



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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

February 25, 2016

David Green, Administrator  
Life Care Center Of Boise  
808 North Curtis Road,  
Boise, ID 83706-1306

Provider #: 135038

Dear Mr. Green:

On **February 5, 2016**, a survey was conducted at Life Care Center Of Boise 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.) **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.

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 **March 8, 2016**. Failure to submit an acceptable PoC by **March 8, 2016**, may result in the imposition of civil monetary penalties by **March 28, 2016**.

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*.

A 'per instance' civil money penalty of **Federal Civil Money Penalty of \$4,500.00 per instance for the instance on February 5, 2016 described at deficiency F0323 (S/S: G)**.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 5, 2016**, 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.**

David Green, Administrator  
February 25, 2016  
Page 3 of 3

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.

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

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

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 **March 8, 2016**. If your request for informal dispute resolution is received after **March 8, 2016**, 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,



NINA SANDERSON, L.S.W., Supervisor  
Long Term Care

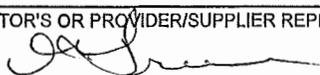
NS/pmt  
Enclosures

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF BOISE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>808 NORTH CURTIS ROAD BOISE, ID 83706</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification and complaint survey from February 1 to February 5, 2016.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Arnold Rosling, RN, BSN, QIDP Haley Young, LBSW Sherrie McElwain, RN</p> <p>Definitions include:</p> <p>AD - Activity Director ADON - Assistant Director of Nursing ASE - Adverse Side Effects BLM - Bureau of Land Management BPSD - Behavioral and Psychological Symptoms of Dementia CAA - Care Area Assessment COPD - Chronic Obstructive Pulmonary Disease GDR - Gradual Dose Reduction GERD - Gastroesophageal Reflux Disease lbs - pounds DM II - Diabetes Mellitus Type II dx - Diagnosis DNS - Director Nursing Services ESRD - End Stage Renal Disease eval. - Evaluation FDA - Food and Drug Administration HTN - Hypertension hx - History IDT - Interdisciplinary Team LE - Lower Extremity LPN - Licensed Practical Nurse LTC - Long Term Care MD - Medical Doctor MDS - Minimum Data Set</p>	F 000	<p><b>RECEIVED</b></p> <p><b>MAR 24 2016</b></p> <p><b>FACILITY STANDARDS</b></p>	

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



TITLE

*Administrative*

(X6) DATE

*3-21-16*

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: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY).	(X5) COMPLETION DATE
F 000	Continued From page 1 mg - Miligram MRI - Magnetic Resonance Imaging NA - Nurse Aide NN - Nurses Note NP - Nurse Practitioner OT - Occupational Therapy po - By mouth Q - Every RD - Registered Dietician res. - Resident RN - Registered Nurse RNA - Restorative Nurse Assistant ROM - Range of Motion R/T - Related To SSD - Social Services Director TV - Television UM - Unit Manager WC - Wheel Chair WBAT - Weight Bearing As Tolerated WNL - Within Normal Limits	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES  The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.  The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time	F 156		

RECEIVED  
MAR 21 2016  
FACILITY STANDARDS

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

PRINTED: 02/24/2016  
FORM APPROVAL  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/05/2016
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706
---	---

(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 156

Continued From page 2.

of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (I)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:  
A description of the manner of protecting personal funds, under paragraph (c) of this section;  
A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.  
A posting of names, addresses, and telephone numbers of all pertinent State client advocacy

F 156

Specific Resident: None

Other Residents: All residents may be affected by this.

Systemic changes: Receptionist updated and posted the ombudsman correct phone number and all other advocacy group phone numbers.

Staff educated as to where the phone numbers can be found for all advocacy groups.

Residents have been educated in resident council about where to find the ombudsman's phone number and advocacy number.

The root cause was found to be failure to update the phone number for the ombudsman

Monitor: Social Services to ensure that phone numbers are accurate by auditing the numbers monthly

Audits to be brought through PI monthly

Date of Compliance: March 15, 2016

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES A. PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF BOISE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>808 NORTH CURTIS ROAD BOISE, ID 83706</b>	
(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 156	<p>Continued From page 3</p> <p>groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined the facility failed to ensure the correct telephone number for a patient advocacy group, and the Ombudsman program, was posted. This failure to provide the correct phone numbers had the potential to affect all 77 residents in the facility. Findings included:</p> <p>On 2/2/16 at 8:45 am observation at the front door entryway, behind the receptionist's desk, revealed a large, framed posting titled, " Help us to ...Serve You Better." A line, on the bottom third</p>	F 156		

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

PRINTED: 11/01/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/05/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF BOISE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>808 NORTH CURTIS ROAD BOISE, ID 83706</b>		
(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 156	Continued From page 4 On 2/2/16 at 8:45 am observation at the front door entryway, behind the receptionist's desk, revealed a large, framed posting titled, " Help us to ...Serve You Better." A line, on the bottom third of the posting listed the Ombudsman's name and a phone number.  On 2/2/16 at 8:46 am, observation of the wall across from Nurses' Station #1 revealed a framed posting with the title, "State Client Advocacy Groups," which contained the line, "Idaho State Ombudsman," and the same phone number as the posting at the front door entryway.  An attempt on 2/2/16 at 8:47 am to contact the Ombudsman using the phone number listed resulted with the recording, "This is no longer a working number."  During an interview, on 2/2/16 at 8:50 am, RN#1, along with the receptionist, also attempted to contact the Ombudsman using the number provided on the postings. The receptionist received the same recording, which indicated the posted number was inaccurate. The interview revealed RN#1 and the receptionist were unaware that the posted number was inaccurate and no longer working.	F 156			
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.	F 226		3/15/16	

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706	
(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	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to implement policies and procedures and thoroughly investigate abuse and neglect allegations for 3 of 20 (#s 17, 18 and 21) residents sampled for staff treatment. R #18 experienced psychosocial harm when the resident reported she was verbally abused by two different staff members and her reports were not thoroughly investigated. This failure to investigate resulted in the resident isolating herself in her room during meals when one of identified staff was on duty. R #17 and RR #21 experienced the potential for harm when instances of potential abuse and neglect were not thoroughly investigated. Findings included:</p> <p>1. R #18 was admitted to the facility on 12/11/15 with diagnoses which included end stage renal disease. Review of the resident's care plan dated 12/18/15, indicated R#18 received staff assistance with connecting and disconnecting her Peritoneal Dialysis machine.</p> <p>The 1/29/16 MDS coded R #18 as cognitively intact.</p> <p>During the group interview on 2/2/16 at 1:00 pm Resident #18 stated she had an argument with LPN #2 in her room. The resident stated since the incident, LPN #2 no longer works with her directly, but does work in the dining room during meals on Saturdays and she felt LPN #2 intentionally ignores her and serves her last. R#18 stated she no longer felt comfortable going to the dining room for meals while LPN #2 was working because it made her feel bad. R#18</p>	F 226	<p>Specific Resident: Resident #17 head to toe assessment has been completed, pain assessment has been updated and resident educated to report any severe pain or inability to walk immediately to nurse.</p> <p>Resident #18 psychosocial wellbeing has been evaluated by Social Services and appropriate follow up has been completed. Abuse was reported to the State during the week of survey, when resident reported verbal abuse to surveyors. A thorough investigation was completed at that time, and abuse and neglect were ruled out.</p> <p>Resident #19 psychosocial wellbeing has been evaluated by Social Services and appropriate follow up has been complete. A thorough investigation was done at the time of the allegation of abuse. Interviews were done with all CNA's that were working that day and still are working here at the facility. Abuse and neglect were ruled out.</p> <p>Other Residents: All resident may be affected by this. All complaints by residents toward staff will be immediately followed up on and abuse protocol initiated as indicated. Any complaints will be investigated timely and investigations documented.</p> <p>Systemic changes: Staff will be inserviced on the abuse policy and reporting immediately to supervisors on all allegations of abuse. All complaints of increased pain or inability to walk will be first investigated by finding the cause and calling the MD and then using the 24 hr report to follow up on.</p>	

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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	<p>Continued From page 9</p> <p>stated she told administration about the issue with LPN #2 and their response was for her not to work with R #18 anymore.</p> <p>During an individual interview on 2/4/16 at 2:00 p.m. R #18 said she had a confrontation with LPN#2 in her room over having to wait one and a half hours for her dialysis treatment. She said LPN #2 came into her room with another staff person and told her she would have to wait twice as long now because 2 people needed to be in her room to care for her. R #18 said she was very upset and crying after the conversation with LPN #2 and felt the nurse was verbally abusive towards her. R #18 said she told the ADON what happened between her and LPN #2. She said the ADON asked her if she could get along with the nurse since she only worked every other Saturday. R #18 said she told the ADON she did not feel comfortable with LPN #2 and did not want to work with her. R #18 said she still had to interact with LPN #2 in the dining room and she continued to be rude to her. She said she avoided going to the dining room for her meals when LPN #2 worked.</p> <p>During this interview, R #18 also stated she had an incident RN #3 regarding unhooking the resident from her dialysis machine. The resident said she waited one and a half hours to be unhooked from her machine. She said when RN #3 came to unhook her she was upset and asked why it took her so long to come. RN #3 responded she had come into the room and attempted to wake R #18 but she did not wake up. R #18 said she told RN #3 she did not attempt to wake her up and that she had been awake the whole time. R #18 said when she told RN #3 this, RN #3 replied. "I did too try to wake</p>	F 226	<p>All future allegations will be investigated.</p> <p>Root Cause: Failure to investigate complaints by residents towards staff will be investigated timely and followed up on with the Abuse Protocol initiated as indicated per policy</p> <p>Monitor: Nurse Managers to audit MD order for change of condition and abuse allegations and ensure investigation is completed thoroughly and reported to the state if indicated, weekly x8, monthly x3. Regional staff to be in monthly to review grievance log/incidents and accidents.</p> <p>Audits to be brought through PI monthly</p> <p>Date of Compliance: March 15, 2016</p>		

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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	<p>Continued From page 10</p> <p>you up." The resident said RN #3 got very close to her face and screamed at her. The resident said she was very upset after the interaction and told the ADON about it. Resident said RN #3 was moved to another hall and did not work with her for about a month.</p> <p>The facility was unable to provide evidence that the two allegations which were reported to the ADON were thoroughly investigated.</p> <p>During an interview on 2/4/16 at 3:15 pm the ADON said if a resident made an accusation or complaint regarding abuse the facility staff would immediately ensure the resident was safe, remove the accused staff person and send them home, report the incident to the DNS, fill out an incident report, interview other staff and residents and assess the resident before allowing the staff to come back on duty. The ADON said she did not document her meeting with R #18 regarding LPN #2 or RN #3. She said both nurses were removed from R #18's room. The ADON did not consider that R #18 had made an accusation of abuse regarding either nurse, and as a result, no investigation was initiated.</p> <p>2. On 2/5/16 at 10:00 am, R #18 stated he had reported a "popping" sound and pain in his right ankle, followed by the inability to walk, to staff on 8/21/15. No diagnostic assessment of the resident's reported injury was documented until 8/24/15, when it was discovered he had a comminuted fracture of his distal tibia and fibula.</p> <p>The facility provided no evidence that an investigation had been conducted about the failure to obtain timely medical services or treatment when the resident presented with a</p>	F 226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706	
(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 11 change in condition (inability to walk and pain).  Interviews with the DNS and Administrator on 2/5/16 at 1:45 pm, and review of the Accident and Incident reports provided by the Administrator revealed that the failure to provide services (timely treatment in response to a significant change in condition) for R #17 from 8/21 - 8/24/15 was not investigated.  3. The facility's Abuse policy and procedure, dated July 2011, documented, "Interviews should be conducted with staff members on all shifts having contact with the resident at the time of the incident..."  A completed abuse investigation, dated 10/16/15, documented RR #19 verbalized a concern about the way she was treated by a CNA and identified the CNA by name. A CNA with a similar name was working at the time of the complaint and was not interviewed by the facility. The facility completed there investigation without interviewing the CNA.  On 2/5/16 at 12:00 pm, the DNS stated the facility did not have a CNA by the identified name and she did not think about interviewing the CNA with the similar name.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her Individuality.	F 241	Specific Resident: Resident #13 has been offered a room change due to a shared bathroom and resident agreed and moved to another room.	

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

PRINTED: 02/24/16  
FORM APPROVAL  
OMB NO. 0938-0

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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) COMPLE DATE
F 241	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interviews and record review, it was determined the facility failed to ensure privacy was maintained for a shared bathroom between rooms occupied by men and women during toileting for 1 of 20 residents (R #13). This deficient practice created the potential for psychosocial harm when the facility failed to recognize a resident's sensitivity and concern of sharing a bathroom with members of the opposite sex. Findings included:</p> <p>R #13's Admission MDS, dated 12/14/15, coded that the resident was always continent of bladder, occasionally incontinent of bowel, and was cognitively intact.</p> <p>On 2/2/16 at 4:30 pm, observation of R #13's room revealed a shared toilet with a pass through to the next room which contained two mobile residents of the opposite gender. R #13 stated she did not use the shared toilet between her room and the room on the other side. When asked the reason, the resident stated, "First thing is it's shared with two male residents. I wish I had known that before I came. Oh well, and I am not going to move again."</p> <p>An interview with LPN #4 on 2/3/16 at 10:45 am, revealed that a pre-admission liaison staff member is usually the first person to discuss the operation of the nursing home with a potential resident or caregiver prior to admission. LPN #4 stated she and other nurse managers actually do the admission process once the resident comes into the facility. LPN #4 stated she did not see a problem with male and female residents sharing a pass through toilet. LPN #4 stated residents</p>	F2	<p>Specific Resident: Resident #13 has been offered a room change due to a shared bathroom and resident agreed and moved to another room.</p> <p>Other Residents: All residents that share a bathroom will be affected by this practice. .</p> <p>Systemic changes: Director of admissions and admission nurses were educated to ensure proper room placement so that no new admit after March 8, 2016 will share a bathroom with a member of the opposite sex. A house wide audit of all residents was done and any residents sharing a bathroom with the opposite sex were interviewed and offered a room move.</p> <p>Root Cause: was identified as a failure to properly place new residents with adjoined bathrooms, a resident of the same sex.</p> <p>After review of F241 it has been found that sharing a bathroom with a member of the opposite sex is a dignity issue and we will no longer have members of the opposite sex share a bathroom.</p>	

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/05/2016
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706
---	---

(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 241	Continued From page 13 were not informed about sharing bathrooms and were never asked during admission and/or after admission if they were comfortable sharing a pass through toilet with a member of the opposite sex.  On 2/3/16 at 1:40 pm, the liaison staff member stated the job requires meeting with the potential resident or caregiver in their home, the hospital, assisted living prior to admission. The liaison stated the possibility of sharing a bathroom with members of the opposite sex was not discussed as part of this pre-admission process.	F 241	Monitor: Director of Admissions will audit new admits to ensure proper placement of residents with a shared bathroom, and then audit on 5 other residents to ensure privacy and dignity needs are met, weekly x8 weeks and monthly x3weeks.  Audits to be brought through PI monthly  Date of Compliance: March 15, 2016	
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 by: Based on observation, interviews and record review, the facility failed to accommodate the needs of 1 of 20 (R #3) sampled residents. This deficient practice had the potential for harm when the facility failed to provide adequate lighting for R #3, who had poor vision and enjoyed drawing and reading in his room. Findings included:  Resident #3 was admitted to the facility on 12/11/15 with diagnoses of diabetes mellitus and end stage renal disease.	F 246		<p style="text-align: center;"><b>RECEIVED</b> <b>MAR 23 2016</b> <b>FACILITY STANDARDS</b></p>

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 14</p> <p>The resident's Activities Evaluation dated 1/12/16 documented preferred activities of arts/crafts, poetry, and creative writing. These activities were documented as "very important" to the resident. This evaluation also indicated the resident's vision to be "impaired/poor but able to see objects."</p> <p>The MDS, dated 1/12/16, coded R #3's vision to be moderately impaired.</p> <p>The current Care Plan, dated 12/11/15, documented, the resident had impaired vision as evidenced by diabetic retinopathy. Interventions included provide resident/responsible party education about visual loss (disease process, adaptations to environment, etc.) and provide adequate lighting.</p> <p>On 2/1/16 at 2:00 pm, two small overbed lights and one light fixture over the sink were observed in R #3's room. There was a small lamp, which the resident had purchased with his own funds.</p> <p>On 2/1/16 at 2:20 pm, the resident stated he preferred to draw and read in his room, but even with the additional lamp he had purchased the lighting was insufficient. The resident stated that he had told the nursing staff that he would needed more light in his room.</p> <p>An interview with the AD on 2/2/16 at 2:30 pm, revealed that she was aware that the resident enjoyed drawing and reading but was unaware of the need for more lighting in his room.</p> <p>An interview with the DSS on 2/2/16 at 2:45 pm, revealed the resident had an appointment with</p>	F 246	<p>Specific Resident: Resident #3 was discharged.</p> <p>Other residents: Resident who have impaired eyesight who like to do activities in their rooms have the potential to be affected.</p> <p>Systemic Changes: Staff inserviced to utilize the 24 report if resident is visually impaired and needs more light or to ensure other residents needs will be met. Accommodation of needs will be reviewed with residents at resident council.</p> <p>Root Cause: Facility failed to ensure that resident's individual needs are met by providing adequate lighting</p> <p>Monitor: Housewide audit of all visually impaired residents to ensure they have appropriate lighting. Nurse Managers to interview 5 residents weekly x8 and monthly x3 to ensure their needs are being met. All admits will be assessed for visual impairment and need are met.</p> <p>Audits to be brought through PI monthly</p> <p>Date of Compliance: March 15, 2016</p>	

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 15 the Commission of the Blind on 12/28/15 but the representative was not there and the appointment was rescheduled for 2/22/16. The DSS stated she was unaware of the resident's need for improved lighting in his room for him to enjoying his activities of choice.	F 246			
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, resident, family, and staff interview, and record review, it was determined the facility failed to provide a meaningful activities program for a resident and to ensure he was taken to scheduled activities. This was true for 1 of 10 (#7) sampled residents, and had the potential for harm if the resident should become bored or experience feelings of isolation. Findings included:  The CAA dated, 5/6/15, documented R#7 was not active prior to admission, was non-verbal and unable to verbalize his needs. He managed his own leisure time by doing self-directed activities such as watching television programs, listening to music, and socializing with visitors.  Resident #7's care plan, dated 7/21/15, documented the resident, was diagnosed with Huntington's Chorea and was at risk for self	F 248			

RECEIVED  
MAR 23 2016  
FACILITY STANDARDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 248	<p>Continued From page 16</p> <p>isolation related to inability to communicate, and dependent on staff for locomotion. R #7 would be assisted to and from activities by staff; would be invited and encouraged to participate in socials/parties; watch sports, musical programs, and cartoons; listen to classical music, sit at the nurses station socializing with staff and residents; and activities would provide 1:1 visits for visual, tactile, and cognitive stimulation.</p> <p>The 1:1 sensory stimulation activities included warm wash cloth to hands and face; lotion/hand massages; manipulating hand held textured objects; pictures of animals/scenery/family; general conversations; and listening to nature sounds and music of choice. The record of R #7's one to one activities included:</p> <p>a. On 11/22, 11/24, 11/27, 12/1, 12/8, 12/14, 12/15, 12/28, 12/30/15, 1/9/16 and 1/12/16, the resident watched cartoons.</p> <p>b. On 12/3 and 12/22/15 and 1/6/16 the resident was shown pictures of horses.</p> <p>c. On 12/4, 12/10, 12/11, 12/21, 12/26, 12/31/15, and 1/2, 1/8, 1/15, and 1/17/16 the resident was asleep/unable to visit.</p> <p>d. On 12/17, 12/24/15, 1/26, 1/27, and 1/28/16 attended parties/music programs and on 1/14 and 1/22/16 he attended church services.</p> <p>The Activities calendar for 2/1/16 through 2/5/16 documented the following activities:</p> <p>a. 2/1/16 - 10:00 am - bingo and 3:00 pm - music.</p> <p>b. 2/2/16 - 10:00 am - current events and 11:00 am - Bible stories</p> <p>c. 2/3/16 - 10:00 am - Ada county voter registration, 3:00 pm - trivia, and Valentines day crafts.</p> <p>d. 2/4/16 - 10:00 am - Nail care and 3:00 pm - music</p>	F 248	<p>Specific Resident: Resident #7 activity assessment and CP was updated to reflect current activity preferences.</p> <p>Other Residents: Residents with the inability to speak and verbalize needs and unable to get to activities without assistance may be affected</p> <p>Systemic Changes: Staff inserviced to get all residents out of their rooms when up in w/c for socialization and activities and document appropriately.</p> <p>Root Cause: Identified as failure to document the amount of activities resident was doing and failure to take to appropriate activities</p> <p>Monitor: Nurse Managers to Audit 5 residents to ensure activity preferences are being met and daily attendance log is accurate, weekly x8 and monthly x3</p> <p>Audits brought through PI monthly</p> <p>Date of Compliance: March 15, 2016</p>		

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 248	Continued From page 17 e. 2/5/16 - 10:30 am - Catholic services, 2:00 pm - movie and/or card games.  Observations from 2/1/15 through 2/5/16 noted R #7 was not assisted to the identified activities and was observed in his room on the following dates and times: a. 2/1/16 - from 1:30 pm to 5:00 pm, b. 2/2/16 - from 7:00 am to 4:30 pm, c. 2/3/16 - from 8:00 am to 4:00 pm, d. 2/4/16 - from 8:00 am to 1:00 pm, and e. 2/5/16 - from 12:00 pm to 2:30 pm.  On 2/2/16 at 3:40 pm, when asked why R #7 was not assisted to the activities on 2/1 and 2/2, the AD provided no explanation. She stated the resident was assisted to church services on Thursdays, music programs throughout the week, and received 1:1 visits on Saturdays for visual and tactile stimulation.  On 2/5/16 at 11:40 am, the resident's family stated up until two months prior, after he was moved to a different room staff would take him to activities and he would sit at the nurses station and watch people. The family member stated after the resident was moved he had not left his room.  On 2/5/15 at 2:00 pm, the DNS and UM confirmed the resident had not been out of his room as much since the room change and they had not assessed the resident to determine a cause for the resident's self-isolation.	F 248			
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE  The facility must provide medically-related social	F 250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 250	<p>Continued From page 18</p> <p>services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide medically-related social service interventions for 2 of 9 (R#s 2 and 6) residents sampled for anxiety and depression. The deficient practice had the potential for harm if residents' symptoms of anxiousness or distress were not effectively addressed. Findings included:</p> <p>1. R #2 was admitted on 12/22/15 with multiple diagnoses including Alzheimer's Disease and depression.</p> <p>Physician Orders, dated 2/5/16, documented Celexa 10 mg daily and Ativan 0.5 mg PRN.</p> <p>The Admission MDS, dated 12/29/15, coded R #2 rarely understood and was rarely understood, had memory impairment, and had trouble concentrating. The CAA coded cognition and psychotropic drug use were to be addressed on the care plan. Psychosocial Well-Being was triggered on the CAA, however, it was not coded to be addressed on the care plan and did not document the rationale why.</p> <p>R #2's care plan, dated 12/29/15, was missing the following sections: Cognition, Psychosocial Well-Being &amp; Behaviors, and Psychotropic Medications. (Refer to F279).</p> <p>Review of the resident's behavior monitoring</p>	F 250	<p>Specific Resident: Resident #2 discharged</p> <p>Resident #6 Symptoms of Depression have been evaluated by Social Services and behavior monitor updated as indicated</p> <p>Other Residents: All residents with symptoms of depression or anxiety may be affected</p> <p>Systemic Changes: Nursing Staff inserviced how to assess changes due to anxiety and depression and report to the nurse, social services and write on the 24 hour report to ensure proper follow up.</p> <p>Root Cause: was not assessing and addressing changes in symptoms of depression or anxiety</p> <p>Monitor: Nurse Managers to audit 24 hour report and new orders weekly x8 and monthly x3 to determine if residents symptoms have changed and then ensure updated behavior monitors and that there is social service involvement</p> <p>Audits to be brought through PI monthly</p> <p>Date of Compliance: March 15, 2016</p>		

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 250	<p>Continued From page 19</p> <p>sheets for January, 2016 revealed that the resident experienced tearfulness on six days in January. The record contained no evidence that the DSS had intervened in response to the resident's mood.</p> <p>On 2/4/16 at 9:20 am the DSS stated she did not complete the psychosocial well-being portion of R #2's care plan for which she was responsible. (Refer to F279.)</p> <p>On 2/5/16 at 9:30 am the DSS stated she met with R #2 at times when the resident was tearful but did not document the interaction in R #2's record.</p> <p>2. R #6 was admitted to the facility on 2/21/15 with multiple diagnoses including hemiplegia, anxiety disorder, and depression.</p> <p>The most recent MDS, dated 12/21/15, indicated R #6 was understood and understood others, and had moderate cognitive impairment. The resident exhibited verbal behaviors towards others 1 to 3 days during the previous 7 days.</p> <p>Current Physician Orders documented Ativan 0.25 mg three times daily, Trazodone 25 mg Monday through Saturday, Zyprexa 10 mg daily and Cymbalta 30 mg daily.</p> <p>R #6's care plan documented the resident had anxiety; [at times] was angry and frustrated with staff, sexually inappropriate; and experienced paranoia related to his stay and his interactions with staff. Interventions included medication for depression and anxiety and staff would evaluate for non-pharmacological interventions that may be effective in minimizing behavior.</p>	F 250			

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706	
(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 250	Continued From page 20  A Social Services note on 12/15/15 documented, R #6 made a comment to the physical therapist regarding moving to Oregon for physician assisted suicide. The DSS followed up with the resident to clarify his statement and to assess if the resident had a plan to hurt himself. Upon assessment the DSS determined the resident did not have a plan.  An Activity Note dated 1/3/16 documented, R #6 had a change in his general health over the previous "weeks" and had experienced a decline in his activity participation, television watching, and socializing with staff and other residents.  On 2/3/16 at 1:55 pm the DSS stated she offered R #6 out patient psychiatric services on 12/15/15 and he refused. The DSS stated she met with the resident on 1/3/16 related to his decline and had not followed up with him since.  On 2/5/16 at 9:35 am the DSS stated R #6's depression had recently worsened and he had not come out of his room to get coffee as often, which was his way of socializing with staff and other residents.	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706	
(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 279	<p>Continued From page 21</p> <p>needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, it was determined the facility failed to develop a Psychosocial Well-Being care plan triggered by the CAA for R #2 and did not ensure R #4's CAA included input from the resident and/or family/representative regarding concerns, preferences and/or suggestions. This was true for 2 of 15 residents' care plans (R#s 2 &amp; 4). These failures created the potential for unmet needs. Findings include:</p> <p>1. R #2 was admitted on 12/22/15 with multiple diagnoses including diabetes, Alzheimer's, hypothyroidism, rheumatoid arthritis, epilepsy, depression, macular degeneration and muscle weakness.</p> <p>Physician Orders, dated 2/5/16, documented Celexa 10 mg (anti-depressant) and Ativan 0.5 mg (anti-anxiety) PRN (as needed).</p> <p>The Admission MDS/CAA dated 12/29/15 coded cognition and psychotropic drug use were to be</p>	F 279	<p>Specific Resident: Resident #2 discharged</p> <p>Resident #4 has had Careplan updated to reflect CAA triggers if indicated. Family and resident input has been utilized.</p> <p>Other Residents: All residents have the potential to be affected who are in the facility</p> <p>Systemic Changes: MDS and Social Services to be inserviced to ensure accuracy of CAA's and Careplans and that they match and that there is documentation in CAA regarding family interviews are conducted</p> <p>Root Cause: was found to be failure of Social Services and MDS to develop a comprehensive careplan and CAA and to ensure they were complete</p> <p>Monitor: Nurse Managers to audit triggered CAA's and ensure family interviews and anything triggered on the CAA are on the CP if indicated or documented why not, weekly x8 and monthly x3.</p> <p>Audits to be brought through PI monthly</p> <p>Date of Compliance: March 15, 2016</p>	

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706	
(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 279	<p>Continued From page 22 addressed on the care plan. Psychosocial Well-Being was triggered on the CAA, however, it was not coded to be addressed on the care plan and did not document the rationale why.</p> <p>R #2's care plan dated 12/29/15 was missing the following sections: Cognition, Psychosocial Well-Being &amp; Behaviors, and Psychotropic Medications. (Refer to F250).</p> <p>During an interview on 2/4/16 at 9:15, am the DNS stated the care plan should be completed within 21 days of admission.</p> <p>During an interview on 2/4/16 at 9:20 am the DSS stated she was responsible for completing the psychosocial well-being and behaviors portion of R #2's MDS and care plan. She said she had not completed it and it should have been completed within 21 days of the resident's admission.</p> <p>During an interview on 2/4/16 at 9:40 am RN #5 stated she was responsible for the psychotropic medications and pain sections of the care plan. She stated those sections for R #2 were incomplete. RN #5 stated the care plan should be completed within 21 days and it was not.</p> <p>During an interview on 2/4/16 at 10:05 am, the ADON stated R #2 had no care plan for depression and she should.</p> <p>2. Resident #4 was admitted on 3/27/15 with encephalopathy, BPSD, agitation, and dementia.</p> <p>The CAA, dated 4/26/15, documented the resident was combative with cares, had dementia with behaviors and explosive personality, was</p>	F 279		

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706	
(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 279	Continued From page 23 alert and oriented to self with confusion, and "at times was delusional and his requests were unreasonable mostly in the late evenings and throughout the night." The area for resident and/or family input regarding concerns, preferences and/or suggestions was insufficient and documented, "Wife cannot care for him and wants him to be long term care."	F 279		
F 280 SS=E	On 2/3/16 the SSD stated there was "room for improvement" when gathering information from the resident and family. 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 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  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.  This REQUIREMENT is not met as evidenced	F 280		

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 24</p> <p>by: Based on staff interview and medical record review, it was determined the facility failed to:</p> <p>a. Revise R #4's transfer status for toileting when the program changed from sit to stand transfer onto toilet to check and change;</p> <p>b. Update R #5's care plan for the use of a wheelchair and the use of Velcro across the door to prevent another resident from wandering into R #5's room; and</p> <p>c. Update fall care plans to include increased supervision for R#s 9 &amp; 11 after multiple falls. This was true for 4 of 15 residents sampled for care plan revisions. This had the potential to result in harm if residents did not receive appropriate care due to lack of direction from the care plan. Findings included:</p> <p>1. The MDS, dated 1/7/16, documented R#4 was totally dependent on staff for transfers and required extensive assistance of two staff for toileting.</p> <p>The Fall care plan, dated 3/27/15, documented R #4 required the use of a Hoyer lift for all transfers. The Bowel and Bladder care plan, dated 3/27/15, documented the resident required the assistance of two staff members with sit-to-stand or Hoyer lift with all transfers on/off the toilet.</p> <p>During an interview with NA #13 on 2/3/16 at 4:00 pm, the NA stated the resident was a check and change for toileting needs and did not use the sit-to-stand for toileting and/or transfers.</p> <p>On 2/3/16, at 4:05 pm, the ADON stated R #4 required a Hoyer lift for transfers, did not use the sit-to-stand, and was on a check and change program for toileting.</p>	F 280	<p>Specific Resident: Resident #4 CP has been updated</p> <p>Resident #5 has discharged</p> <p>Resident #9 has been discharged.</p> <p>Resident #11 CP has been updated</p> <p>Other Residents: All residents may be affected by this practice</p> <p>Systemic Changes: IDT Members and Nursing staff educated to ensure careplans are revised to reflect appropriate care of the resident.</p> <p>Root Cause: Failure to update Careplans to reflect appropriate care of the individual resident.</p> <p>Monitor: Nurse Managers to audit 5 care plans to ensure the appropriate care for each resident weekly x 8 and monthly x3.</p> <p>Audits will be brought through PI monthly.</p> <p>Date of Compliance: March 15, 2016</p>	

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 25</p> <p>2. Resident #5 was admitted to the facility on 9/9/15 with diagnoses of DM II with a history of hypoglycemia, anxiety disorder and difficulty walking.</p> <p>Resident #5's most recent quarterly MDS, dated 12/17/15, documented the resident was cognitively intact. The resident required minimal assistance with transfers, eating, toileting and personal hygiene.</p> <p>Review of Resident #5's care plan, dated 9/21/15, revealed several areas of interventions that were no longer accurate. These were:</p> <p>*Discharge Plan: There was an intervention that documented, "Provide resources for apartments in Salmon Idaho." On 2/1/16 at 1:30 pm the resident stated she had a home in the Boise area, and was planning on discharging to that location.</p> <p>*Activities of Daily Living - Self Care Deficit: There was an intervention that documented, "Resident has Velcro guard to door to discourage other residents from entering her room ..." The Velcro was no longer used by the resident.</p> <p>*Falls: There was an intervention: "Remind resident and reinforce safety awareness - Lock brakes on bed, chair etc. ..." The resident used a walker and no longer used a wheelchair at the time of survey. The resident's care plan also contained an intervention to use a cushion to her wheelchair as a protection from impaired skin integrity.</p> <p>An interview with the DON on 2/3/16 at 3:30 pm, confirmed that the resident's care plan had not been revised when care needs changed, as the</p>	F 280			

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 26</p> <p>resident no longer used a Velcro guard on the door, or a wheelchair for locomotion</p> <p>3. Resident #9 was admitted to the facility 11/3/14 with diagnoses of aftercare following joint replacement surgery, Parkinson's disease, history of falling at home and unspecified dementia with behavioral disturbances.</p> <p>The most recent annual MDS, dated 11/9/15 documented the resident was not able to be interviewed but had no problems with long or short-term memory. Resident #9 had modified independence with decision making.</p> <p>Review of the resident's care plan, dated 11/3/14, revealed the care plan had not been revised when care needs changed. In addition, when the care plan was revised it failed to provide sufficient information to direct care. For example:</p> <p>Falls: There was an intervention: "Staff to check resident every hour and monitor for pain ... 12/13/14." The resident's record documented this intervention was changed to 15 minutes checks on 9/26/15.</p> <p>The care plan for falls dated 1/2/16, documented an intervention of "will start sitter, female in evenings." The care plan failed to document what the sitter was allowed to do, i.e., provide direct care.</p> <p>Care plan lack of revisions were presented to the Administrator and DON on 2/5/16 at 3:00 pm and they made no comment about the need to revise the resident's care plan.</p> <p>4. Resident #11 was admitted to the facility on 10/21/14 with diagnoses of unspecified dementia</p>	F 280			

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 27 with behavioral disturbance, difficulty in walking, impaired vision and anxiety disorder.  The most recent quarterly MDS, dated 11/24/15, documented the resident had moderate cognitive impairment, and required limited assistance with transfers and ambulation.  The care plan for falls, dated 10/21/14 documented, "[R #11] has 1:1 sitter from 7am to 9 pm ..." The care plan failed to document what the sitter was allowed to do, i.e., provide direct care.  Interview with the Administrator and DON on 2/5/16 at 3:00 pm revealed no further information about the need to assure that the care plan was revised as needed and that revisions provided sufficient information to direct care.	F 280			
F 282 SS=D	483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow the care plan regarding transfers for 1 of 20 (Resident #2) residents sampled for ADL assistance. The deficient practice created the potential for harm if the resident was injured when not provided enough support during transfers. Findings included:	F 282			

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/06/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 282	Continued From page 28  Resident #2 was admitted to the facility on 12/22/15 with diagnoses that included rheumatoid arthritis, epilepsy, macular degeneration and muscle weakness. The most recent MDS dated 12/29/15 documented Resident #2 required extensive 2 person assistance with her ADLs including transfers.  Resident #2's care plan, dated 12/29/15, documented she required "extensive assist of 2 persons to transfer from bed to chair and back."  During an observation on 2/3/16 at 9:25 am RN # 10 transferred Resident #2 from her wheelchair to her bed, without a second person to assist, with the use of a gait belt. Resident #2 said, "ouch," multiple times. RN #10 struggled with the transfer of Resident #2 and stopped twice during the transfer. The gait belt was pulled up over the resident's chest and cutting into her armpit area.  During an interview on 2/3/16 at 9:30 am, RN #10 stated Resident #2 was a one person transfer and had been for so for "a while." She said Resident #2 was stronger since working with the therapy department.  During an interview on 2/3/16 at 9:45 a.m. the ADON confirmed that, based on the resident's current care plan, Resident 2 should have been transferred by two persons. She said the CNAs told her the resident had progressed but the care plan was not updated and the need for two-staff transfer was still in effect.	F 282	Specific Resident: Resident #2 has been discharged  Other Residents: All residents have the potential to be affected who transfer with staff assistance in the facility  Systemic Changes: Nursing and therapy staff educated to update careplans when transfer status changes and to write on 24 hr report to communicate those changes. Nursing staff educated to transfer residents according to care plan.  The root cause was failure to update careplans with new transfer status  Monitor: Nurse Managers will audit 5 residents a week to ensure careplans have proper transfer status and 5 residents are observed being transferred per careplan. weekly x8 and monthly x3  Audits will be brought through PI monthly  Date of Compliance: March 15, 2016		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323			

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 323	<p>Continued From page 29</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure 2 of 7 (#s 9 &amp; 11) sampled residents were adequately supervised to prevent falls. Resident #9 was harmed when the facility failed to prevent or adequately supervise the resident resulting in multiple falls, including a fall with fracture requiring hospitalization. Resident #11 sustained injuries including a laceration, skin tear, and swelling from multiple falls. Findings included:</p> <p>1. Resident #9 was admitted to the facility 11/3/14 with diagnoses of aftercare following joint replacement surgery of the left hip, Parkinson's disease, history of falling at home and dementia with behavioral disturbances.</p> <p>The most recent annual MDS, dated 11/9/15, documented the resident was not able to be interviewed but had no problems with long- or short-term memory and had modified independence with decision making. The resident required extensive assistance with transfers, did not ambulate in her room, and had multiple falls since the last assessment, including one with a major injury.</p> <p>The most recent quarterly MDS assessment,</p>	F 323	<p>Specific Resident: Resident #9 is discharged</p> <p>Resident #11 CP has been assessed and updated to reflect increased supervision</p> <p>Other residents who have had multiple falls may be affected. An audit of residents care plans who have had multiple falls was completed to ensure they have been evaluated and provided adequate supervision .</p> <p>Systemic Changes: Staff educated to the importance of placing residents with multiple falls on increased supervision timely to reduce risk of injuries related to falls. Also educated to ensure documentation of the type of increased supervision is in place.</p> <p>Root Cause: Was failure to put increased supervision in place more timely to reduce the number of falls and reduce the risk of injury</p> <p>Monitor: Audits to be done in weekly Fall meeting with IDT members to audit all falls, weekly x8 and monthly x3 to ensure a form of increased supervision has been assessed and implemented if indicated.</p>	

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0397

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/05/2016
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706
---	---

(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 30 dated 8/13/15, documented the resident was cognitively intact, required extensive assistance for transfers and had multiple falls since the previous assessment with no injuries.</p> <p>The DNS provided a document that had a list of the falls the resident had from 11/17/14 until 1/2/16, a total of 17 falls. Review of the falls that had occurred in the previous 6 months revealed that the facility documented the falls, then wrote in the recommendations/ actions portion of the incident reports what they were to do. Interviews with the resident were not included as part of the investigation to implement actions to prevent further falls, and no root cause analysis of the multiple falls was documented. The fall investigations and conclusions included:</p> <ul style="list-style-type: none"> <li>- NN 8/30/15 at 7:03 am, "Staff heard calls coming from resident's room, Resident found in room sitting on floor near bed, leaning on left elbow. Stated she was reaching for tissues ..."</li> <li>The corresponding incident report documented: Resident walking with RNA. Are having [name of mental health group] come in for [psychiatric evaluation] [No explanation provided as to how this was determined as a pertinent fall prevention measure]. [Family member] does not want walker used in room, will discuss fall prevention with son and staff regarding putting safety equipment within reach for safety and self-transferring."</li> <li>- NN 9/13/15 at 6:40 pm, "This nurse was walking down the hall looked into resident's room and saw that she was sitting on the floor between her wheelchair and bed. She was more on her right hip facing her bed." The corresponding incident report documented: "Resident would not let a sitter be around her. Will do [urinalysis]. Alarm</li> </ul>	F 323	<p>Audits will be brought through PI monthly</p> <p>Date of Compliance: March 15, 2016</p>	

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <p style="text-align: center;">135038</p>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <p style="text-align: center;">02/05/2016</p>	
NAME OF PROVIDER OR SUPPLIER  <p style="text-align: center;">LIFE CARE CENTER OF BOISE</p>			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 31 would scare her. [Family member] refused to send her out for [psychiatric evaluation] ..."</p> <p>- 9/22/15 at 9:45 am, the IDT met to discuss the recent falls the resident had. The documentation lacked any reference or documentation to show staff were trying to determine the root cause of the frequent falls. The decision documented, "Will increase supervision to 15 minute checks for safety as resident has had repeat falls." Review of the resident's care plan revealed it was not revised, (Refer to F280) and at the time of the survey, the care plan continued to call for checks on an hourly basis, rather than the additional supervision of 15-minute checks.</p> <p>The nursing staff documented the resident was self-transferring or found walking in her room and hallway without supervision on 10/3/15, 10/10/15 (three times), 10/16/15, 10/22/15, and 10/27/15.</p> <p>On 11/7/15 at 10:33 am, a NN documented, "At 9:45 am CNA alerted this nurse that resident is on the floor. This nurse went to room noted resident lying on the floor on her right side. Resident was going through her roommate's dresser before the fall. Resident took all her roommate's belonging from dresser and put them on the floor. Resident lying on the floor on a bedside mat for her roommate. Assessed resident for ROM and injuries. Resident refused ROM no visible injuries noted. Floor with clutter due to resident had put stuff form [sic] dresser. Resident transferred to bed with assist of 4 person due to not tolerating transfers well...gait unsteady ..."</p> <p>Further review of the clinical record revealed that as a result of this fall, the resident sustained a hip fracture and required hospitalization and a hip</p>	F 323			

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 32 replacement surgery.</p> <p>The resident was readmitted to the facility on 11/16/15 and was in a wheelchair with few attempts to stand or transfer until incident reports documented:</p> <p>11/30/15 at 9:20 am, "Resident yelling help me and found him [sic] on her hands and knees on the floor." Recommended interventions were: "Lipped mattress placed on bed. Continues with 15 minute checks ..."</p> <p>12/26/15, no time documented, "Resident found on floor in room stated she was reaching for something and slipped off of bed." Recommended interventions were: Will educate staff to assist resident with needs after meals ..."</p> <p>1/2/16 , no time documented, "Resident fell forward in wheelchair in hallway, stated she was attempting to pick up a book. No book in sight. Balance in chair compromised due to kyphosis." Recommendations were: "1) OT to eval WC for appropriateness, 2) will initiate sitter in evening."</p> <p>The resident's clinical record contained multiple documentations by nursing staff where the resident was found standing, ambulating and leaning out of the wheelchair almost falling.</p> <p>Review of the fall risk assessments completed after the recorded falls revealed the resident was at high risk for falling, with an increase in her risk score between 11/30/15 and 1/2/16.</p> <p>The resident's care plan for falls, dated 11/3/14 documented, "at risk for fall related injury as evidenced by hx of fall with left hip pinning</p>	F 323			

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 33</p> <p>required," and "At risk for falls r/t impaired mobility, Parkinson's disease, fall risk score and hx of osteoporosis. Resident will independently self-transfer without calling for assistance."</p> <p>The second problem, added 8/26/15, documented, "Normal progression of disease process with unavoidable and/or predictable decline."</p> <p>The third problem, added 11/16/15, documented, "Recent readmit with dx right femoral fracture with replacement and HTN."</p> <p>The fourth problem, dated 12/21/15, documented, "WBAT to right LE precautions."</p> <p>The care plan had more than twenty interventions; most of the interventions could not be determined whether they made a significance in preventing the resident from falling or when they were initiated for the resident. Interventions the facility had in place at the time of the survey were:</p> <ul style="list-style-type: none"> <li>- Provide/observe use of adaptive devices <ul style="list-style-type: none"> <li>· Walker</li> <li>· Wheelchair with auto locking brakes.</li> </ul> </li> </ul> <p>5/13/15</p> <ul style="list-style-type: none"> <li>- Remind resident and reinforce safety awareness <ul style="list-style-type: none"> <li>· Lock brakes on bed, chair, etc. before transferring</li> <li>· Educate remind resident to request assistance prior to ambulation</li> <li>· Appropriate footwear</li> <li>· Other: Non-skid socks</li> </ul> </li> <li>- Extensive assist of one person to transfer from bed to chair and back</li> <li>- Staff to check resident every hour and monitor</li> </ul>	F 323			

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 34 for pain, toilet repositioning, and fluid needs (4 P's) 12/13/14</p> <ul style="list-style-type: none"> <li>- Rug at bedside to prevent sliding</li> <li>- Low bed in place with lipped mattress. 11/18/14</li> <li>- Do not leave alone in bathroom or on bedside commode</li> <li>- Falling star/leaf program</li> <li>- Continue to educate staff to assist with needs after meals. 12/28/15</li> <li>- Assure items are within reach at resident's level, 12/28/15</li> <li>- RNA program per plan of care 1/15/16.</li> </ul> <p>Another "Falls" care plan problem area, dated 1/2/16, documented, "At risk for fall injury as evidenced by: previous fall... Normal progression of disease process with unavoidable and/or predictable decline." The care plan provided a space for the disease process(es) to be listed, but that space was blank. The interventions were:</p> <ul style="list-style-type: none"> <li>- Report falls to physician and responsible party.</li> <li>- Remind resident and reinforce safety awareness: <ul style="list-style-type: none"> <li>·Educate/remind resident to request assistance</li> <li>·Other: will start sitter female in the evening.</li> </ul> </li> </ul> <p>Therapy to reevaluate for positioning.</p> <p>The DON provided a document, dated 12/11/15 that documented, "... (R #9) has a history of delusions which have caused psychosocial distress and falls. She believes that her stuffed bear and her stuffed cat are real...She climbs on the floor and crawls around to find her cats...We have assessed the need for a 1:1 sitter and due to resident's paranoia and delusions we have determined that a 1:1 would not benefit for her." At the time of the survey, the resident had a sitter in the evening.</p>	F 323			

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES A. PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 35</p> <p>Observation of Resident #9 on 2/2/16 at 12:20 pm revealed the resident was up and propelling her wheelchair throughout the facility. No supervision was provided as the resident propelled herself out of the restorative dining room and headed toward her room. On 2/4/16 at 12:30 pm, the resident was observed sitting in her wheelchair outside her room. No staff were observed to be present to provide supervision.</p> <p>On 2/3/16 at 2:30 pm, the DNS and ADON asked to provide evidence that the 15-minute supervision checks were completed after the need was identified on 9/22/15, as well as information about the date when the resident actually started with a sitter. The supervision checks were provided and revealed they were being completed hourly, not every 15 minutes as recommended by the IDT in 9/22/15. The sitter was started on 1/2/16 with the resident; however only on afternoons.</p> <p>2. Resident #11 was admitted to the facility on 10/21/14 with diagnoses of dementia with behavioral disturbance, difficulty in walking, impaired vision, and anxiety disorder.</p> <p>The most recent quarterly MDS assessment, dated 11/24/15, documented the resident had moderately impaired cognition and required limited assistance with transfers and ambulation. The resident had multiple falls since the previous assessment with minor injuries.</p> <p>Resident #11's care plan for falls had multiple problems listed. The first problem, dated 10/21/14, documented, "[R #11] is at risk for falls r/t impaired vision, dementia, depression unsteady gait at times, hx of falls, and fall risk</p>	F 323			

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 36</p> <p>score assessment 25. [R #11] is taking antipsychotic and antidepressant medications, ASE of these medications included increase risk of falls. The second problem, dated 1/29/15, documented, "Family encouraged to bring in non-skid slippers secondary to non-compliant with calling and waiting for assistance. Resident has poor safety awareness, poor insight to own limitations." The third problem, dated 5/27/15, documented, "Resident awaiting for memory care placement, on waiting list." The fourth problem, dated 12/7/15, documented, "Resident has hx of frequent falls."</p> <p>The resident's current care plan documented 28 interventions with several that had multiple components to them. Most of the interventions were the same as those listed in example #1 of this deficiency. The different interventions of significance were:</p> <ul style="list-style-type: none"> <li>- [Name] has 1:1 sitter from 7am to 9pm for added supervision, then on every 15 minute checks when sitter is not with her. (8/26/15)</li> <li>- Staff to stay with her when she is toileting, as resident allows. (9/18/15)</li> <li>- Staff to look in on [R #11] when passing room, assessing safety and potential needs, continue with 15 minute checks. (5/27/15)</li> <li>- Auto lock brakes to W/C. (9/18/15)</li> <li>- [Name] has a history of crawling around on the floor looking for items. (No date)</li> <li>- Encourage resident to eat in hallway by nurse's station as she allows for increased supervision.</li> </ul>	F 323			

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 37 (9/18/15)  Review of the resident's record for documentation of falls revealed a history of falls, including the following:  - 8/25/15 at 9:24 pm, "Nurse said that she was walking past her room and saw resident on the floor sitting with her head against her bed and her feet out in front of her. ROM WNL and no complaints of pain. However she has a laceration on the back of her head, bottom right (behind her ear and a little bit down.) Resident reported no pain. Resident said that she was 'putting her tissue away.' Nurse cleaned her up and noticed that it was about 1/4 inch long ..."  - 8/27/15 at 9:47 pm, "...Resident assisted to floor after losing balance in hallway. Resident with dementia, blind, and poor safety awareness. 15 minute checks in place ..."  - 9/10/15 at 5:43 pm, "at approx., 4:45 pm this nurse was alerted that resident was on the floor in the hallway by her room. When this nurse arrived, resident had been assessed by another nurse and staff was assisting the resident off the floor ..."  - 9/19/15 at 11:27 pm, "At approx. 5 pm another nurse heard a 'thud' while standing at nurses station, she looked to her left and noted resident on the floor in front of outside door ..." The location where the resident was found was on a different unit within the facility from where she resided.  - 10/10/15 at 3:19 pm, "...at 1240 this staff heard a loud thud and returned to room with co-worker	F 323			

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES At PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 38</p> <p>nurse. Resident was sitting on the floor with her back against the wall. Stated that she was attempting to go wash face. Stated she hit her head ...."</p> <p>- 10/19/15 at 10:17 pm, "Hears noise and when staff entered room, res lying on floor next to rolling table on left side/back. Swelling around right eye starting. Res bleeding from skin tear 1.5 cm over right eye, 1/8 cm skin tear to bridge of nose and 2 cm skin tear to rt wrist ..."</p> <p>- 10/20/15 at 9:53 pm, "At approx(imately) 3:15 pm this nurse was alerted to resident's room. This nurse observed resident sitting on the floor legs out and both hands on the floor, there was a health shake on the floor to the left of her and a puddle of it next to the container ..."</p> <p>Review of facility documentation did not reflect if the resident had sitters or whether they had been in place when the six falls occurred after 8/26/15. In addition, since the resident's last fall on 10/20/15, the resident's record also contained documentation where she was found ambulating in her room and hallways on many occasions, although, per the care plan, a sitter was to be present as an intervention to prevent accidents.</p> <p>The DON was interviewed on 2/4/16 at 11:00 am about the resident's multiple falls and injuries, which included skin tears, lacerations, and swelling. The DON was also interviewed about the lack of 15 minute checks and a sitter as were care planned for this resident. The DON stated the sitters were not CNAs so were only to observe and remind resident not to stand and walk around because sitters have no training in caring for personal needs and transferring a</p>	F 323			

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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  F 329 SS=E	<p>Continued From page 39 resident.</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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 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 staff interview and record review, the facility had failed to assure that residents were free from unnecessary medications by implementing a gradual dose reduction for a psychotropic medication, assessing and documenting justification for the continued use of</p>	F 323  F 329	<p>Specific Resident: Resident #2 has been discharged</p> <p>Resident #6 Behavior monitor has been evaluated for accuracy, GDR has been attempted per policy and there is justification of use for medications that resident is taking</p> <p>Resident #11 has been re-evaluated for a GDR and documentation to support why if it is not indicated</p> <p>Resident #4 had nonpharmacological interventions updated and are more specific to resident</p> <p>Other Residents: All other residents have the ability to be affected who are on psychotropic medications</p>	

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 40</p> <p>psychotropic medication, and/or monitoring resident behavior to determine the ongoing necessity of psychotropic medications for 4 of 20 (#s 2, 4, 6, &amp; 11) sampled residents. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 12/22/15 with diagnoses that included Alzheimer's and depression. The resident's physician orders, dated 2/5/16, included Celexa 10 mg daily and Ativan 0.5 mg PRN.</p> <p>Review of the most recent MDS dated 12/29/15 documented Resident #2 rarely understood and was rarely understood, had memory impairment and trouble concentrating, and had not displayed any behavioral symptoms.</p> <p>The January 2016 MAR documented Resident #2 received Ativan 0.5 mg by mouth as needed 14 times in one month. Resident #2 received Ativan two times on 1/13/16 and had 2 falls on the same day, and once on 1/27/16 and had a fall on that day.</p> <p>A "monthly flow record" indicated Resident 2 was monitored for behaviors that included "tearfulness" and "anxious statements." The record indicated Resident #2's diagnosis was depression and the psychoactive drug was Celexa. Although it was administered, there was no behavior monitoring sheet regarding the Ativan.</p> <p>During an interview on 2/4/16 at 9:40 am, RN #9 stated the staff was not required to document the resident's behavior before the Ativan was given, the non-pharmacological interventions that were attempted or the effect of the medication after</p>	F 329	<p>Systemic Changes: educated SS regarding ensuring nonpharmacological interventions are specific to each resident. Also NP educated to ensure documenting reason why GDR should or should not be attempted or what the benefits to the resident are to continue the medication at the current dose, Nursing staff educated on using the nonpharmacological interventions for each individual resident to reduce behaviors</p> <p>Monitor: Unit managers, social services will bring audits through psychotropic meeting weekly. Members will audit residents on psychotropic medications to ensure proper documentation of medication use is in place and GDR has been attempted or that justification is in place to indicate why GDR is not clinically indicated. and that nonpharmacological interventions are being attempted and that meds are not being used unnecessarily weekly x8 and monthly x3</p>	

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

PRINTED: 02/27/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 41 administration.</p> <p>During an interview on 2/5/16 at 8:25 am the ADON stated there should have been a behavior monitoring sheet for Resident #2's Ativan. She said the non-pharmacological interventions and when they were attempted would be on the behavior monitoring sheet. She said the staff were to document the effectiveness of the Ativan on the back of the MAR under the results heading where they write "helpful" or "effective."</p> <p>During an interview on 2/4/16 at 10:05 am the Corporate Nurse stated the word "anxiety" was too vague of a reason to administer a PRN medication to a resident. She also said the word "effective" was not enough detail about the resident's behavior after administration of the anti-anxiety medication.</p> <p>2. Resident #6 was admitted to the facility on 2/21/15 with diagnoses that included anxiety disorder, paranoia/delusions/agitation and depression. The physician's orders at the time documented Resident #6 received Ativan 0.25 mg three times daily, and Zyprexa 10 mg daily.</p> <p>The most recent MDS, dated 12/21/15, indicated Resident #6 was understood and understood others, had moderate cognitive impairment, exhibited verbal behaviors towards others 1 to 3 days during the previous 7 days, had no psychosis, and no hallucinations or delusions.</p> <p>A care plan, dated 3/2/15, documented Resident #6 received psychotropic medication for diagnoses of depression and anxiety. The care plan indicated the staff would evaluate for non-pharmacological interventions that may be</p>	F 329			

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 42</p> <p>effective in minimizing behavior. The care plan listed his psychosocial problems as anxiety, becoming angry and frustrated with staff, sexual inappropriateness and paranoia related to his stay and his interactions with staff, but when asked about specific concerns he was unable to identify any.</p> <p>"Behavior/Intervention Monthly Flow Record" for November 2015 through February 2016 documented Resident #6 was monitored for verbal aggression, physical aggression and paranoia. The resident exhibited the target behaviors on 11/19/15, 11/30/15, and 12/16/15. No behaviors were documented for the month of January 2016, or for 2/1/16 through 2/5/16.</p> <p>Review of the clinical record showed no examples of Resident #6's specific paranoia or delusional behavior. Staff failed to describe the resident's behaviors in sufficient detail that they could be reviewed and assessed to determine if there were modifiable, non-pharmacological interventions which could be effective.</p> <p>During an interview on 2/4/16 at 6:00 pm the ADON said she did not know what Resident #6's specific paranoia was or what exactly he was paranoid about or what his delusions were. She said the word "paranoia" listed on the Behavior Monitoring Sheet was vague and did not provide detail to how his paranoia manifested itself.</p> <p>3. Resident #11 was admitted to the facility on 10/21/14 with diagnoses of dementia with behavioral disturbance and anxiety disorder.</p> <p>The most recent quarterly MDS assessment, dated 11/24/15, documented the resident had</p>	F 329			

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/05/2016
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706
---	---

(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 329	<p>Continued From page 43</p> <p>moderate cognitive impairment, required limited assistance with transfers and ambulation, had multiple falls since the previous assessment with minor injuries and received psychotropic medications seven days a week.</p> <p>Review of physician's orders, dated 6/2/15, documented an order for Zyprexa 5mg daily at bedtime.</p> <p>The resident's care plan for Psychotropic Medications had two problems identified. The first was dated 10/21/14 and documented, "Use of psychotropic drug places resident at risk for drug-related hypotension, gait disturbance, cognitive impairment, behavioral impairment, ADL decline, and decline in appetite." The second problem was dated 10/21/14 and documented, "[R #11] is taking antidepressants for dx of depression per MD order. She is also taking an anti-psychotic for dx of BPSD, has order for PRN anti-psychotic increased behaviors r/t BPSD. "</p> <p>An undated care plan intervention documented staff to monitor effectiveness of psychotropic drugs and review for changes at psychotropic committee meeting. Communicate psychotropic committee recommendations to MD.</p> <p>The Zyprexa was due for a GDR on 12/7/15. The pharmacist sent a recommendation to the physician. On 12/9/15 the Nurse Practitioner declined the GDR with a documented response of, "Lowest effective dose. Pt (patient) requires sitter. Benefits (greater than) risks, No (change at) this time." The Nurse Practitioner failed to write a justification that explained why this was the lowest effective dose, or provide a reason that a GDR could not be attempted and/or was</p>	F 329		

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 329	<p>Continued From page 44</p> <p>clinically contraindicated. There was no explanation of what "benefits" the resident had by taking the Zyprexa. The resident's care plan documented the sitter was needed because of her frequent falling. The facility had not completed a root cause analysis on the falls to determine if the falls were medication related.</p> <p>Review of the monthly "Behavioral/Intervention Monthly Flow Record" showed the following documentation of behaviors:</p> <p>November 2015: Behavior 1) Combative: No documented incidents; 2) Resistive to cares: 2 episodes on 11/7/15; 3) verbally aggressive: 3 episodes on 11/3/15 nights, 3 episodes on 11/7/15 afternoons, unknown on 11/21/15 on afternoons; 4) Physically aggressive: 2 episodes on 11/21/15; 5) Intrusive wandering: 1 episode on 11/21/15.</p> <p>December 2015: Behavior 1) Combative: 8 episodes on 12/13/15; 2) Resistive to cares: 3 episodes on 12/7/15 afternoons and 6 episodes on 12/7/15 on afternoons; 3) verbally aggressive: 6 episodes on 12/7/15 afternoons and 8 episodes on 12/13/15 afternoons; 4) Intrusive wandering: 4 episodes on 12/7/15 and 6 episodes on 12/13/15.</p> <p>January 2016: Behavior 1) Combative: No documented episodes; 2) Resistive to care: 7 episodes on 1/28/16 on night shift; 3) verbally aggressive: 1 episode on 1/18/16 and 1 episode on 1/27/16 both were night shift; 4) Physically aggressive: no episodes documented; 5) Intrusive wandering: 2 episodes on 1/3/16 and 1 on 1/19/16 both were night shift.</p> <p>Review of the "Psychotropic/Behavior</p>	F 329		

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 45 Management Summary" documented for 1/15/16 meeting, "12/9/15 Zyprexa was declined for GDR per interview with staff she was verbally aggressive and has [illegible] episode of wandering."</p> <p>Social service staff was interviewed on 2/4/16 at 2:30 p.m. and failed to provide any further information about the medication GDR not having a written justification for use and the lack of information on the committee document.</p> <p>4. R #4 was admitted with multiple diagnoses including Parkinson's, anxiety, and dementia with behavioral disturbances.</p> <p>January 2016 Physician Orders documented Zyprexa 10 mg by mouth every day at 4:00 pm.</p> <p>February 2016 Physician Orders documented: a. Ativan 0.5 mg every morning for anxiety/agitation b. Ativan 0.5 mg every bedtime for anxiety/agitation. b. Ativan 0.5 mg every 6 hours as needed for anxiety/depression. c. Zyprexa 2.5 mg every day in the morning for BPSD. d. Zyprexa 15 mg every day at 4:00 pm for BPSD.</p> <p>A Physician's telephone order, dated 1/8/16, documented, "Discontinue Zyprexa 10 mg by mouth every day at 4:00 pm. Start Zyprexa 15 mg by mouth every day at 4:00 pm."</p> <p>The Psychosocial Well-being care plan dated 1/20/16, documented at times the resident was combative with staff in the evening and night; talked to people that were not there due to confusion and not hallucinations; delusional; and</p>	F 329		

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 46</p> <p>intrusively wandered throughout the facility and was redirected by staff. Interventions included: call the resident by his preferred name; encourage spouse to stay involved; review in psychotropic meeting; redirect if he is intrusively wandering; one-to-one staffing; if upset try different staff, reapproach, leave in safe place, reassurance, and reorientation.</p> <p>Behavioral intervention monthly flow records documented:</p> <p>a. November 2015 - Refused cares 2 of 63 observed opportunities, experienced distressful delusions 3 of 63 observed opportunities, and was not combative with cares for 63 of 63 observed opportunities. The flow sheet did not include what the distressful delusions were.</p> <p>b. December 2015 - The resident was combative with staff 1 of 63 observed opportunities, was not resistive to cares for 63 of 63 observed opportunities, and did not experience distressful delusions for 63 of 63 observed opportunities.</p> <p>c. January 2016 - Refused cares 1 of 63 observed opportunities, combative with cares 1 of 63 observed opportunities, experienced distressful delusions 1 of 63 observed opportunities, and intrusively wandered for 1 of 39 observed opportunities.</p> <p>Nurses notes from 11/1/15 to 12/8/15 did not document concerns related to the identified behaviors. There were no nurse notes to review from 12/8/15 to 1/3/16. Nurses notes reviewed from 1/3/16 to 1/6/16 documented each night after dinner the resident intrusively wandered into other residents' rooms, and required minimal redirection.</p> <p>R #4's medical record contained three Social</p>	F 329			

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

FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 47</p> <p>Service notes from July 2015 to January 2016 and were related to the quarterly MDS assessments. The notes did not document social services had assisted the facility in an attempt to determine the root cause for intrusive wandering, intermittent combative behaviors and/or intermittent resistance to cares. The notes did not document non-pharmacological interventions had been attempted and failed prior to the continuation and increase in the dose of Zyprexa.</p> <p>R#4 was observed through out the survey with 1:1 supervision.</p> <p>On 2/3/16 at 10:30 am, during a family interview it was stated the resident was incredibly modest and had a difficult time emotionally with his incontinence and asking for help. The family stated R #4 worked for the Forest Service and BLM most of his life and was always on the go. The family stated the resident had a difficult time adjusting to his new surroundings and would constantly look for his wife.</p> <p>On 2/3/16 at 2:40 pm, when asked what attempts had been made to determine the root cause for R #4's identified behaviors, the SSD provided no explanation. When asked questions related to the family interview, the SSD stated the resident had become distressed at times looking his wife and he would call out her name. When asked what had done to address R #4's distressed behavior, the SSD provided no explanation. When asked what had been done to assist the resident with changes in his bladder habits, the SSD provided no explanation. When asked why the Zyprexa was increased, the SSD stated the staff had verbalized on 1/2/16 the resident was combative and refused cares, and he intrusively wandered</p>	F 329		

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 F 518 SS=F	<p>Continued From page 48 with successful redirection on 1/3 through 1/6/16. 483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to assure that all staff were knowledgeable and able to implement emergency procedures. Seven of 9 staff members interviewed were unable to list the order of evacuation for residents in the case of an emergency. The failure to assure that all staff were aware of correct evacuation procedures had the potential to affect all 77 residents of the facility. Findings included: An undated Fire Safety &amp; Disaster Preparedness policy indicated under "Evacuation Procedures" that the following measures should be taken when evacuation has been ordered: Have ambulatory residents ready and bedfast residents up in wheelchairs if possible. Otherwise, push beds into the hallway if necessary. " During an interview on 2/1/16 at 4:00 pm, RN #7 stated that during the evacuation of residents in an emergency, ambulatory residents go first, then bedbound residents and residents in wheel chairs go last. During an interview on 2/2/16 at 7:20 am CNA #8</p>	F 329 F 518	<p>Specific Resident: None Specified</p> <p>Other Residents: This has potential to affect all residents in the facility</p> <p>Systemic Changes: Education to staff to ensure they know correct evacuation procedures. Evacuations procedures educated in orientation. Will have maintenance increase emergency drills 2x month for 2 months.</p> <p>Root Cause: Failure of staff to know what residents should be evacuated first</p> <p>Monitoring: Maintenance Director to interview 10% of staff, weekly x8 and monthly x3 to ensure they are aware of evacuation policy</p> <p>Audits to be brought through PI monthly</p> <p>Date of Compliance: March 15, 2016</p>		

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 518	<p>Continued From page 49</p> <p>stated the order of evacuation during an emergency was bed bound residents and then ambulatory residents.</p> <p>During an interview on 2/5/16 at 10:30 a.m. LPN #4 stated the order of evacuation during an emergency was total assist residents first, then residents who were easily transferred and residents who could transfer themselves would be last.</p> <p>During an interview on 2/5/16 at 11:00 a.m. RN #9 stated the order of evacuation during an emergency was residents closest to danger would evacuate first. RN #9 stated whichever hall the danger was on would be evacuated first and then the subsequent halls.</p> <p>During an interview on 2/5/16 at 11:05 am, the ADON stated the order of evacuation for an emergency was residents who needed more assistance would go first, then residents who needed less assistance and last was residents who were independent.</p> <p>During an interview on 2/5/16 at 11:08 am, the Administrator stated the order of evacuation during an emergency was bedridden residents first, then confused residents and ambulatory residents last.</p> <p>During an interview on 2/5/16 at 11:30 am the Administrator stated his previous answer was incorrect and the correct order of evacuation during an emergency was ambulatory residents first, then residents who use wheelchairs and walkers followed by bed-bound residents. The administrator stated it was important for all staff to know the order of evacuation so residents were</p>	F 518			

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

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/05/2016
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 518	Continued From page 50 not hurt during an emergency and were evacuated correctly.	F 518			



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

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

April 19, 2016

David Green, Administrator  
Life Care Center Of Boise  
808 North Curtis Road,  
Boise, ID 83706-1306

Provider #: 135038

Dear Mr. Green:

On **February 5, 2016**, an unannounced on-site complaint survey was conducted at Life Care Center Of Boise. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007209**

This complaint was investigated in conjunction with the facility's annual recertification and relicensure survey between February 1 through February 5, 2016. The survey team made general quality of care and quality of life observations in the facility over five days. The observations included call light response times, resident privacy, and overall facility cleanliness. Twenty residents were reviewed specifically for these issues. Five resident and five family interviews were conducted, including an interview with the identified resident. The Ombudsman was interviewed regarding concerns and complaints in the facility. Over eighteen residents participated in a resident group interview regarding daily life and quality of care in the facility. Reportable events, including resident to resident altercations, were reviewed from July 1, 2014 through February 1, 2015. Key facility personnel were interviewed, including the facility Administrator, Director of Nursing, Social Worker, and Therapists. Interviews were conducted with multiple facility Licensed Nurses and Certified Nursing Assistants.

**Allegation #1:** A resident in the facility was allowed to wander into other residents' private living space.

**Findings #1:** A resident in the facility had dementia, and had a history of wandering around the facility into other resident rooms.

Initially the facility placed a Velcro stop sign across the doors of residents affected by this behavior, which this stopped the resident from going into the rooms. Over time, the Velcro wore out and the resident once again was able to enter resident living spaces. The facility then placed one on one supervision with the resident. This practice was in place at the time of the survey, and the resident was no longer wandering into other residents' private spaces.

Since the facility had identified and corrected the problem, no deficiencies were cited related to this allegation.

**Conclusion #1:** Substantiated. No deficiencies related to the allegation are cited.

**Allegation #2:** The reporting party stated call lights in the facility were not answered in a timely manner.

**Findings #2:** Call light response times were watched by the survey team over a five day period, including morning and evening shifts. Some residents reported, in general, that the call lights are not answered in a timely manner, but could not identify specific instances or trends. Observations of the survey team did not validate this. All facility staff were seen entering resident rooms answering lights during the survey.

The Director of Nursing and Assistant Director of Nursing stated during the interview they have come in early or stayed late looking for long call light waits. They both stated they had not found any long waits.

Facility staffing records were reviewed, with sufficient staff scheduled to meet resident needs.

**Conclusion #2:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #3:** The facility was dirty, with insects present.

**Findings #3:** Resident interviews were conducted regarding facility cleanliness and insects. One resident stated there was "a problem" with ants in her room. The resident's room was clean at the time of the interview, and no insects were observed.

The Maintenance Supervisor was interviewed and provided evidence of a pest control agreement. The agency came at least monthly for pest prevention. The maintenance person was not aware of any complaints about ants in resident rooms. An environmental tour with the maintenance staff was conducted as part of the standard survey and cleanliness was part of the observation tour. Nothing was found during the tour.

David Green, Administrator  
April 19, 2016  
Page 3 of 3

No other residents or resident family members reported the presence of insects or concerns with facility cleanliness. Residents in the group interview were satisfied with facility cleanliness, and reported they had not seen ants or other insects. The Ombudsman's office reported they had not received any complaints about facility cleanliness or insects, and had not observed those issues during visits to the facility.

**Conclusion #3:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #4:** The facility was not accommodating resident bathing preferences and was not providing assistance to change bed linens.

**Findings #4:** The medical records of sampled residents indicated residents were offered and assisted with bathing activities at least twice per week. The facility's practice was to change the bed linens on the days residents were bathed. One resident stated she preferred to have a bath every three days, which was scheduled by the facility, but on one occasion her bed linens were not changed. The resident reported this to the Director of Nursing, and the linens were changed. The resident continued to be upset about the situation, concerned that it would happen again. The facility then created a system where the staff offered to change the resident's linens daily, allowing her to accept or decline as she chose. The resident reported this had resolved the concern, and no further concerns were reported.

**Conclusion #4:** Unsubstantiated. Lack of sufficient evidence.

One of the allegations was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink that reads "David Scott RN for D.S.". The signature is written in a cursive style.

DAVID SCOTT, RN, Supervisor  
Long Term Care

DS/pmt