200 hall. The facility failed to prepare the residents and work with them on alternate choices of this significant issue. Observation of the 300 hall dining area did not confirm there wasn't enough room for the residents to eat in the dining area. The room was quieter than the main dining room and three tables were not even used during meal observation.

The complaint was substantiated and a deficiency written at F242, Residents choices.

CONCLUSIONS:

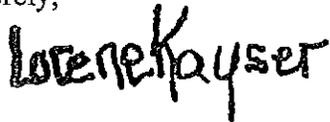
Substantiated. Federal deficiencies related to the allegation are cited.

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

Robin J. Leary, Administrator
February 10, 2015
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If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The letters are cursive and somewhat slanted to the right.

LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor
Long Term Care

LKK/dmj