



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

May 26, 2015

Irene C. Riggs, Administrator
Life Care Center of Sandpoint
1125 North Division Street
Sandpoint, ID 83864-2148

Provider #: 135127

Dear Ms. Riggs:

On **May 8, 2015**, a survey was conducted at Life Care Center of Sandpoint by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

Irene C. Riggs, Administrator
May 26, 2015
Page 2 of 4

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 8, 2015**. Failure to submit an acceptable PoC by **June 8, 2015**, may result in the imposition of civil monetary penalties by **June 29, 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; and
- Include dates when corrective action will be completed in column (X5).

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **June 12, 2015 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **June 12, 2015**. A change in the seriousness of the deficiencies on **June 12, 2015**, may result in a change

Irene C. Riggs, Administrator
May 26, 2015
Page 3 of 4

in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 12, 2015** includes the following:

Denial of payment for new admissions effective **August 8, 2015**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 8, 2015**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 8, 2015** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

Irene C. Riggs, Administrator
May 26, 2015
Page 4 of 4

<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:

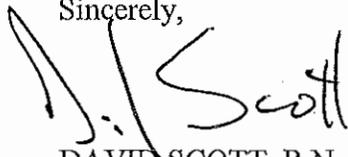
- BFS Letters (06/30/11)

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

This request must be received by **June 8, 2015**. If your request for informal dispute resolution is received after **June 8, 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 survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2.

Sincerely,



DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj
Enclosures

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT	STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864
---	--

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Linda Hukill-Neil, RN, Team Coordinator Brad Perry, BSW, LSW Linda Kelly, RN Kendra Deines RN, BSN</p> <p>The survey team entered the facility on May 4, 2015 and exited on May 8, 2015.</p> <p>This report reflects changes resulting from the Informal Dispute Resolution (IDR) process completed on July 30, 2015</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record mcg = Micrograms MDS = Minimum Data Set assessment PRN = As Needed TID = Three times a day</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,</p>	F 164	<p>Corrective Actions: F164 Res. #4 privacy is being maintained by curtains being closed during cares. LN #8 was able to return demonstration proper knowledge of privacy techniques used to ensure</p>	6/11/15

RECEIVED
SEP - 2 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Helee Riggs</i>	TITLE ED.	(X6) DATE 06/08/2015
---	--------------	-------------------------

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.

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1126 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 164	<p>Continued From page 1</p> <p>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> <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 staff interview, it was determined the facility failed to ensure privacy was maintained for 1 of 13 sample residents (#4). This failure to provide privacy during personal care created the potential for a negative effect on the resident's psychosocial well-being. Findings included:</p> <p>On 5/7/15 at 11:05 AM, Resident #4's window curtain was observed left open while a surveyor and LN #8 were in the room for a skin check. The LN raised the bed, assisted rolling the resident onto her left side, and pulled the resident's brief</p>	F 164	<p>resident privacy in front of the Staff Development Nurse (SDC). LN #8 explained she was very nervous in front of the surveyor, is why she missed closing the curtain.</p> <p>Identify other res. Who may have been affected: The residents have the potential to be affected by the window curtains not being closed. Audits will be performed to ensure residents privacy is being maintained by closing the curtains on the window to outside.</p> <p>Systemic change: How corrective action will be monitored: Nursing staff will be in-serviced on the need to maintain resident privacy by closing the curtain to the outside window when providing cares for a resident. LN's and nursing assistants were tested on privacy knowledge, what needs to occur when caring for residents to ensure privacy is maintained.</p> <p>How corrective action will be monitored: Nurse Manager's will audit resident's to ensure privacy is maintained</p>	

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 164	Continued From page 2 away to inspect her back and bottom for a resolved pressure ulcer. The resident's backside and buttocks were exposed towards the window. LN #8 then assisted the resident with rolling from side to side and onto her back, so that the resident's soiled brief could be changed, peri care performed, and a new brief applied. The window curtain was open throughout the course of the skin inspection and personal care. A garden courtyard was directly outside the resident's window. Immediately afterward, the LN was asked if she noticed the window curtain was open. The LN stated, "I didn't think about the curtain. My bad ... I looked right at it too." On 5/7/15 at 5:03 PM, the Administrator and DON were informed of the privacy concern. There was no additional information provided to alleviate the issue.	F 164	weekly times twelve weeks. Audits to begin on June 8, 2015. Audits will be brought to the Performance Improvement Committee for review of continued compliance.		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, review of abuse policies and procedures, review of abuse investigation reports, and staff interview, it was determined the facility failed to operationalize its abuse policies and procedures when it did not ensure all	F 226	Corrective Actions: Resident #19 had discharged from the facility on Feb. 18, 2015. Comments and concern card was addressed at the time with resolution and acceptance of plan by resident and spouse. Identify other res. Who may have been affected: Residents residing in the facility had the potential to be affected by the management team not acknowledging allegations of abuse and or neglect	6/11/15	

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 226	Continued From page 3 allegations of abuse/neglect were reported to the state survey and certification agency. This was true for 1 of 3 sampled alleged violation investigations. Failure to submit the allegations of potential abuse/neglect placed residents at risk for abuse. Findings included: Review of the facility's written evidence of alleged violations during the abuse task revealed various allegations toward the DON, in one report dated 1/29/15. One of the allegations in this report referred to a comment card left by Resident #19 on 12/17/14 that described alleged neglect of this resident. In the investigation of the alleged violation, the Administrator wrote, "We ruled out that any neglect happened on December 18th [for resident #19] but failed to call the allegation in. I am responsible for this mistake and take full responsibility for it." The facility was notified of this issue on 5/8/15 at 12:30 p.m. No further information was provided by the facility about the issue.	F 226	while reviewing Concerns and comment cards. This was an isolated event and was an oversight by the management team. Allegations of abuse and or neglect will be called into the state hotline within 24 hours of receipt. Systemic change: Concerns and comment cards will be reviewed by Social Services first to acknowledge any allegations of abuse or neglect. If present they will bring to or phone the Executive Director or designee immediately to ensure call to hotline is made within 24 hours. An in-service was provided by the Regional Vice President on June 3, 2015 to the Executive Director, Director of Nursing, Assistant Director of Nursing and Social Services related to identifying abuse and or neglect allegation when not put into such terms by our clients. Nursing in-service related to identifying allegations of abuse and neglect and proper procedures to follow.		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced	F 246	How corrective action will be monitored: Audits will begin on June 8, 2015 by Social Services of any Concerns and		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 246	<p>Continued From page 4</p> <p>by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a resident call light was within reach for a resident (#6). The deficient practice had the potential to cause harm if the resident's needs were not met. Findings included:</p> <p>Resident #6 was admitted to the facility on 7/15/11 with multiple diagnoses including a history of falls.</p> <p>The resident's 4/4/15 quarterly MDS assessment documented the resident was severely cognitively impaired with a BIMS of 5 and required extensive one-person assistance for transfers.</p> <p>The resident's 4/2/15 Falls Care Plan documented a problem of, "Alteration in mobility and safety" with Approaches of: ***Call light within reach; ***Pressure pad alarm to bed...; and, ***Resident is in room close to nurses station."</p> <p>On 5/6/15 at 8:32 AM, Resident #6 was observed in her bed with her covers on. The room was diagonally across from the nurses station and the door was fully opened. The resident's call light pad was on the floor next to the her bed, which was in the upright position. The outside call light was not illuminated. CNA #3 and Job Shadow #4 went into the room, past the resident's bed, retrieved Resident #6's roommate's breakfast tray and then left the room. At 8:45 AM, the call pad was still on the floor and the resident began to move around in bed. At 8:46 AM, CNA #3 and CNA #5 took Resident #4 from the dayroom next to the nurses station to her room to lay down. At 8:50 AM, Resident #6 was still in bed, with the</p>	F 246	<p>Comment cards received daily Monday thru Friday and nurse managers on Saturday and Sunday to identify allegations of abuse and or neglect for twelve weeks and if proper procedure was followed. Audits will be brought to the Performance Improvement Committee for review of continued compliance.</p> <p>F246 Corrective Actions: Res. # 6 call light was changed out from the soft touch style to the regular push button style and attached with a clip to the bed within reach of the resident. The Soft touch call light was discontinued as a fall prevention attempt as it proved to be ineffective. The resident could demonstrate during the survey to the c.n.a. how to hold the soft touch call light where it would not alarm and put it down beside the bed.</p> <p>Identify other res. Who may have been affected: Res. residing in the facility had the potential to be affected by the call</p>	06/11/15	

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 246	Continued From page 5 call pad still on the floor and there were no staff at the nurses station or in the 400 hallway. At 8:52 AM, CNA #s 3 and 5 and Job Shadow #4 were observed in the hallway. At 8:55 AM, CNA #3 was shown the call pad on Resident #6's floor and CNA #3 stated, "She knocked her call light on the floor." She then picked it up and placed it in the bed with the resident. The light went off and CNA #3 turned it off. When asked why there was not a clip to keep the call pad in place on the blanket or the bed, CNA #3 said the resident liked to move it around and it was hard for her to move it, because the resident could not unclip it. On 5/6/15 at 4:40 PM, the Administrator and DON were informed of the issue. On 5/7/15 at 4:08 PM, the Administrator said CNA #3 had talked to Resident #6 and asked about the call pad. The resident then demonstrated and lifted up the call pad, by the cord and gently placed it on the floor and the call light did not go off. The Administrator said the staff had been unaware the resident could relocate the call pad, until this incident. When asked why the resident did not have a push button call light, the Administrator said the resident would not use that type of call light. When asked if the resident said she put the call pad on the floor during the 5/6/15 observation, the Administrator stated, "She wouldn't remember, but she does know how to put it on the floor."	F 246	light not being attached to the bed and accessible. An audit of call lights was done on June 8, 2015 to ensure all call lights had clips available to secure to the bed within residents reach by the maintenance department. Systemic change: Nursing staff was in-serviced on the need to ensure residents call lights are accessible to resident and have a clip in place while in their rooms and if a call light clip is missing to replace it immediately, extra clips will be available at each nurse's station. How corrective action will be monitored: Audits will be conducted starting June 8, 2015 by managers. Audit weekly for twelve weeks to ensure call lights are accessible to resident and have a clip in place. Audits will be brought to the Performance Improvement Committee for review of compliance.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280	F280 Corrective Actions: Resident # 1 care plan has been reviewed and updated on transfer status. Res. care planned to be	6/11/15

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 280	<p>Continued From page 6</p> <p>incapacltated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews with staff and record review, it was determined the facility failed to review and revise the care plan for 4 of 15 sampled residents (#1, #8, #10 & #13) to ensure accuracy and consistency. The failure resulted in inconsistent interventions being implemented that could affect residents' health.</p> <p>1. Resident #1 was admitted to the facility in 2012 with multiple diagnoses including developmental delay.</p> <p>The 4/14/15 quarterly MDS documented the resident required one-person limited assist with transfers, extensive one person assist with toileting, and the use of a wheelchair to ambulate.</p>	F 280	<p>checked on every hour for assistance with ADLs and any transfers. Res. #1 care plan has been updated for nursing staff to ensure O2 is available in the O2 tank every three hours while on the tank and to assist res. to get new tank as needed.</p> <p>Res # 10 Oxygen order was discontinued as he no longer requires it. UTI care plan was updated as resolved.</p> <p>Res. #8 UTI care plan was updated as resolved.</p> <p>Identify other residents who may have been affected: Care plans for residents who need assistance with transfers have been reviewed and updated to ensure the current info. for transfers is in place. Resident care plans have been reviewed to ensure any temporary illnesses or interventions are up to date and resolved as appropriate. Res. who have oxygen orders care plans have been reviewed and updated to reflect procedures for changing the tubing monthly and their O2 concentrator filter cleaned by Central Supply monthly. Physician's orders and TARs have been audited to ensure they match with the care plan. Residents who use O2 tanks are being</p>	

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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)	(X6) COMPLETION DATE
F 280	<p>Continued From page 7</p> <p>The resident's CAA dated 1/13/15 states the "resident does transfer self and toilet self at times...is often independent with transfers, resident may need assistance r/t to cognition...staff have been 1 person assist to setting up resident with transfers, bed mobility, toileting..."</p> <p>The care plan for Resident #1 documented interventions for the activities of daily living: *Resident requires 1-staff extensive assist with ADLs: toileting, hygiene, dressing, and bed mobility. *Resident independent with wheelchair mobility with set-up, and is also independent with transfers in his room...</p> <p>Note: Refer to F323 for details about Resident #1's falls from the resident transferring himself.</p> <p>On 5/5/15 at 8:55 a.m., the resident was observed wheeling himself in front of a recliner and transferred himself from the wheelchair to the recliner. No staff were present for the transfer.</p> <p>On 5/5/15 at 8:20 a.m., when asked how the resident transferred, CNA #6 said the resident was "able to stand and get to the toilet himself, just have to help him clean up. We just have to stand by him to help him transfer."</p> <p>On 5/6/15 at 8:40 a.m., the resident was observed transferring himself from the wheelchair to recliner alone in his room without staff present.</p> <p>On 5/6/15 at 8:30 a.m., the RCM was asked if Resident #1 was an independent transfer or one person assist. She said, "He is supposed to be a one-person assist but he transfers himself."</p>	F 280	<p>monitored every three hours to ensure oxygen is available in the tank and assisted in getting a full/new tank as needed.</p> <p>Systemic change: In-service nursing staff on the need to keep care plans accurate and reflective of resident's current needs and to the physician's orders. Res. who are on oxygen tanks will be monitored every three hours while up and on tanks to ensure O2 is available at all times. O2 tubing will be changed out monthly and as needed per policy. O2 concentrator filters will be cleaned by central supply monthly.</p> <p>How corrective action will be monitored: Nurse Managers will conduct audits of the following;</p> <ul style="list-style-type: none"> + Care plans for residents who require assistance with transfers to ensure correct transfer intervention is on care plan. + Acute care plans will be audited for accuracy to resident's current condition and or resolved as appropriate. + Physician's orders for O2 match the care plan and TAR. 	

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 280	<p>Continued From page 8</p> <p>The facility could not specify which intervention in the care plan, one-person assist or independent with transfers, was accurate.</p> <p>2. Resident #1 was admitted to the facility in March 2012 with multiple diagnoses including coronary atherosclerosis, congestive heart failure, chronic ischemic heart disease, and chronic airway obstruction.</p> <p>The resident's most recent MDS assessment, dated 4/14/15 documented the resident required oxygen.</p> <p>The resident's care plan and April physician recapitulation orders documented, "O2 [oxygen] 0-3 liters via NC [nasal cannula] to keep sats [oxygen saturation] equal or greater than 90%."</p> <p>On 5/5/15 at 2:30 p.m., CNA #6 attempted to put new oxygen tubing on Resident #1, but the resident resisted. She told the resident his oxygen tank was empty and that she would get him a new one, but he said "no, no, no," and that he wanted to get it himself. CNA #6 said "okay," and the resident wheeled himself down to the subacute hallway. CNA #6 stated this was not uncommon for the resident. The resident was observed sitting in front of a door saying "Oxygen, oxygen, oxygen," and the RCM helped him get a new tank.</p> <p>On 5/7/15 at 10:20 a.m., the DON was asked what might happen if no one was present at that station to refill the oxygen tank. She stated, "There is a chance there would not be anyone there...She [CNA #6] should have went [sic] with him, it isn't care planned."</p>	F 280	<ul style="list-style-type: none"> + O2 tubing is care planned to be changed out monthly and ensure documentation is complete. + Central Supply cleaning logs of filters cleaned per in use concentrator monthly. + Res. Who have oxygen routine are checked every three hours when up and on O2 tank to ensure O2 is available. <p>Audits to begin on June 8, 2015. Audits will be performed weekly x 12 weeks. Audits to be taken to the Performance Improvement Committee monthly to ensure continued compliance.</p>		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 280	<p>Continued From page 9</p> <p>Note: Refer to F328 for details on concerns with Resident #1's oxygen treatment.</p> <p>3. Resident #10 was readmitted to the facility on 12/8/14 with multiple diagnoses, including Cauda equina syndrome with neurogenic bladder, acontractile detrusor, and congestive heart failure.</p> <p>The resident's April and May 2015 recapitulation Physician's Orders and TARs documented: *Change Oxygen (O2) tubing weekly on Sunday nights; *Clean filter on O2 concentrator weekly on Sunday nights; *O2 0-3 liters per nasal cannula (NC) to keep sats above 90%, obtain saturations every shift, 2 times a day.</p> <p>The resident's April 2015 MAR and a Physician's Order, dated 4/22/15, documented: *Levaquin 500 mg orally one tablet daily for 7 days with the diagnosis of UTI. The MAR documented the resident was administered the Levaquin from 4/22/15 until 4/28/15, when it was discontinued.</p> <p>The resident's Edema Care Plan documented, "Potential for respiratory compromise r/t [related to] CHF," and the interventions documented included, "Oxygen per MD orders, clean filter weekly and change tubing monthly." Note: The Physician's Order and the TAR documented the tubing was to be changed weekly.</p> <p>The resident's UTI Acute Care Plan documented, "Alteration in urinary elimination R/T [related to]</p>	F 280			

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 280	<p>Continued From page 10</p> <p>urinary tract infection," and the interventions documented included, "Meds, labs & tx [treatment] as ordered by MD ... Monitor for S/S [signs/symptoms] of adverse reaction to antibiotic until complete ... Levaquin 500 mg PO [by mouth] X [times] 7 days."</p> <p>On 5/7/15 at 2:05 PM, the DON was interviewed regarding Resident #10's oxygen and UTI Care Plans. The DON acknowledged the oxygen Care Plan should have been updated to reflect the oxygen tubing was to be changed weekly instead of monthly, stated the resident was "not indicated" to have a UTI still, and the LNs should have crossed through the UTI Care Plan and written resolved.</p> <p>4. Resident #8 was admitted to the facility on 3/23/15 with multiple diagnoses including atrial fibrillation, muscle weakness, and severe dementia.</p> <p>The resident's physician's admitting orders (PAO), dated 3/23/15, and the recapitulation May 2015 Physician's Orders (RPO) documented: PAO: "Ciprofloxacin (Cipro) 500 mg oral Twice Daily ... Last taken 3/22/15 #10 UTI [urinary tract infection]." Note: The #10 was to signify a total of 10 tablets to be given for 5 days. RPO: "3/23/15 Ciprofloxacin 500 mg tablet Take 1 tablet PO [by mouth] twice daily (UTI)." There was a line crossed through the order and hand written "DC'd" to reflect the Cipro had been discontinued.</p> <p>Resident #8's current UTI Acute Care Plan documented: "Alteration in urinary elimination R/T urinary tract infection," and the interventions documented,</p>	F 280		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 280	Continued From page 11 "Meds, labs & tx as ordered by MD ... Cipro 500 mg PO 1 tab BID [twice a day] X 5 days." On 5/7/15 at 2:15 PM, the DON was interviewed in regards to Resident #8's UTI Care Plan. The DON acknowledged the UTI "should be resolved," and the Care Plan should have been so revised. On 5/7/15 at 5:05 PM, the Administrator and DON were informed of the Care Plan concerns. The facility did not provide any additional information.	F 280			
F 309 SS=E	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, resident and staff interview, and record review, it was determined the facility failed to ensure 6 of 13 sample residents (#s 1, 2, 7, 10, 11 and 12) and 3 random residents (#s 15, 16 and 17) had: a) Orders and/or care plan for an implanted intrathecal (IT) pain pump that included the dose of the medication, location of the pump and interventions (R#2); b) Physician orders for pain level assessments, fentanyl pain patch placement monitoring, TED hose (type of anti-embolism stocking) placement	F 309 F309	Corrective Actions: Resident #2 has an updated care plan and orders for the implanted intrathecal (IT) pain pump with information regarding medications dose(s) and volume, location and interventions to use. The MAR was updated to include the IT information with refill interval date marked to alert nursing to arrange for appointment at the pain clinic. Resident #1, 10, 12, & 17 Fentanyl patches being monitored and documented per policy by licensed nurse. Resident #7 has expired. Res. #1 pain level is being monitored per shift and documented. Res. #11 dialysis shunt is being monitored daily for thrill and bruit.	6/11/15	

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 309	<p>Continued From page 12</p> <p>and laboratory (lab) tests were followed; and, c) Communication between a dialysis provider and the facility was maintained.</p> <p>Lack of information in IT pain pump orders and direction in the care plan placed Resident #2 at risk for staff not to recognize complications which could result in delayed interventions. Failure to follow physicians orders placed residents at risk for unmanaged pain, diversion of transdermal pain medication, delayed treatment related to lab tests and unmanaged edema (swelling). In addition, incomplete documentation before and after dialysis and by a dialysis provider placed Resident #11 at risk for medical complications. Findings include:</p> <p>1. Resident #2 was admitted to the facility in July 2013 with multiple diagnoses, including chronic pain syndrome, chronic degenerative disc disease of the lumbar spine, osteoarthritis, chronic obstructive pulmonary disease, history of stroke and neuropathy.</p> <p>The resident's most recent quarterly MDS assessment coding, dated 4/26/15, included moderate cognitive impairment with a BIMS score of 11, extensive assistance for all ADLs except eating, and almost constant pain at a level of 8 on scale from 0-10 with 10 as the worst pain.</p> <p>The resident's pain CAA analysis of findings, dated 1/26/15, documented, "Long hx. [history] of chronic pain although pain has increased. Cymbalta for pain was discontinued in November, and her pain pumps [sic] battery is almost done...MD [physician] increased scheduled dose of morphine..."</p> <p>The resident's Physician Orders for May 2015</p>	F 309	<p>Pre/post dialysis communication form is completed prior to dialysis by facility licensed nurse (LN) and then sent to the dialysis center for their section to be filled out and upon return to skilled nursing facility the post dialysis section is completed by the LN. LN to call dialysis center to obtain information if they do not document in their section.</p> <p>Res. # 15 has discharged. Res. #16 has expired.</p> <p>Other residents who may be affected: No other res. have implanted intrathecal pain pumps at this time. Upon admission of a res. with an implanted IT pain pump information will be on MAR monitoring for a low reservoir alarm and refill date. A care plan will be implemented to monitor the implanted pain pump with location identified and interventions to use. Residents who have been prescribed a Fentanyl patch have had their MAR updated to ensure monitoring of patch is being documented every shift per policy and pain scales documented every shift. Residents with physician's orders for TED hose are care planned, on TAR (treatment administration record) and on resident</p>		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 309	<p>Continued From page 13</p> <p>pain medication orders included:</p> <ul style="list-style-type: none"> * 7/2/13 - "fentanyl pain pump - schedule II INFO [information] Other chronic pain"; * 7/2/13 - acetaminophen 325 mg suppository 1 or 2 per rectum every 4 hours PRN for pain or fever; * 7/2/13 - acetaminophen 325 mg tab, 1 or 2 tabs by mouth (PO) every 4 hours PRN pain or fever * 2/13/14 - morphine 30 milligrams (mg) 1 tablet (tab) PO twice a day; and, * 11/11/14 - Percocet 5-325 mg tab, 1 every 4 hours PO every 4 hours PRN pain. <p>There were no other orders regarding the IT fentanyl pain pump.</p> <p>The resident's care plan identified, "Pain: chronic back pain as evidenced by complains of pain relating to arthritis" as a problem on 7/15/13. The goals included, "Resident will state/demonstrate relief or reduction in pain intensity within one hour after receiving interventions through next review date," with a target date of 5/11/15. Approaches included, "Administer/observe for effectiveness and for possible side effects from routine pain medication (see MAR)..."</p> <p>The care plan did not include anything about the IT fentanyl pain pump.</p> <p>On 5/4/15 at 1:15 pm, the resident was interviewed and asked about her pain. The resident showed the surveyor the IT pump that was implanted in her right abdomen, and said she had had the IT pump for "many years." She said her pain was "severe" before the battery was "recently" changed, and that the pain had been much better since.</p>	F 309	<p>as ordered. Residents who are receiving pain medications have been reviewed for pain assessments are present.</p> <p>No other residents on dialysis at this time. Upon admission of a resident with dialysis shunt monitoring will be done daily for assessment of thrill and bruit. Pre/post dialysis communication form is completed prior to dialysis by facility licensed nurse (LN) and then sent to the dialysis center for their section to be filled out and upon return to skilled nursing facility the post dialysis section is completed by the LN.</p> <p>Systemic change: Licensed Nursing staff in-serviced on implanted IT pump and necessary monitoring, documentation of pain level assessments, Fentanyl patch monitoring and documentation of such each shift, ensuring placement and removal of TED hose (anti embolism stockings) as ordered, completion of the pre/post dialysis form, calling dialysis center to get info. if their documentation is incomplete, documentation in the TAR (treatment assessment record) for assessment of the dialysis shunt site as ordered and care planned. Fentanyl patches will be</p>		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 309	<p>Continued From page 14</p> <p>The resident's April and May 2015 MARS included "7/2/2013 fentanyl pain pump - schedule II INFO" and the other aforementioned pain meds.</p> <p>Review of the resident's clinical records revealed there were no other orders, instructions, information or care plan regarding the IT fentanyl pain pump.</p> <p>On 5/4/15 at 10:35 am, the DON stated that Resident #2 had an implanted "baclofen" pain pump.</p> <p>On the morning on 5/5/15, the DON provided a list of residents with implanted devices with Resident #2's implanted device listed as a "baclofen" pain pump.</p> <p>On 5/6/15 at 11:50 am, the DON was asked to provide documentation regarding the dose of the IT fentanyl, the location of the implanted device, follow-up appointment information and interventions in case of problems or pump malfunction. The DON stated, "I know it says fentanyl but it's baclofen." The DON reviewed the resident's paper chart but did not find any of the requested documentation. However, the DON found a physician's note that documented fentanyl in the pain pump. The DON stated, "I always thought it was baclofen." The DON said a packet of information about the IT pump may be on the med cart at the nurses station.</p> <p>On 5/6/15 at 12:05 pm, the surveyor and DON went to the med cart, however, the DON did not find any information about the IT pain pump on the med cart or at the nurses station.</p>	F 309	<p>monitored by one nurse per shift per Life Care policy.</p> <p>How corrective action will be monitored:</p> <p>Nurse Managers will conduct audits weekly for twelve weeks of MARS and TARS for:</p> <ul style="list-style-type: none"> + any omissions in documentation on residents pain scale every shift, + implanted pain pumps will be monitored for effectiveness and follow-up appointment, + TED hose are applied/removed as ordered and documented, + Dialysis resident's shunts are Monitored as ordered by M.D. and Documented, + Pre/post dialysis communication form is completed post dialysis. <p>Audits to begin on June 8, 2015. Audits to be taken to the Performance Improvement monthly meeting to ensure compliance or corrective action needed.</p>		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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)	(X6) COMPLETION DATE	
F 309	<p>Continued From page 15</p> <p>On 5/7/15 at 3:00 pm, the DON provided pain clinic visit notes which she said she found in the resident's overflow chart. The most recent pain clinic visit note, dated 11/18/14, documented the IT pump contained fentanyl 1000.0 micrograms/milliliter (ug/mL) and bupivacaine 15 milligrams/mL (mg/mL), delivered fentanyl 384.4 ug per day and bupivacaine 5/772 mg per day, the Volume" was 2.0 mL, the refill interval was 98 days and the "Low Reservoir Alarm Date" was 2/24/15. The DON confirmed this information was not readily accessible to staff or other health care providers.</p> <p>The facility did not provide any other information which resolved the issue.</p> <p>2. Resident #10 was readmitted to the facility on 12/8/14 with multiple diagnoses, including idiopathic peripheral neuropathy and chronic pain.</p> <p>Resident #10's Pain Care Plan documented the problem of chronic pain as evidenced by complaints of pain relating to neuropathy, restless leg syndrome and history of substance abuse. The interventions were documented as, "LN to administer pain medications as prescribed: Fentanyl patch. LN to check and apply Fentanyl patch per physician's order ... Resident has a long hx [history] of chemical and alcohol dependency..."</p> <p>The resident's May 2015 recapitulation Physician's Orders documented: *Fentanyl 50 mcg/hr transdermal patch apply 1 patch topical every 72 hours. *2 LN to check placement and date of Fentanyl patch at change of every shift 2 times a day.</p>	F 309			

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1126 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 309	<p>Continued From page 16</p> <p>The resident's April and May 2015 MAR documented an order, dated 12/8/14, for a 50 mcg Fentanyl transdermal patch.</p> <p>The resident's April and May 2015 MAR documented, "2 LN to check placement and date of Fentanyl patch at change of qs [every shift] 2 X [times]/day." The April MAR documented 19 times where only one LN signed off the placement of the patch. The May MAR documented five times where only one LN signed off the placement of the patch.</p> <p>3. Resident #16 was admitted to the facility on 4/17/15 with multiple diagnoses, including pathologic fracture of vertebrae, spinal stenosis, and lumbago.</p> <p>Resident #16's Pain Care Plan documented the problem of acute pain as evidenced by complaints of pain relating to fracture of spine. The interventions documented included, "Administer/observe for effectiveness and for possible side effects from pain medication - Routine pain medication (see MAR) - PRN pain medication (see MAR)."</p> <p>The resident's May 2015 recapitulation Physician's Orders documented: *Fentanyl 25 mcg/hr transdermal patch apply topical every 72 hours. *2 LN to check Fentanyl patch placement and date 2 times a day.</p> <p>The resident's April and May 2015 MAR documented an order, dated 4/17/15, for a 25 mcg Fentanyl transdermal patch.</p>	F 309			

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 309	<p>Continued From page 17</p> <p>The resident's April and May 2015 MAR documented, "2 LN to check Fentanyl Patch placement and date 2 x [times a] day." The April MAR documented 11 times where only one LN signed off the placement of the patch and on 4/19/15 for the day shift there was no LN who signed for the Fentanyl patch placement. The May MAR documented seven times where only one LN signed off the placement of the patch and on 5/5/15 for the day shift there was no LN who signed for the placement of the Fentanyl patch.</p> <p>On 5/7/15 at 1:52 PM, the DON was asked about Fentanyl patch placement checks for Resident #s 16 and 10. The DON stated, "I know there's [sic] holes in there. I had too many patches missing and so I wanted to make sure they were seen per shift." The DON said she considered the Fentanyl patch a medication that was an "easy one to divert." The DON acknowledged the Fentanyl placement check at least twice a day was not a corporate policy, but it had been made the facility's policy. The DON also stated the checking of placement ensured residents were receiving the Fentanyl and the patch had not been accidentally removed.</p> <p>4. There were similar findings in regards to two LNs checking Fentanyl patch placements for Resident #17.</p> <p>On 5/7/15 at 5:05 PM, the Administrator and DON were informed of the Fentanyl placement checks not being completed as ordered. The facility did not provide any additional information to alleviate the concerns.</p> <p>5. Resident #12 was readmitted to the facility on</p>	F 309		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 309	<p>Continued From page 18 7/14/14 with multiple diagnoses, including chronic pain.</p> <p>The resident's Pain Care Plan documented a target date of 8/6/15 with an Approach of, "LN to monitor and assess for pain every shift and administer medication as prescribed for pain."</p> <p>The resident's April and May 2015 MAR documented an order, dated 4/17/15, for a 25 mcg transdermal patch.</p> <p>The resident's April and May 2015 MAR documented, "2 LN to check Fentanyl Patch placement and date 2 x [times a] day." The April MAR documented three times where only one LN signed off the placement of the patch and the May MAR documented one time where only one LN signed it off.</p> <p>On 5/7/15 at 1:52 PM, the DON was asked about Fentanyl patch placement checks. The DON stated, "I know there's [sic] holes in there."</p> <p>6. Resident #7 was admitted to the facility on 1/14/14 with multiple diagnoses, including paralysis agitans.</p> <p>The resident's physician's telephone orders, dated 6/4/14, documented, "Compression stockings on Bilateral legs, on in AM off at bedtime" for edema.</p> <p>The resident's Risk for Pressure Ulcers, with a target date of 8/6/15, documented an Approach of, "Ted Hose- On in AM; Off in PM."</p> <p>On 5/5/15 at 8:10 AM, the resident was observed in his wheelchair in the 100 hallway dayroom,</p>	F 309			

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 309	<p>Continued From page 19</p> <p>eating breakfast. The resident wore sandals without any socks or compression hose on either foot.</p> <p>On 5/7/15 at 11:45 AM, the DON was informed of the observation. She stated, "I would have to ask who worked that day." At 4:45 PM, the DON informed the surveyor she had checked with the CNA and the hose were not placed on the resident's feet the morning in question.</p> <p>7. Resident #1 was admitted to the facility in 2012 with multiple diagnoses including chronic chest pain.</p> <p>The resident's pain care plan dated 9/30/12 documented a problem of chest pain and a history of gout. Interventions for pain included: "*Assess, treat, and document for pain every shift, and PRN as needed. *LN to monitor and assess for pain q [every] shift. Document pain level and provide routine and PRN [as needed] pain medication as prescribed. Document effectiveness."</p> <p>The resident's February 2015 MAR documented pain assessments every shift (started 3/21/12). February 1-8, 2015 had no documentation for assessment of pain on the evening shift.</p> <p>The resident's February 2015 MAR also documented, "2 LN's to check placement of Fentanyl patch at change of each shift, q shift." (Started 1/24/14) Twenty-three instances of only one nurse sign off on this check occurred during the month of February (23 out of 84 checks or 27% of checks were missing from documentation).</p>	F 309		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 309	<p>Continued From page 20</p> <p>The resident's March 2015 MAR documented the same Fentanyl patch check order as above. Eight instances of only one nurse signing off on this check occurred during the month of March.</p> <p>Note: Recognizing pain by assessment and checking the application of the pain patch helps the resident maintain his highest practicable level of well being by preventing pain.</p> <p>On 5/7/15 at 10:20 a.m., the DON was asked about the missing documentation, and agreed the documentation for Fentanyl placement checks for February and March, and pain assessment documentation for February, was "not there."</p> <p>8. Resident #11 was admitted to the facility in 2013 with multiple diagnoses including cirrhosis of the liver, severe chronic kidney disease, with a renal dialysis status.</p> <p>The care plan for the resident regarding dialysis/renal failure documented the following interventions (started 8/21/13): "**Communicate with dialysis center regarding medication, diet, lab results. Coordinate resident's care in collaboration with dialysis center; *Monitor shunt site every shift for redness, swelling, pain, bleeding, and by palpating for thrill and auscultating for bruit. Notify dialysis of absence of thrill or bruit or s/s (signs and symptoms) of infection; *Observe and report to physician complications related to renal failure...; and, *Resident to receive dialysis 3x [times] weekly on Monday, Wednesday, Friday."</p>	F 309		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 309	<p>Continued From page 21</p> <p>Note: The resident had an internal arteriovenous fistula (AVF or "shunt") that was used to access the veins and arteries needed for dialysis. Assessment for "thrill" and "bruit" ensured proper circulation of blood flowing through the vein and artery at the site. Assessment of redness, swelling, or pain also ensured no complications with the fistula.</p> <p>Record review of the March and April 2015 "Dialysis Record Shunt" revealed missing assessment of: *Check thrill & bruit every shift (38 out of 93 for March and 36 out of 93 for April); *Shunt site checks every shift... (36 out of 93 for March and 36 out of 93 for April); *Check shunt every 30 min for 2 hours post return from dialysis... (24 out of 52 for March and 32 out of 48 for April); and, *Pre/Post dialysis sheet completed & sent with res [resident] and completed on return with res (9 out of 21 for March and 11 out of 18 for April).</p> <p>There was no "Pre/Post Dialysis Communication" documentation done by the facility for pre- or post-assessments on 3/6, 4/15, and 4/17.</p> <p>"Pre/Post Dialysis Communication" documentation by the Dialysis Service had no documentation (except vital signs) twice in March (3/16 & 3/27/15) and and twice in April (4/3 & 4/4/20/15). The condition of the site, assessment of bruit, assessment of thrill, and additional information about the visit or type of vascular access was not completed on these dates.</p> <p>On 5/7/15 at 1:30 p.m., the RCM stated, when asked if there were any other place these assessments could be, "Just those forms in the</p>	F 309		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 309	<p>Continued From page 22 binder [referring to "Pre/Post Dialysis Communication" forms]. Maybe progress notes but those are the only ones I know of."</p> <p>Note: Progress notes for March and April 2015 did not reveal any additional dialysis assessments.</p> <p>On 5/8/15 at 12:30 p.m., the facility was notified of these issues. The facility did not provide any further information.</p> <p>9. Resident #15 was admitted 1/28/15 for a hospice respite stay and was discharged 2/2/15. The resident was admitted with multiple diagnoses including alzheimers.</p> <p>Review of physician recapitulation orders documented interventions for pain: **Pain assessment every shift...; *Tylenol 325 mg tablet 1 tab every 4 hrs PO PRN; *Tylenol 325 mg tablet 2 tabs every 4 hrs PO PRN; *Hydrocodone 5mg-325mg acetaminophen tablet 0.5 to 1 tab every 6 hrs PO PRN; and, *Tramadol 50 mg tablet up to 4x [times] daily PO PRN."</p> <p>Review of the January 2015 MAR had no pain assessments documented for the evening shift on 1/29, 1/30, 1/31, & 2/1/15.</p> <p>Review of the resident's "Interim Care Plan" documented multiple needs to focus on, however, pain was not a "resident need" documented on.</p> <p>On 5/8/15 at 10:20 a.m., the DON said "it's not there," when asked about the incomplete pain assessments and care plan.</p>	F 309			

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

PRINTED: 09/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 309	Continued From page 23 On 5/8/15 at 12:30 p.m., the facility was notified of these issues. The facility did not provide any further information.	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, policy and procedure review, and staff interview, it was determined the facility failed to: *Prevent pressure ulcers from developing; *Prevent healed pressure ulcers from recurring; *Follow physician intervention recommendations; *Ensure treatment orders were clear; and, *Ensure treatment orders were followed. This affected 1 of 3 residents (#4) reviewed for pressure ulcers. The resident also developed an additional Stage II pressure ulcer to the coccyx while in the facility. Findings included: The facility's Pressure Ulcer Prevention policy, revised on 10/7/10, documented: "Repositioning should be part of the resident's care plan and regular routine to reduce the duration and magnitude of pressure over	F 314	F314 Corrective Action: Resident #4 MD orders, care plan, and TAR have current pressure ulcer prevention interventions. Appropriate pressure relieving wheelchair cushion/Vector and a Sapphire alternating air mattress are in place per M.D. order to reduce the risk of pressure ulcers. Repositioning is being done and documented per current care plan interventions. Res. will have skin checks weekly to ensure early detection of altered skin integrity. Other residents who may be affected: Res. who are assessed to be high risk for pressure ulcers or are admitted with pressure ulcer(s) have had their care plans and TARs reviewed to ensure appropriate prevention interventions are in place to reduce the risk of pressure ulcers and the early detection of any change in skin integrity in a pressure area.	6/11/15	

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 314	<p>Continued From page 24</p> <p>vulnerable areas of the body...A two-hour turning schedule is appropriately used as a guideline. Frequency of repositioning is determined by the resident's individualized needs (individual assessment) and the support surface in use. Some residents may require repositioning on an hourly basis..." and</p> <p>"Use a pressure-redistributing seat cushion for residents whose mobility is reduced and who are at risk of pressure ulcer development. Limit the time the resident spends seated in a chair (including wheel chairs) without pressure relief."</p> <p>1. Resident #4 was admitted to the facility on 8/9/10 with multiple diagnoses including hemiplegia, peripheral vascular disease and above knee amputation.</p> <p>The resident's Fax Order Request/Notification Form, dated 3/5/14, documented, "[Resident #4] continues to decline slowly. She is not eating well despite cueing. Is her weight loss expected & unavoidable?" In the physician's section, dated 3/6/14 was a check mark next to the word "yes."</p> <p>The resident's weight history documented the resident's weight from July to September 2014, ranged from 112- to 118 pounds and from December 2014 to March 2015, it ranged from 113- to 118 pounds:</p> <p>The resident's 7/29/14 quarterly MDS assessment documented the resident: *Was severely cognitively impaired with a BIMS of 5; *Required extensive assistance for bed mobility, transfers, dressing, personal hygiene, bathing, and toilet use; *Had a range of motion impairment for the upper</p>	F 314	<p>Systemic changes:</p> <p>In-serviced licensed nursing and nursing assistants on pressure ulcer prevention interventions and the need to follow individualized care plans. The importance of documenting on the TAR and turning schedules the interventions that are ordered by the physician, how to clarify and proceed to update the care plan, if it does not match the current MD orders, or to seek a new MD order if no longer appropriate.</p> <p>How corrective action will be monitored:</p> <p>Res. assessed to be high risk of development of a pressure ulcer or has a pressure ulcer will be audited by nurse managers for current interventions on care plan, documented on TAR, and in place to reduce the risk of pressure ulcer(s) starting June 8, 2015. Audits will be done weekly for 12 weeks to ensure appropriate interventions are in place and documented, care planned, and match M.D. orders. Audits to be taken to the Performance Improvement monthly meeting to ensure compliance or corrective action needed.</p>		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 314	<p>Continued From page 25 and lower extremities on one side; *Was frequently incontinent of bladder; *Did not have a pressure ulcer; and, *Was at risk of pressure ulcers.</p> <p>a. Resident #4's Braden Scale, dated 8/11/14, documented a score of 13, which placed the resident at a moderate risk of developing pressure ulcers.</p> <p>The resident's Pressure Ulcer care plan, with target dates of 6/9/14 and 8/20/14, documented problems of, "Resident has potential fo[r] pressure ulcer relating to decreased mobility..." Undated interventions included: "Provide pressure relieving or reduction device, pressure reduction mattress, Vector cushion in W/C [wheelchair]," and "Turn and reposition resident every 2 hours and PRN."</p> <p>The resident's August 2014 TAR documented a nurse's order, dated 5/22/14, to "turn every hour, LN to check." There were no check marks on the form. However, progress notes on 8/19/14, 8/20/14, and 8/22/14 documented the resident was turned every hour on those dates.</p> <p>The resident's August 2014 Monthly Flow Report documented the resident was repositioned every hour on one of two shifts on 8/20/14, 8/30/14, and 8/31/14. There were no check marks on any other day in August. Note: CNAs worked 12 hour shifts on the resident's unit at that time.</p> <p>The resident's August 2014 Monthly Flow Report documented the resident was not repositioned every two hours for 16 of 31 days.</p> <p>The following documentation was reviewed in the</p>	F 314			

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 314	Continued From page 26 resident's Pressure Ulcer Status Record (PUSR), Acute Care Plan (ACP), Progress Notes (PN), Fax Order Request (FOR), Physician Telephone Orders (PTO), Nurse Practitioner Notes (NP), and Care Plan (CP): *8/19/14 at 11:01 AM and 8:57 PM (PN)- "Resident with excoriated area to l[ef]t buttocks and Calmoseptine to area, will turn every h[ou]r and monitor till resolved. MD faxed." Complaining of pain from her wound. Pain meds given, repositioned in her wheel chair. She continued to complain loudly, begging to be put to bed to relieve her pain...Calmoseptine on open area..." *8/20/14 at 1:38 PM (PN)- "0.7 x[by] 0.6 open area to lt inner buttocks. Cleaned with n/s [normal saline] and Mepilex to area...MD faxed...Re-positioned to side in bed;" *8/20/14 (PUSR)- Location: Left ischial; Stage: II; Measurements: 0.7 x 0.6 cm with 0.5 x 0.2 cm area at 10 o'clock; Granulation: "Surrounding tissue dark but blanchable;" *8/20/14 (ACP)- Problem: "Open area L buttocks Stg II." Approach: "1. Reposition to side in bed [and] when in w/c every 2 hrs. 2. Continue w/c cushion. 3. Mepilex border;" *8/22/14 at 8:30 AM (PN)- "Her appetite is fair. She has weight loss that is expected and unavoidable per MD." Note: From 6/17/14 to 8/19/14, the resident's weight ranged from 119- to 117 pounds; *8/27/14 (PUSR)- Measurements: 1.0 x 0.2 cm; Color: Pink base; *9/2/14 (FOR)- The facility requested orders to treat weight loss prevention and wound healing, *9/4/14 (PN)- "Resident seen by wound team today for a stage 2 to her left ischial. Area is resolved today." b. Resident #4's Braden Scale, dated 9/25/14,	F 314			

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 314	<p>Continued From page 27</p> <p>documented a score of 13, which placed the resident at a moderate risk of developing pressure ulcers.</p> <p>The resident's Pressure Ulcer care plan, with the target date of 11/6/14, documented problems of, "Resident has potential fo[r] pressure ulcer relating to decreased mobility..." Undated interventions included: "Provide pressure relieving or reduction device, pressure reduction mattress, Vector cushion in W/C ... Turn and reposition resident every 2 hours and PRN."</p> <p>The resident's September 2014 TAR, documented a nurse's order, dated 5/22/14, documented, "Turn every hour, LN to check." There were no check marks on the form. However, progress notes from 9/25/14 to 9/29/14 documented the resident was turned every hour for those dates.</p> <p>The resident's September 2014 Monthly Flow Report documented the resident was repositioned every hour on one of two shifts on 9/26/14, 9/27/14, and 9/30/14. There were no check marks on any other day in September.</p> <p>The resident's September 2014 Monthly Flow Report and TAR documented the resident was not repositioned every two hours for 17 of 30 days.</p> <p>The resident's medical record also documented: *9/25/14 (PN)- "Resident seen by wound nurse and PT [Physical Therapy] for reopened area to her left ischial. Area is fragile and was recently resolved stage 2 on 9/5/14 that is open again. Area measures 0.5 x 0.6 cm with a tan center</p>	F 314			

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 314	<p>Continued From page 28</p> <p>and surrounding tissue is pink and blanchable and measures 5.0 x 2.8 cm;"</p> <p>*9/25/14 (PUSR)- Location: Left ischial; Stage: II; Measurements: 0.5 x 0.6 cm; Depth: [less than] 0.1; Color: tan scab present [with] surrounding tissue red; Appearance: Fragile [and] open;</p> <p>*9/25/14 (ACP)- Problem: "Open area L buttocks Stg II...Area reopened" Approach: "McKesson cream to area each shift by LN [and] prn. Pressure reducing w/c cushion [and] pressure relieving mattress;"</p> <p>*10/1/14 (PN)- "RAR [Resident At Risk] Review for skin: Resident is on regular pureed diet with fortified foods and thin liquids. She eats with staff assistance...Her ADI [Average Daily Intake] of meals is 26 [percent]. W[ei]ght 111.6 lbs on 9/26/14. She is within her IBWR [Ideal Body Weight Range] of 106-130 lbs. She has a healing stage 2 to her left ischial that has recently reopened...;"</p> <p>*10/3/14 (PUSR)- Measurements: 0.3 x 0.1 cm; Depth: [less than] 0.1; Color: surrounding area pink blanchable;</p> <p>*10/7/14 (PN)- "RAR [Resident At Risk] Review for skin: ...Her ADI of meals is 47 [percent]. Wt 111.4 lbs on 10/3/14. She is within her IBWR...Her weight loss is expected and unavoidable [No explanation provided]. She has a healing stage 2 to her left ischial that is healing slowly..;"</p> <p>*10/8/14 (PUSR)- "Resolved;" and,</p> <p>*10/10/14 (PN)- "Late entry for 10/8/14-Resident seen by wound team for a resolved stage 2 to her left ischial. Area is closed today...Resident will continue to be turned every 2 hrs..."</p> <p>c. Resident #4's 12/31/14 annual MDS assessment, documented the resident: *Was severely cognitively impaired with a BIMS</p>	F 314			

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 314	<p>Continued From page 29 of 3;</p> <ul style="list-style-type: none"> *Required extensive assistance for bed mobility, transfers, dressing, personal hygiene, bathing, and toilet use; *Had a range of motion impairment for the upper and lower extremities on one side; *Was always incontinent of bowel and bladder; *Did not have a pressure ulcer; *Had a healed stage 2 pressure ulcer; and, *Was at risk of pressure ulcers. <p>The resident's Braden Scale, dated 10/22/14, documented a score of 13, which placed the resident at a moderate risk of developing pressure ulcers.</p> <p>The resident's January 2015 TAR, included a nurse's order, dated 10/24/14, that documented, "Turn and reposition every 2 hours in Bed and Wheelchair. 2[times a] day."</p> <p>The January 2015 TAR contained a column of boxes labeled "Days" and one labeled "Eves." All the boxes in January were signed.</p> <p>Conversely, the resident's January 2015 Monthly Flow Report documented the resident was not repositioned every two hours on 1/4/15 and 1/8/15 and from 1/9/15 to 1/31/15, the resident was not repositioned every hour.</p> <p>The resident's Pressure Ulcer care plan with the target date of 2/11/15, documented problems of, "Resident has potential fo[r] pressure ulcer relating to decreased mobility..."</p> <p>Approaches included:</p> <ul style="list-style-type: none"> *Undated, "Provide pressure relieving or reduction device, pressure reduction mattress, Vector cushion in W/C " and "Turn and reposition resident every 2 hours and PRN." and 	F 314		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 314	<p>Continued From page 30</p> <p>*10/8/14, "Lipped care mattress for pressure reduction [with] ledge definitions."</p> <p>The resident's medical record also documented: *1/8/15 (PN)- "Resident on alert for an open area to her left gluteal fold. Approximately [sic] 1.5 cm x 1 cm.;" Note: This wound was clarified by the facility to be on the left ischial. *1/9/15 (PUSR)- Stage: II; Measurements: 0.8 x 0.8 cm; Color: dry pink base; *1/9/15 (ACP)- Problem: "Stg II Left gluteal fold" with Approach of, "1. Last up, First down schedule. 2. Frequent turning in bed every hour during the day, every 2 [hours at] hs [night];" *1/11/15 (PN)- "Late entry for 1/089/2015 [sic] -Resident seen by wound team for a reoccurring stage 2 to her left gluteal fold. Area has been open before...We will initiate turning and repositioning every 1 hour during the day and every 2 hrs at night;" *1/13/15 (PN)- "RAR Review for skin: ...Wt 114.6 lbs on 1/8/14 [15]. She is within her IBWR...ADI of meals is 54 [percent];" *1/16/15 (PUSR)- Measurements: 0.5 x 0.5 cm; Color: pink base; *1/23/15 (PN)- "Resident seen by wound team today for a slowly resolving stage 2 pressure area to her left gluteal fold. Area measures 0.4 x 0.5 cm and is recurrent. No drainage or odor. Depth [less than] 0.1 cm.;" *1/29/15 (PN)- "...Area measures 0.5 x 0.5 cm and is [less than] 0.1 cm in depth." *2/6/15 (PUSR)- Measurements: 0.5 x 0.2 cm; Depth: [less than] 0.1 cm; Color: pale pink; Appearance: dry pale pink base; *2/10/15 (NP)- "The p[atien]t is seen in her room with the DNS present. She reports that the patient has a It ischial lesion that heals and recurs. It has been present greater than one month this time.</p>	F 314		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 314	Continued From page 31 The pt is on a 2[inch] offloading w/c cushion. She has a R[ight] AKA [above knee amputation] and has Lt hemiplegia. She tends to rock when seated, increasing abrasion from her brief. CGs [sic] have tried using a different type of brief to keep edges off the abrasion...Assessment [and] Plan:...PT to assess for w/c positioning needs. Consider Jay 3 w[ith] gel ischial inserts or similar. Pt may need to have support beneath Lt leg to compensate for hemiparesis and leaning to Lt. Consider pommel." *2/10/15 (PTO)- "1) P.T. to assess for w/c cushion (Recommend 4[inch] cushion [for] ischial offloading, consider "Pommel").;" *2/10/15 (PN)- "New cushion ordered that is 4 inches to assist with offloading ischial area due to resident CVA [Cerebrovascular Accident] and left sided weakness." *2/10/15 (CP)- "Vicair Vector w/c cushion;" *2/11/15 (PUSR)- Measurements: 0.2 x 0.1 cm; Depth: [less than] 0.1 cm; Color: pale pink; Appearance: dry edges; *2/12/15 (FOR)- "Received order for PT to eval[uate] for w/c cushion/seat to facilitate ADLs [and decrease] risk for skin breakdown. Okay [with] you if OT [Occupational Therapy] to address. She is now on Vector cushion." Under the physician's section was a box for OT to evaluate and treat with a check mark next to "yes;" *2/19/15 OT evaluation: "New orders for O.T. w/c positioning, however nursing using Vector pressure relieving cushion which was in use prior and also using lateral supports, which were in proper position. Pt was sitting upright with good UB [upper body] alignment no leaning R or L." *2/19/15 (PTO)- "D/C [discontinue] order for O.T. Eval [and] Tx [treatment] for w/c positioning as nursing has provided pt [with] Vector pressure	F 314			

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 314	<p>Continued From page 32</p> <p>relieving cushion also has lateral supports good w/c positioning at this time."</p> <p>*2/20/15 (PUSR)- Measurements: 0.2 x 0.1 cm; Depth: [less than] 0.1 cm; Color: pale pink; Appearance: dry white edges;</p> <p>*2/20/15 (PN)- "...She has a pressure relieving mattress and a 4[inch] pressure relieving wheelchair cushion to offload area;"</p> <p>*2/25/15 (PN)- "Resident seen on wound rounds today for a stage 2 to her left ischial that is now resolved...She has a pressure relieving mattress on her bed and a 4[inch] pressure relieving cushion in her wheelchair to off load area;" and,</p> <p>*3/4/15 (PN)- "Resident seen on wound team today for a stage 2 to her left ischial. Area is still resolved today...Resident has a pressure relieving mattress on her bed and a 4[inch] pressure relieving wheel chair cushion to off load area when sitting."</p> <p>d. Resident #4's Braden Scale, dated 1/9/15, documented a score of 15, which placed the resident at risk of developing pressure ulcers.</p> <p>The resident's March 2015 TAR, included a nurse's order, dated 10/24/14, that documented, "Turn and reposition every 2 hours in Bed and Wheelchair. 2[times a] day."</p> <p>The resident's March 2015 TAR contained a column of boxes labeled "Days" and one labeled "Eves." All the boxes in March were signed or there was a corresponding progress note, except for 3/4/15 and 3/13/15.</p> <p>The resident's March 2015 Monthly Flow Report documented the resident was not repositioned every two hours 8 of 31 days.</p> <p>The resident's Pressure Ulcer care plan, with the</p>	F 314			

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 314	<p>Continued From page 33</p> <p>target date of 4/10/15, documented problems of, "Resident has potential fo[r] pressure ulcer relating to decreased mobility, frequent re-occurring stage 2 left gluteal fold..."</p> <p>Approaches included:</p> <p>*Undated-"Provide pressure relieving or reduction device, pressure reduction mattress, Vector cushion in W/C;"</p> <p>*Undated - "Turn and reposition resident every 2 hours and PRN;"</p> <p>*Undated - "Last up for meals, and first down;"</p> <p>*10/8/14 - "Lipped care mattress for pressure reduction [with] ledge definitions;" and,</p> <p>*2/10/15 - "Vlcair Vector w/c cushion."</p> <p>The resident's medical record also documented:</p> <p>*3/19/15 (PN)- "Resident seen by wound team today for a stage 2 to her coccyx. Area measures 1.0 x 0.5 cm and has a tan colored base. Area looks like it is a open area due to shearing...She has a pressure relieving mattress when in bed and a 4[inch] pressure relieving wc cushion when sitting up. She is turned and repositioned every 2 hours by staff;"</p> <p>*3/19/15 (PTO)- "Regular Duoderm to Stage II on coccyx ... Sapphire lipped air mattress for skin risk prevention/pressure reduction and ledge definitions;"</p> <p>*3/24/15 (PN)- "RAR review for skin; Resident with a new stage 2 on her coccyx...ADI of meals is 43 [percent]. Wt 114.8 lbs on 3/16/15. She is within her IBWR. Wt has been stable for 180 days;" and,</p> <p>*3/27/15 (PN)- Resident seen by wound team today for a stage 2 to her coccyx. Area is resolved today...When up in her wheelchair she sits on a 4[inch] vector cushion for pressure relief."</p>	F 314		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 314	<p>Continued From page 34</p> <p>Resident #4's Braden Scale, dated 4/6/15, documented a score of 12, which placed the resident at high risk of developing pressure ulcers.</p> <p>The resident's May 2015 TAR, included a nurse's order, dated 10/24/14, that documented, "Turn and reposition every 2 hours in Bed and Wheelchair. 2[times a] day."</p> <p>The resident's May 2015 TAR contained a column of boxes labeled "Days" and one labeled "Eves." All the boxes in May were signed [up to the time of the survey review of this record]except for the evening of 5/4/15.</p> <p>The resident's Pressure Ulcer care plan, with the target date of 7/24/15, documented problems of, "Resident has potential for pressure ulcer." Undated Approaches included: *"Provide pressure relieving or reduction device: Lipped air mattress...Vector cushion in wheelchair;" *"Turn and reposition resident every 2 hours and PRN to help minimize skin breakdown and promote comfort;" and, *"Last up for meals, and first down;"</p> <p>On 5/5/15 at 8:02 AM, the resident was observed sitting in her wheelchair with a Vector cushion in the chair in the main dining room and assisted by an aide with breakfast. At 8:35 AM, the resident had eaten 80 percent of her meal and had drunk 50 percent of her liquids, and was assisted out of the dining room by an aide to the 400 hallway. At 9:15 AM, the resident was observed in her wheelchair in the 400 hallway dayroom for the "Bible Reading" activity. At 9:35 AM, two CNAs took the resident to the bathroom. At 10:00 AM,</p>	F 314		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 314	<p>Continued From page 35</p> <p>the resident was in her wheelchair near the 400 hallway nurses station. At 10:12 AM, two CNAs took the resident to lie down.</p> <p>On 5/7/15 at 11:05 AM, the resident's healed pressure ulcer sites were observed. The ulcers were observed to be healed and had what appeared to be scar tissue where the left ischial and coccyx ulcers had been.</p> <p>On 5/7/15 at 9:15 AM, Resident Care Manager (RCM) #1 was asked to review the TAR order dated 10/24/14 to "turn and reposition every 2 hours in Bed and Wheelchair. 2[times a] day." When asked what that order meant, she stated, "That doesn't make sense." When asked since there were only two spaces to document repositioning per day, was the order to only turn two times a day, each shift, or something else and she stated, "It's not clear."</p> <p>On 5/7/15 at 11:10 AM, Occupational Therapist (OT) #2 reviewed the physician's telephone order, dated 2/10/15, and the OT assessment and order, dated 2/19/15 regarding the Vector w/c cushion. When asked about the evaluation, she said the Vector cushion had a built-in area, which was similar to a Pommel device for the resident's positioning needs, and OT #2 recommended the resident stay with the same cushion she had used. When asked about the order recommendation for a 4 inch cushion, she said the Vector cushion's height could be adjusted. When asked if she would have measured it at the time of the evaluation, she said she would have. When asked to measure the resident's w/c cushion, OT #2 brought the resident's w/c into the hallway, measured the cushion, and stated, "Two and a half" inches.</p>	F 314		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY DR 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 314	Continued From page 36 On 5/7/15 at 2:30 PM, the DON, when asked how the 8/20/14 left ischial pressure ulcer developed, she said, "Not sure." When shown the blank August 2014 TAR to turn every hour, she stated, "They're not documenting." When asked about the resident's August 2014 Monthly Flow Report regarding turning the resident, she stated, "There's holes [sic] ... There's no proof it's done. Not according to this documentation." When asked about similar issues with the resident's September 2014 TAR and Monthly Flow Report, she stated, "There's holes [sic], so it appears it had not been done." The DON reviewed the resident's January 2015 Monthly Flow Report and the January 2015 TAR, which documented the order for 10/24/14 to "turn and reposition every 2 hours in Bed and Wheelchair. 2[times a] day." When asked about the documents, she stated, "It's not clear," and she said the nurses documented turning and repositioning was done, but the CNA documentation was "not supporting" that. When asked about the 3/19/15 pressure ulcer to the resident's coccyx, she reviewed the March 2015 Monthly Flow Report and March 2015 TAR and stated, "Oh yea, holes." When asked what "last up for meals, and first down" meant, she said it was for the resident to be the last one out of bed before meals and to be the first one laid down after meals. The DON was informed of the 5/5/15 morning observation and then asked if the resident should have been kept up that long. The DON said, "No." On 5/8/15 at 11:15 AM, the DON provided the surveyor with a letter from the NP dated 5/7/15, which documented: "I reviewed the chart of [Resident #4] and my wound consult note from 2/10/15. At that time the	F 314		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 314	<p>Continued From page 37</p> <p>patient was on a pressure reducing wheelchair cushion as appropriate for the depth and type for her original wound. If the wound had been pressure of the type stated in the chart, it should have resolved and not recurred with the measures put in place by [Facility Name] nurses...I suggested ischial inserts in her wheelchair cushion as a preventative measure, not as a curative measure because of the likelihood of wound recurrence with her adult failure to thrive should she continue to lose weight;</p> <p>*...one of the problems was that the patient would constantly rock back and forth when up in her wheelchair. This would increase abrasion to the ischial area, and because of being an amputee, the patient would lean to the left. This would increase abrasion to one side;</p> <p>*The patient's wound was originally assessed by skilled nursing staff as pressure, however, the correct diagnosis would most likely have been moisture associated dermatitis and abrasion. The fact that the patient healed quickly once abrasion was eliminated would indicate that the wound was not primarily pressure. No offloading appeared to be needed in order for this wound to heal.; and,</p> <p>*The combination of weight loss...would certainly contribute to a wound recurrence, but again, not necessarily due to pressure..."</p> <p>Note: The resident's medical record documented the resident had not been turned and repositioned according to orders and care plan. The 2/10/15 order contradicted the above statement, as it specifically documented a 4 inch cushion for ischial offloading. The only document in the resident's chart which indicated the resident constantly rocked back and forth, was from the NP note, dated 2/10/15. The progress notes, OT evaluation, care plan, and observations did not</p>	F 314		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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)	(X6) COMPLETION DATE	
F 314	Continued From page 38 indicate the resident rocked constantly while in her wheelchair. The OT evaluation, dated 2/19/15, documented the resident had good upper body alignment and had not leaned to the right or left. Weight records and progress notes documented the resident had not lost a significant amount of weight at the time of each episode of skin breakdown and the resident's weight had been stable. Resident #4 developed a left ischial Stage 2 pressure ulcer on 8/20/14, which recurred on 9/25/14, when the order for hourly turning and repositioning had not been followed and the order for every two hour turning and repositioning was not consistently followed. The left ischial Stage 2 pressure ulcer recurred again on 1/8/15, when turning and repositioning orders did not clearly direct staff. After the skin broke down, staff did not follow the care plan to turn and reposition the resident every hour. The NP recommendation order was not followed when OT did not evaluate the height of the resident's wheelchair cushion for offloading purposes. Nursing progress notes additionally indicated staff mistakenly believed the height had been considered and adjusted. The resident developed a new Stage 2 pressure ulcer to the coccyx when turning and repositioning orders did not clearly direct staff and the intervention was not implemented consistently. Staff also did not consistently follow the care plan regarding last up for meals and first down after meals.	F 314			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a	F 315	F315 Corrective Actions: Res. # 10 Clarification of the physician's order was received related to Catheter care. Res. #10 care plan	6/11/15	

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 315	<p>Continued From page 39</p> <p>resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents with urinary catheters received necessary care and services to prevent urinary tract infections. This was true for 1 of 1 (#10) sample residents reviewed for urinary catheters. Resident #10 had a suprapubic catheter and the facility failed to consistently provide catheter care, which created the potential for urinary tract infections or other complications associated with indwelling catheter use. Findings included:</p> <p>Resident #10 was readmitted to the facility on 12/8/14 with multiple diagnoses, which included Cauda equina syndrome with neurogenic bladder, acontractile detrusor disorder, and acute kidney failure.</p> <p>The resident's quarterly MDS assessment, dated 4/1/15, documented moderately impaired cognition with a BIMS of 11, indwelling catheter, and neurogenic bladder.</p> <p>Resident #10's Urinary Catheter Care Plan documented, "Resident has a super [sic] pubic catheter," with interventions of, "Provide catheter care per policy resident prefers to due [sic] his</p>	F 315	<p>and TAR has been updated to reflect current physician's orders, as allowed by res. and interventions to use if res. is resistive.</p> <p>Other residents who may be affected: Res. who have a catheter placed have had their care plans and TARs reviewed to ensure accurate to the physician's orders for catheter care.</p> <p>Systemic Changes: In-service provided to LNs and nursing assistants on the need to provide catheter care per MD order, care plan and to document care that was provided. Nursing in-serviced on potential for infection.</p> <p>How corrective action will be monitored: Audits starting June 8, 2015. The Infection Control nurse or nurse manager will conduct audits twice a week for four weeks then weekly for 8 weeks to ensure catheter care is being provided and documented per MD order and care plan. Also the nurse managers will audit the care plans to the MD orders to ensure they match monthly for three months. Audits to be taken to the Performance</p>		

Changes made per phone call with BFS 3:25pm 7/24/15 CLR

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 315	<p>Continued From page 40</p> <p>own catheter care but is unable to clean and empty catheter appropriately, staff to check and clean catheter to prevent infections ... Be aware resident is still colonized with MRSA in urine."</p> <p>The resident's Progress Notes documented: 4/6/15 - "...he has a suprapubic Cath [catheter] that at times he refuses to let staff clean and empty for him d/t [due to] he is unable to clean his Cath correctly..." 4/22/15 - "Resident lethargic. UA [urine analysis] sent to lab for C&S [culture and sensitivity]. Resident started on Levaquin 500 mg daily X [times] 7 days..." 4/24/15 - "Continues ABX [antibiotic] for UTI [urinary tract infection]. C&S came back from lab today and sensitivity to Levaquin and seen by house M.D. Continue ABX as ordered..."</p> <p>The resident's 5/2015 recapitulated Physician's Orders documented: "Foley catheter care TID [three times a day] every shift."</p> <p>Resident #10's 4/2015 and 5/2015 TAR documented that foley catheter care was to be completed TID for the day, evening, and night shifts. The TAR had boxes for the LNs' initials per shift to signify foley catheter care had been completed. The record documented the following dates/shifts that the physician-ordered catheter care was provided: 4/5/15 - night shift; 4/6/15 - night shift; 4/8/15 - night shift; 4/9/15 - night shift; 4/17/15 - day shift; 4/19/15 - day shift; 4/25/15 - evening shift;</p>	F 315	Improvement Committee monthly for monitoring of continued compliancc.	

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 315	Continued From page 41 5/3/15 - evening shift; 5/4/15 - evening shift; and, 5/5/15 - evening shift. On 5/7/15 at 2:05 PM, the DON was interviewed in regards to Resident #10's catheter care. The DON stated, if the care was not documented then the catheter care was "not done." On 5/7/15 at 5:05 PM, the Administrator and DON were informed of the concerns with inconsistent catheter care. The facility did not provide any additional information to alleviate the issue.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure residents received the appropriate care and services, including adequate supervision, to prevent falls for 1 of 13 sampled residents (Resident #1). This failure created the potential for more than minimal harm when Resident #1 sustained six falls within a year. Findings include: Resident #1 was admitted to the facility in March 2012 with multiple diagnoses including	F 323	F323 Corrective Actions: Res. # 1 room assessed for accident hazards, care plan has been reviewed and updated to ensure transfer status is accurate and environment is as free of accident hazards as possible. Hourly checks are in place and care planned to offer assistance with transfers or other res. needs. Res. wants to maintain his independence and has the right to make these decisions per his legal guardian. Therapy evaluation to ensure transfers are as safe as possible as res. self-transfers. Identify other res. Who may have been affected: Res. who have fallen in the last 30 days will have their incident/accident report filed according to their name	6/11/15

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 323	Continued From page 42 developmental delay. The resident's 4/14/15 quarterly MDS documented the resident: *Was moderately cognitively impaired with a BIMS score of 9; *Required one-person limited assistance with transfers; and, *Extensive one-person assistance with toileting. Previous MDS assessments documented: *10/11/14 (quarterly) documented 1 fall with injury *1/3/15 (annual) documented 1 fall with injury *2/17/15 (quarterly) documented 1 fall with injury and 1 fall without injury *4/14/15 (quarterly) documented 1 fall with injury The resident's 1/13/15 CAA documented the resident "is at risk for falls r/t [related to] decreased mobility, incontinence, behaviors, and non-compliance with requesting assistance, history of falls, use of oxygen tubing, and high risk medications. Resident does require assistance with transfers and other ADLs. Resident has DD [developmental delay] with behaviors and non-compliance." The resident's fall care plan, dated 9/30/12, documented: **Resident uses non-alarmed self-releasing wheelchair belt as a reminder to seek assistance prior to transfer; *He will frequently transfer in his room. Please remind resident to sit up as he is able, and remind resident if he is weak to ask for assistance; and, *Remind resident and reinforce safety awareness...educate/remind resident to request assistance prior to ambulation."	F 323	and kept in a binder. The binder will be brought to the weekly falls meeting to ensure review of previous interventions to ensure a new interventions is care planned and in place. Systemic change: In-service LNS on the need to update care plans with new and appropriate interventions after each fall. Interventions added to the computerized care plan already in place should be dated and initialed by the person adding the new intervention. Incident/accident reports will be filed by resident name and the binder will be brought to the falls committee meeting by the D.O.N. so the prior falls interventions can be added along with the new intervention to the fall report/accident report. How corrective action will be monitored: Audits to begin on June 5, 2015 of res. who have fallen by the falls committee weekly for twelve weeks to ensure new interventions are in place, being followed/and care planned. Audits to be taken to the Performance	

Changes made per phone call BRJ. 3:25pm 7/24/15 EJR

Alisa LCN and/or ED. Act. Dir., Rem's

WR

by the Fall Committee (Alyssa, LPN, ED, Activity Director &/or Rem)

Changes made per permission via telephone call with ED on 7/24/2015 3:25 PM

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT	STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864
---	--

(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 323	<p>Continued From page 43</p> <p>The resident's ADL care plan, dated 10/14/12, documented: "**Resident may need non-age appropriate education, or guidance r/t DD, resident may have burst of anger if he is not understanding...; *Resident requires 1-staff extensive assist with ADLs: toileting, hygiene, dressing, and bed mobility; *Resident independent with wheelchair mobility with set-up, and is also independent with transfers in his room...; and, *Resident is often non-compliant with transferring self and toileting self, remind him to ask for assistance."</p> <p>Note: Refer to F280 for details about inconsistencies in the care plan relating to independent and one-person assistance.</p> <p>Record review revealed the resident had six falls from 4/22/14 to 4/5/15:</p> <p>The Fall Risk Evaluation on 4/22/14 documented, "Resident found on floor...suspect that resident fell asleep in wheelchair and was not wearing seatbelt...educated on safety precautions and seatbelt use." No further documentation or investigation was provided about this fall by the facility.</p> <p>The 8/29/14 Incident Follow-up & Recommendation Form and attached investigation documented the resident "is assisted x1 with ADLs, transfers, and toileting. Resident does at times self-transfer without asking for assistance. He will often slump forward in his wheelchair and doze...the resident started to fall asleep in his chair and leaned forward and lost his balance. He had his seat</p>	F 323	Improvement Committee monthly for monitoring of continued compliance.	
-------	--	-------	---	--

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 323	<p>Continued From page 44</p> <p>belt unhooked at the time." This was identified as the root cause of the fall after investigation. New interventions included, "Double check of the self-releasing seat belt, check resident's position frequently, resident reminded to always have his seat belt fastened when up in his wheelchair for safety."</p> <p>Note: Review of the resident's record did not provide evidence of checks of self-releasing seat belt or the resident's position until 4/1/15, although the resident's TAR included the intervention, "Rsident checked every 30 minutes while restraint is on..."</p> <p>On 11/15/14, the Incident Follow-up & Recommendation Form and attached investigation documented the resident was "independent with transfers and mobility in wheelchair to and from room." The cause of the fall was determined to be from the resident losing his balance as he pulled his pants up after toileting himself. "Resident is often independent and will not call staff with toileting needs and help with dressing and transfers." Interventions identified as a result of this investigation included, "Rsident was educated on calling for help with toileting when needed, and assist with voiding during the day."</p> <p>Note: Record review of past Fall Risk Evaluations documented previous falls on 1/3/13 and 1/21/14, when the resident fell out of his wheelchair and attempted to self-transfer to the toilet.</p> <p>The 1/16/15 Incident Follow-up & Recommendation Form and attached investigation documented the resident was</p>	F 323		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 323	<p>Continued From page 45</p> <p>"independent with transfers and mobility in w/c. One assist with toileting. CNA heard resident yelling out...found resident sitting on his buttocks...still attempts to stand and transfer on his own without calling for help...it appears resident attempted to transfer himself from recliner to w/c and became weak, losing his balance, and falling." Interventions included: "Resident was educated on calling for help before transferring. He is now a one to two person assist with all transfers."</p> <p>The 2/5/15 Incident Follow-up & Recommendation Form and attached investigation documented the resident "does not always call for help when he needs it...one assist with...transfers and toileting..." The form documented the resident had been dressed on the toilet, became angry, refused help, and leaned forward to put on his socks, causing him to slip off the toilet. An abrasion to the left knee was noted. An intervention from this investigation included, "Resident was educated about allowing staff to help him."</p> <p>The 4/5/15 Incident Follow-up & Recommendation Form and attached investigation documented the resident was "independent with transfers and mobility in w/c. One assist with toileting." It documented the resident attempted to transfer himself from recliner to the wheelchair and lost his balance, causing the fall. It stated his feet became tangled in his oxygen tubing and that maintenance was referred to assess cords in the room.</p> <p>On 5/4/15 at 12:30 p.m., Resident #1 was observed dozing on and off in his wheelchair, leaning forward with his chin touching his chest</p>	F 323			

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 323	<p>Continued From page 46 with the seatbelt fastened.</p> <p>On 5/5/15 at 8:55 a.m., the resident was observed dozing off in his wheelchair, leaning forward with his chin touching his chest. The seatbelt was not on. He dozed on and off down the hallway on his way to his room. When he reached his room he wheeled himself in front of the recliner and transferred himself from the wheelchair to the recliner. No staff were present for the transfer.</p> <p>On 5/5/15 at 8:20 a.m., CNA #6 was asked to describe how the resident transferred. She said the resident was "able to stand and get to the toilet himself, just have to help him clean up. We just have to stand by him to help him transfer."</p> <p>On 5/6/15 at 8:40 a.m., the resident was observed in his room while he transferred himself from the wheelchair to the recliner without staff present.</p> <p>On 5/5/15 at 2:40 p.m., CNA #6 when asked when Resident #1 was required to wear a seatbelt, stated, "He used to lean forward, he hasn't done it in a while, so we don't use it anymore."</p> <p>On 5/6/15 at 8:30 a.m., the RCM was asked if the resident was able to independently transfer or whether he required one person assist. She said, "He is supposed to be a one person assist but he transfers himself."</p> <p>On 5/7/15 at 10:20 a.m., the DON was asked what interventions had been put into place for the resident's falls. She said, "He takes it [the seatbelt] on and off, he has it so that he doesn't</p>	F 323		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 323	Continued From page 47 lean too far forward. [The resident] is [the resident], I can't change him and he is going to do what he wants to do because he gets upset." When asked if supervision had ever been increased, she said, "He gets very agitated with one-on-one [supervision]. We would not do every-15-minute checks, not with him." When asked if he could be checked more often, she said, "We could definitely check on him more." On 5/8/15 at 10:30 a.m., the DON said, in regards to the resident's falls and interventions in place, "we just re-educate and re-educate..." The facility failed to specify whether the resident was a one-person assist or independent in his toileting and transfers (refer to F280), and were inconsistent in implementing one or the other interventions. Increased supervision was not provided by the facility, which provided only re-education as an intervention, despite the resident's pattern of continuous falls and impaired cognitive status.	F 323		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	F328 Corrective Actions: Res. #10 care plan has been updated to reflect MD orders of no longer needing Oxygen (O2). Res. #10 oxygen saturations are checked and documented on his TAR per the physician's order. Res. #3 is receiving O2 per the physician's order and is care planned accurately as it was updated to reflect current liter flow per MD order. O2 tubing is changed monthly and O2	6/11/15

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1126 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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)	(X6) COMPLETION DATE	
F 328	Continued From page 48 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents received proper treatment, monitoring and care for oxygen administration. This was true for 4 of 5 (#s 1, 3, 10, & 13) residents sampled for oxygen use. This deficient practice created the potential for harm should a resident experience a drop in oxygen saturation resulting in anxiety, confusion and/or respiratory distress. Findings included: Perry & Potter's, Clinical Nursing Skills & Techniques, 7th Edition, 2010, states on p. 629, "Treat oxygen therapy as a medication ... As with any drug, continuously monitor the dosage or concentration of oxygen. Routinely check the health care provider's orders to verify that the patient is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." 1. Resident #10 was readmitted to the facility on 12/8/14 with multiple diagnoses, including congestive heart failure (CHF), edema, hypertension, and anemia. The resident's April and May 2015 recaptitulation Physician's Orders and TARs documented: *Change Oxygen (O2) tubing weekly on Sunday nights; *Clean filter on O2 concentrator weekly on Sunday nights; and, *O2 0-3 liters per nasal cannula (NC) to keep sats above 90%, obtain saturations every shift, 2 times a day.	F 328	concentrator filter cleaned monthly per MD order and care planned. O2 saturations are checked every shift and recorded in the TAR per MD order. Res. #13 is receiving O2 per MD order. O2 tubing is changed monthly and O2 concentrator filter is cleaned monthly along with having the O2 saturation monitored and documented on the TAR per MD orders. Res. #1 is receiving O2 per MD order. O2 tubing is changed monthly and O2 concentrator filter cleaned monthly per MD order and documented on the TAR. O2 saturation monitoring done each shift and documented per MD order on the TAR. Res. #1 is being monitored every three hours while on O2 tank for O2 available in the portable tank and assisted to get a new tank when empty. Identify other res. Who may have been affected: Res. who have MD orders for O2 have had their care plans reviewed and updated as necessary to ensure tubing is changed monthly and O2 concentrator filters are cleaned monthly. MD orders are followed for monitoring O2 saturation levels and documented on the TAR.		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 328	<p>Continued From page 49</p> <p>The resident's Edema Care Plan documented, "Potential for respiratory compromise r/t [related to] CHF," and the interventions documented included, "Oxygen per MD orders, clean filter weekly and change tubing monthly." Note: The Physician's Order documented the tubing was to be changed weekly. Refer to F280 as related to Care Plan revisions.</p> <p>Resident #10's TAR documentation revealed the oxygen tubing and oxygen filter had not been changed on 5/3/15 as ordered. The resident's oxygen liter flow and saturation rate also were not documented as follows: 4/5/15 evening shift; 4/12/15 evening shift; 4/17/15 day shift; 4/19/15 day shift; 5/3/15 evening shift; 5/4/15 day shift - no liter flow rate only; and, 6/5/15 day shift - no liter flow rate only.</p> <p>On 5/7/15 at 2:05 PM, the DON was interviewed regarding about the documented failure to change the resident's oxygen tubing, clean the concentrator filter, and monitor the administration of oxygen. The DON said the resident no longer used oxygen, but staff had not sought to have these orders discontinued by the physician. She stated that because these orders were still active, the nurses should have been implementing, monitoring and documenting oxygen cares according to physician order.</p> <p>On 5/7/15 at 5:05 PM, the Administrator and DON were informed of the oxygen administration concerns. The facility did not provide any additional documentation to alleviate the issue.</p>		<p>Systemic change:</p> <p>F 328 In-service to LN and nursing assistants regarding the importance of following MD orders for O2 including changing tubing monthly and cleaning the O2 concentrator filters monthly. The need to monitor O2 saturation levels per MD order and document on TAR. Ensure care plan accurately reflects the O2 tubing changed monthly and O2 filters cleaned monthly. Every three hour checks on resident # 1 and other residents with oxygen to ensure O2 tank has oxygen and or the need to get a new tank for them while in use.</p> <p>How corrective action will be monitored:</p> <p>Res. who have O2 ordered will be audited by nursing managers starting June 8, 2015 weekly for twelve weeks to ensure O2 tubing is changed monthly, O2 concentrator filters cleaned monthly, O2 saturations are being monitored/ documented per MD orders on the TAR, Res. #1 and other res. on portable O2 have been monitored every three hours while on O2 tank and that Care plans are accurate.</p> <p>Audits to be taken to the Performance Improvement Committed for continued monitoring of compliance.</p>	<p><i>Changes made per phone @ 3:25pm 7/24/15 WJR</i></p>	

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 328	<p>Continued From page 50</p> <p>2. Resident #3 was admitted to the facility on 6/25/14 with multiple diagnoses, including chronic obstructive pulmonary disease (COPD), shortness of breath, and pneumonia.</p> <p>The resident's April and May 2015 recapitulation Physician's Orders and TARs documented: *Change Oxygen (O2) tubing weekly on Sunday nights; *Clean filter on O2 concentrator weekly on Sunday nights; and, *O2 0-3 liters per nasal cannula (NC) to keep sats above 90%. 3 times a day.</p> <p>The resident's Respiratory Care Plan documented, "Resident requires the use of oxygen at times for complaints of SOB [shortness of breath], difficult to breath r/t [related to] DX [diagnosis] of: Pneumonia/COPD," and interventions that included, "Oxygen may be used as ordered by physician: Oxygen 0-2 liters NC prn to keep sats [saturation] equal to or above 90%." Note: The Physician's Order that directed staff to change the oxygen tubing and concentrator filter weekly was not documented on the Care Plan.</p> <p>Resident #3's TAR documentation revealed the oxygen tubing was not changed and the oxygen filter had not been cleaned on 5/3/15 as ordered. The resident's oxygen liter flow and saturation rate were not documented as follows: 4/5/15 night shift; 4/6/15 night shift; 4/8/15 night shift; 4/12/15 evening & night shift; 4/17/15 day shift; 4/21/15 day shift; 5/3/15 evening shift; and,</p>	F 328			

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 328	<p>Continued From page 51 5/4/15 evening shift.</p> <p>On 5/4/15 at 1:10 PM, the resident was observed in her room eating lunch and did not have her oxygen via N/C in place. On 5/5/15 at 9:08 AM, 12:28 PM, and 5/6/15 at 11:50 AM, the resident was observed in her room with her oxygen at 2 to 2.5 liters and the N/C in place. Resident #3 said she had become very dependent upon her oxygen, which she used more than not.</p> <p>On 5/7/15 at 1:52 PM, the DON was interviewed about oxygen monitoring, oxygen tubing changes, and cleaning of the filter. The DON acknowledged any failure to document cares indicated the cares were not provided.</p> <p>3. Resident #13 was admitted to the facility on 8/11/14 with multiple diagnoses, including chronic obstructive pulmonary disease (COPD), postinflammatory pulmonary fibrosis, and atrial fibrillation.</p> <p>The resident's April and May 2015 recapitulation Physician's Orders and TARs documented: *Change Oxygen (O2) tubing weekly on Sunday nights; *Clean filter on O2 concentrator weekly on Sunday nights; and, *O2 0-3 liters PRN (as needed) per nasal cannula (NC) to keep sats above 90%. 3 times a day.</p> <p>The resident's Breathing Difficulty Care Plan documented, "Potential for difficult breathing related to chronic condition," and the interventions included, "O2 0-3 L [liters] to keep sats greater than 90%." Note: The Physician's Order that staff change the resident's oxygen tubing and concentrator filter</p>	F 328		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1126 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 328	<p>Continued From page 52 was not documented on the Care Plan.</p> <p>Resident #13's TAR documentation revealed the oxygen tubing was not changed and the oxygen filter had not been cleaned on 5/3/15 as ordered. The resident's oxygen liter flow and saturation rate were not documented as follows: 4/5/15 night shift; 4/6/15 night shift; 4/9/15 evening & night shift; 4/12/15 evening & night shift; 4/17/15 day shift; 4/20/15 evening shift; 5/1/15 evening shift; 5/2/15 evening shift; 5/3/15 evening & night shift; and, 5/4/15 evening shift.</p> <p>On 5/6/15 at 11:30 AM and 1:30 PM, the resident was observed in her room without her N/C in place or the oxygen turned on. Resident #13 stated she very rarely used oxygen during the day, but used it more frequently at nighttime.</p> <p>On 5/7/15 at 1:52 PM, the DON was interviewed in regards to the oxygen monitoring, the change of the oxygen tubing, and cleaning of the filter. The DON acknowledged any failure to document cares indicated the cares were not provided.</p> <p>4. Resident #1 was admitted to the facility in 2012 with multiple diagnoses, including coronary atherosclerosis, congestive heart failure, chronic ischemic heart disease, and chronic airway obstruction.</p> <p>a. The resident's care plan and physician</p>	F 328			

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1126 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 328	<p>Continued From page 53</p> <p>recapitulation orders for May 2015 documented interventions of:</p> <ul style="list-style-type: none"> *Clean O2 concentrator filter weekly (started 6/28/14) and *Change O2 tubing weekly on Sun noc (Sunday night) (Started 10/24/14) <p>Record review of the February and March 2015 TAR revealed the above interventions were not documented as completed 3 of 4 Sundays for both months.</p> <p>On 5/7/15 at 10:20 a.m., the DON was notified the TARs documented these cares were not provided. No further information was provided.</p> <p>b. Resident #1's 4/14/15 quarterly MDS documented the resident required oxygen therapy.</p> <p>The resident's care plan and April physician recapitulation orders documented, "O2 [oxygen] 0-3 liters via NC [nasal cannula] to keep sats [oxygen saturation] equal or greater than 90%."</p> <p>Review of "fax order requests" documented Resident #1 experienced a hypoxic (low oxygenation) event on 1/15/15: "[Resident #1] refused his O2 this evening and became barely conscious. Took 3 assist to help him with peri [perineal] care. After holding nasal canula to his nose for several minutes to increase O2 ... kept swatting O2 away."</p> <p>On 5/5/15 at 2:30 p.m., CNA #6 attempted to put new oxygen tubing on Resident #1, which the resident resisted. The CNA told the resident his oxygen tank was empty and she would get him a new one, but he said "no, no, no," and that he</p>	F 328			

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 328	Continued From page 54 wanted to get it himself. CNA #6 said, "Okay," and the resident wheeled himself to the subacute hallway. CNA #6 stated this was not uncommon for the resident. Resident #1 sat in front of the oxygen transfill station door saying "oxygen, oxygen, oxygen," and the RCM helped him get a new tank. The RCM and LN #7 were the only staff present at the nurse's station. At 2:35 p.m., LN #7 stated there is a lot of traffic around that station, but no one is assigned to sit there. Note: The resident had a history of becoming hypoxic (low blood oxygen levels) without supplemental oxygen, and could possibly become hypoxic if a staff member couldn't help him get a new tank in a timely manner. On 5/7/15 at 10:20 a.m., the DON was asked what might happen if staff were present at that station to refill the resident's oxygen tank. She stated, "There is a chance there would not be anyone there, I can see your concern. She [referring to CNA #6] should have went [sic] with him, it isn't care planned." On 5/8/15 at 12:30 p.m., the facility was notified of these issues. No further information was provided.	F 328			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose	F 329	F329 Corrective Actions: Res. # 5 has had MAR updated to reflect her current sleep monitoring requirements. Staff are monitoring her sleep patterns every shift including nights and documenting. Res. #1 and res. #5 are having consistent monitoring of their pain by	6/11/15	

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 329	<p>Continued From page 55 should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to adequately monitor drug regimens for 2 of 15 sampled residents (#1 & #5), specifically monitoring the effectiveness of pain and sleep medications. The failure created the potential for residents to receive unnecessary drugs. Findings include:</p> <p>1. Resident #5 was admitted to the facility 4/4/14 with multiple diagnoses, including insomnia.</p> <p>Review of the resident's physician recapitulation orders for April 2015 documented: *Trazodone 50 mg tablet PO daily at bedtime for Insomnia (started 10/23/14) and *Melatonin 3 mg, give 1 tab PO at bedtime for insomnia (started 10/23/14)</p>	F 329	<p>using the pain scale and documenting the medication effectiveness.</p> <p>Identify other res. Who may have been affected: Res. receiving pain medications had the potential of being affected by not monitoring the intensity of the pain and the effectiveness of the pain medication as ordered to ensure meeting the res. needs. Res. receiving pain meds have been audited to ensure pain intensity is being monitored on pain scale and documented along with the effectiveness of the pain med once given documented. Res. on medications for insomnia had the potential to be affected by not monitoring the patterns of sleep to ensure medication is effective. Res. who receive a medication for insomnia will be audited to ensure patterns of sleep are monitored and documented including all shifts.</p> <p>Systemic change: LNs serviced on the importance of reassessment and documentation of pain medications to ensure residents have good pain management and to contact the MD as needed if pain is not resolved. LNs to ensure all pain meds given have intensity of pain level and effectiveness of medication.</p>	

*CHANGE MADE
Plc Phone call
BFS-3:22pm
11/24/15
LWR*

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 329	<p>Continued From page 56</p> <p>Resident #5's care plan dated 9/12/14 documented the use of Trazodone for insomnia with an intervention of, "Behavior team to assess for continued need and effectiveness."</p> <p>Record review of the resident's March, April, and May 2015 TARs for Resident #5 revealed sleep monitors for the day and evening shifts, however, the resident's sleep was not monitored during the night shift to determine the medication's efficacy.</p> <p>On 5/7/15 at 10:20 a.m., the DON stated night shift needed to measure the medication's effectiveness by monitoring and documenting the resident's sleep patterns.</p> <p>2. Resident #1 was admitted to the facility March 2012 with multiple diagnoses including chronic chest pain.</p> <p>Resident #1's pain care plan dated 9/30/12 documented: "...provide...PRN pain medication...Document effectiveness and, *Notify the resident's physician if they do not state/demonstrate relief or reduction of pain after one hour of receiving the first intervention."</p> <p>Review of the March 2015 MAR documented: *Norco 7.5 mg-325 mg tablet give 1 tab PO daily (started 10/21/14-3/2/15); *Norco 7.5 mg-325 mg tablet give 1 tab PRN up to 3x [times] daily (started 10/21/14-3/2/15); and, *Tylenol 650 mg 1 tab TID PO PRN (started 1/29/14)</p> <p>The resident's February 2015 "Pain Flow Sheet" documented 7 of 28 pain reassessments were not completed and were missing the pain</p>	F 329	<p>documented.</p> <p>How corrective action will be monitored: Nurse managers to audit MARs (survey report mistakenly says TAR but that is for treatments not medications) to ensure intensity of pain level and the effectiveness of the medication documented also audit insomnia medications ensuring hours of sleep are monitored and documented on all shifts to ensure effectiveness of the insomnia medication. Audits to start on June 8, 2015. Audits will be conducted weekly for twelve weeks. Audits to be taken to the Performance Improvement Committed for continued monitoring of compliance.</p>		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 329	<p>Continued From page 57 intensity scale.</p> <p>On 5/7/15 at 10:45 a.m., the DON agreed these pain re-assessments were missing for February.</p> <p>On 5/8/15 at 12:30 p.m., the facility was notified of missing medication documentation issues. No further information was provided by the facility.</p> <p>3. Resident #2 was admitted to the facility in July 2013 with multiple diagnoses, including chronic pain syndrome, chronic degenerative disc disease of the lumbar spine, osteoarthritis, chronic obstructive pulmonary disease, history of stroke and neuropathy.</p> <p>The resident's care plan identified, "Pain chronic back pain As Evidenced By complains of pain relating to arthritis" as a problem on 7/15/13. Approaches included, "Administer/observe for effectiveness and for possible side effects..."</p> <p>The resident's Physician Orders for May 2015 included Percocet 5-325 milligram, 1 tablet by mouth every 4 hours PRN (as needed) for pain, ordered 11/11/14.</p> <p>The resident's Pain Flow Sheets contained documentation that PRN Percocet was not consistently monitored for efficacy for 6 of 28 administrations in April 2015 and 1 of 14 administrations in May 2015.</p> <p>On 5/8/15 at 9:55 am, the DON was asked about the resident's PRN pain medication efficacy. The DON reviewed the documentation then confirmed it was not consistently documented as having been monitored.</p>	F 329		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure 2 of 2 ovens were free of debris and cleaning chemical residue. This had the potential to affect 13 of 13 (#s 1-13) sampled residents and all residents who dined in the facility. This failure created the potential of cross contamination from food and chemical residue. Findings included:</p> <p>On 5/4/15 at 10:07 AM, with the Certified Dietary Manager (CDM) in attendance, two of two ovens were observed. The first oven contained a two-inch high, three-inch wide and four-inch long accumulation of black food debris on the bottom, inside of the oven. The CDM stated, "Something boiled over." Next to the food debris was a one-foot by eight-inch faint white area. When asked to define the substance, the CDM said it appeared to be oven cleaner residue which "looks like it didn't get cleaned out." The second oven also had a one-foot by six-inch faint white area on the bottom inside of the oven. The CDM stated the second oven had "chemical in it."</p>	F 371	<p>F371</p> <p>Corrective Actions: No specific resident was affected by this practice. The two ovens were cleaned 5/6/15 during the survey.</p> <p>Identify other res. Who may have been affected: Res. residing in the facility had the potential to be affected by the two ovens not being wiped out timely after oven cleaner had been used.</p> <p>Systemic change: Certified dietary manager has updated the cleaning schedule to assure the two ovens are cleaned. Kitchen employees educated on proper chemical usage and following the manufactures instructions for the oven cleaner for resident safety.</p> <p>How corrective action will be monitored: CDM to audit the cleanliness of the two ovens weekly times twelve weeks. R.D. will also audit the two ovens weekly for twelve weeks then monthly. Audits will be taken to the Performance Improvement Committee monthly for continued monitoring of compliance.</p>	6/11/15	

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 371	Continued From page 59 The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart 601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils documented, "... (C) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." Chapter 7, Part 7-2, Operational Supplies and Applications, Subpart 202.12 Conditions of Use documented, "Poisonous or Toxic Materials shall be:...(B) Applied so that:...(2) Contamination, including toxic residues due to drip, drain, fog, splash or spray on food, equipment, utensils, linens, and single-service and single-use articles is prevented..."	F 371			
F 431 SS=E	On 5/6/15 at 4:40 PM, the Administrator and DON were informed of the issues. No further information was provided by the facility. 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	F431 Corrective Actions: Res. #10 expired medication was removed immediately taken out of the medication cart and a new card of the meds obtained. All expired biological supplies (test tubes for blood draws) have been removed from medication room and replaced with new ones. Expired IV solution was returned to the pharmacy. Identify other res. Who may have been affected: Res. medication cards have been	6/11/15	

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 431	<p>Continued From page 60</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure two expired bags of IV (Intravenous) fluids, an expired blister pack of Ondansetron (medication prescribed for nausea) tablets for Resident #10, and expired biological supplies (test tubes for blood draws) were removed from the medication rooms and medication cart. This was true for 2 of 3 medication rooms and 1 of 4 medication carts checked for expired medications. This failed practice created the potential for decreased efficacy for Resident #10's nausea and any resident who could have received the expired IV fluid and the potential to have altered lab results if labs had been drawn in an expired test tube. Findings included: On 5/6/15 at 2:25 PM, during inspection of the Subacute Medication Room #2 with the DON</p>	F 431	<p>audited to ensure no expired meds are in supply. Res. who were scheduled for lab draws may have been affected prior to them being taken out of stock. Res. who needed IV solution may have been affected prior to them being taken out of stock.</p> <p>Systemic change: LN in-serviced on the need to check labels for expired medications and remove them from stock prior to expiration date. Night shift LN to check IV emergency kits every month for outdated supplies and return them to the pharmacy. Lab draw tubes will also be checked by the night nurse to monitor expiration dates and pull from service upon that date or prior and items listed above will be pulled from stock if expires prior to next audit.</p> <p>How corrective action will be monitored: D.O.N. or nurse manager to audit medication rooms weekly for twelve weeks then monthly for any outdated meds, lab draw tubes, and IV supplies. Audits to start on June 8, 2015. Nurse managers to audit med carts to ensure no expired medications are stocked in cart weekly times four weeks then monthly times two months. Audits will be brought to the Performance</p>	

changes per phone call with BJS 3:25pm 7/24/15 LAR

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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)	(X6) COMPLETION DATE
F 431	Continued From page 61 present, the following medications were found: *2 bags of 5% Dextrose Injection 1,000 ML which had expired 4/2015. The DON acknowledged the IV fluid had expired and should not have been available for resident use. On 5/6/15 at 2:58 PM, during inspection of the Team #4 Medication Cart and the Long Term Medication Room and with the ADON present, the following medication and lab test tubes were found: *1 blister pack with 6 tablets remaining of Ondansetron for Resident #10 which had expired 2/13/15; *2 red top serum lab test tubes which had expired 3/2014; *6 red top serum lab test tubes which had expired 4/2014; *7 blue top PT/INR (Prothrombin time/international normalized ratio) lab test tubes which had expired 12/2014; and, *1 blue top PT/INR lab test tube which had expired 11/2014. The ADON acknowledged the medication and all the lab test tubes had expired and needed to be discarded.	F 431	Improvement Committee monthly for monitoring of continued compliance.	
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	F 456	F456 Corrective Actions: Res. #1 received the second anti-tip bar during the survey and is attached to the wheelchair. Res. #12 also had second anti-tip bar applied during survey.	6/11/15

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1126 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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 456	Continued From page 62 This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interview, it was determined the facility failed to maintain two residents' wheelchair anti-tip bars in a safe operating condition. This was true for 2 of 13 (#s 1 & 12) sampled residents and had the potential for injury if the residents were to fall backward in their wheelchairs. Findings included: 1. On 5/8/15 at 8:10 AM, two surveyors observed Resident #12's wheelchair in the resident's room. The chair had an anti-tip bar to the back right lower portion of the chair, but not to the left lower portion. An oxygen e-cylinder was attached to a metal tank holder on the left side of the chair. On 5/8/15 at 8:10 AM, the resident was asked how long she had used the wheelchair and she said for about six weeks. On 5/8/15 at 9:35 AM, the Maintenance Director was interviewed. When asked about the observation, he stated, "They should have two" anti-tip bars, because the oxygen e-cylinders and metal tank holders were heavy and therefore posed an increased risk for tipping backwards. He said the tank holders made it difficult to attach the anti-tip bar below the holder as there was limited space to snap the connection into place. 2. On 5/5/15 at 2:45 p.m., Resident #1's wheelchair was observed with an anti-tip bar on the back right side, but not on the left. The resident's oxygen tank was mounted on the left side.	F 456	Identify other res. Who may have been affected: Res. with 02 holders attached to their wheelchairs have had the second anti-tip bar attached. Systemic change: When an 02 tank is added to the back of a wheelchair two anti-tip bars will be used at all times. Maintenance staff, LNs, and nursing assistants have been educated on the need to apply two anti-tip bars when an 02 tank is applied to a wheelchair for res. safety. How corrective action will be monitored: An audit will be conducted by maintenance staff of wheelchairs with 02 tanks. Audits to start June 8, 2015 will be done weekly for twelve weeks to ensure two anti-tip bars are applied at all times for res. safety. Audits will be brought to the Performance Improvement Committee monthly for monitoring of continued compliance.		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(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 456	Continued From page 63 On 5/5/15 at 2:45 p.m., the Director of Rehabilitation said, "The tip bar is there because of the weight of the oxygen tank, but it is a good question why it is not on the left side." Please refer to the interview above with the Maintenance Director indicating there should have been two anti-tip bars.	F 456		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents' medical records were complete, accurate and filed correctly for 4 of 15 sample residents (#s 2, 5, 8 and 10) and 2 random residents (#s 16 and 18). The failure created the potential for more than minimal harm if residents' medical decisions were based on incomplete, inaccurate or misfiled information. Findings	F 514	F514 Corrective Actions: Res. #2 had the psychopharmacological medication review form removed from her chart when it was noted it was misfiled and place in the correct medical record for res. #18. Res. # 16 and #10 had the month and year entered onto their MAR/TAR and bowel protocol records. Res. # 8 physician's orders have been updated to reflect that the res. is not able to make her own healthcare decisions. Identify other res. Who may have been affected: Newly admitted residents residing in the facility had the potential be affected by the month and year not being on their MAR/TAR and bowel protocol. This would not have caused	6/11/15

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY DR 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	<p>Continued From page 64 included:</p> <p>1. Resident #2 was admitted to the facility in July 2013 with multiple diagnoses, including chronic pain syndrome, chronic atrial fibrillation, chronic obstructive pulmonary disease, chronic degenerative disc disease and a history of irritable bowel syndrome and neuropathy.</p> <p>Review of Resident #2's medical record on 5/5/15 revealed it contained a "Psychopharmacological Medication (other than antipsychotic)" review form for another resident.</p> <p>The Psychopharmacological Medication review form, dated 10/20/14, was for Resident #18's Depakote. The form contained documentation that the resident's physician declined a gradual dose reduction of the Depakote.</p> <p>On 5/5/15 at 10:30 am, the facility's receptionist, who also copied records for the survey team, confirmed that Resident #18's clinical documentation was filed in the wrong resident's clinical record.</p> <p>On 5/8/15 at 1:45 pm, the Administrator and DON were informed of the misfiled documentation. The facility did not provide any other information regarding the issue.</p> <p>2. Resident #16 was admitted to the facility on 4/17/15 with multiple diagnoses, including pathologic fracture of vertebrae, spinal stenosis, and venous insufficiency.</p> <p>The resident had three pages of MAR/TAR documentation, two pages titled "Medication</p>	F 514	<p>any harm as the months are pulled when a new month is added. This was an oversight by the LN doing the admission paperwork.</p> <p>Res. with a legal guardian had the potential to be affected by the physician inaccurately marking their ability to make their own healthcare decisions.</p> <p>Systemic change: Medical records and LNs in-serviced to file forms into the correct medical record and to watch for any misfiled forms and if found file in correct medical record. Admission to notify doctors upon admit if a res. has a legal guardian and have the LN get a new order if incorrectly stated on ability to make own decisions.</p> <p>How corrective action will be monitored: Medical records to audit new admits weekly to ensure month and date is on all MAR/TAR and bowel protocols for twelve weeks. Audits to begin on June 8, 2015. Social Services dept. to audit physician's orders to ensure marked correctly per guardianship paperwork or DPOA resident unable to make own</p>	<p><i>per changes made with phone call 3:25pm 7/24/15</i> BFS RR</p>	

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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	<p>Continued From page 65</p> <p>Record" and one page titled "Bowel Protocol." The three pages documented medications and treatments with LNs' Initials, signifying these various medications and treatments had been administered during the month. All three of the pages had a place to document the month and year and this area was blank.</p> <p>On 5/7/15 at 9:30 AM, RCM #1 was interviewed regarding Resident #16's three pages of MAR/TARs and the lack of a month and year. She stated the MAR/TARs were for May 2015. The RCM stated, "You wouldn't be able to tell which month it was. The nurses are supposed to be sure they write the dates on the forms they pull."</p> <p>3. Resident #10 was readmitted to the facility on 12/8/14 with multiple diagnoses, including acute kidney failure, coronary atherosclerosis, and Cauda Equina syndrome with neurogenic bladder.</p> <p>The resident had a one-page MAR/TAR titled, "Bowel Protocol." The one page documented medications and treatments with LNs' signatures, signifying bowel movements were monitored. The Bowel Protocol page had a place to document the month and year and this area was blank.</p> <p>On 5/7/15 at 9:30 AM, RCM #1 was interviewed regarding Resident #10's one page MAR/TAR and the lack of a month and year. She stated the MAR/TAR was for May 2015. The RCM stated, "You wouldn't be able to tell which month it was. The nurses are suppose to be sure they write the dates on the forms they pull."</p> <p>4. Resident #8 was admitted to the facility on</p>	F 514	<p>decisions. Audit to begin on June 8, 2015 and will be done on 100% of res. who have someone else responsible for healthcare decisions then weekly on new admits who have a DPOA or guardian responsible for their healthcare decisions for twelve weeks. Audits will be brought to the Performance Improvement Committee monthly for monitoring of continued compliance.</p>		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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	<p>Continued From page 66</p> <p>3/23/15 with multiple diagnoses, including dementia without behavioral disturbance.</p> <p>The resident's 3/29/15 admission MDS assessment documented the resident was severely cognitively impaired with a BIMS of 2.</p> <p>Resident #8 had a General Power of Attorney, dated 7/30/14, in which a family member had been named as her attorney-in-fact and agent to act in her name and for her benefit. The General Power of Attorney documented, in part, "...everything necessary in exercising any of the powers herein granted as fully as I might or could do if personally present and fully competent..."</p> <p>The resident's Advanced Directives Care Plan documented, "The appointed health care representative ... will make all health care decisions -- the resident is not able to make her own health care decisions."</p> <p>Resident #8's recapitulation May 2016 Physician Orders documented, "3/23/15: Resident is capable of making own health care decisions."</p> <p>On 5/7/15 at 2:15 PM, the DON was interviewed in regards to the ability of the resident in making her own health care decisions. The DON stated the resident was not capable of making her own decisions and the physician had inadvertently circled the "Yes" response on the admitting orders for the ability to make own health care decisions.</p> <p>On 5/8/15 at 1:15 PM, the facility was notified of these issues. No further information was provided to alleviate the concerns.</p>	F 514			