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

February 16, 2016

Valari Zahiri, Administrator
Life Care Center of Post Falls
460 N. Garden Plaza Ct.
Post Falls, ID 83854-7941

Provider #: 135135

Dear Ms.. Zahiri:

On **February 5, 2016**, a survey was conducted at Life Care Center of Post Falls 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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 **February 29, 2016**. Failure to submit an acceptable PoC by **February 29, 2016**, may result in the imposition of civil monetary penalties by **March 20, 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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 11, 2016 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **March 11, 2016**. A change in the seriousness of the deficiencies on **March 11, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 11, 2016** includes the following:

Denial of payment for new admissions effective **May 5, 2016**. [42 CFR §488.417(a)]

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

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **February 5, 2016** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

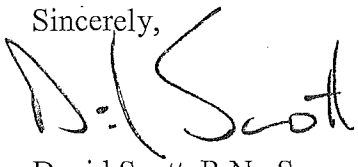
- BFS Letters (06/30/11)

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

This request must be received by **February 29, 2016**. If your request for informal dispute resolution is received after **February 29, 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,



David Scott, R.N., Supervisor
Long Term Care

DS/lj
Enclosures

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from February 1, 2016 to February 5, 2016. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Presie Billington, RN Ann Monhollen, RN, MSN Deborah Abasciano, RN Survey Definitions: ADL = Activities of Daily Living BID = Two Times a Day BIMS = Brief Interview for Mental Status CBC = Complete Blood Count CNA = Certified Nurse Aide COPD = Chronic Obstructive Pulmonary Disease DM = Dietary Manager DON = Director of Nursing F = Fahrenheit IDT = Interdisciplinary Team LN = Licensed Nurse MAR = Medication Administration Record mcg = micrograms MDS = Minimum Data Set assessment mg = milligrams ml = milliliters NMT = Nebulized Mist Treatment PO = By Mouth PRN = As Needed RCM = Resident Care Manager RDCS = Regional Director of Clinical Services SSD = Social Services Director SOAP = Subjective, Objective, Assessment, Plan SOB = Shortness of Breath	F 000	This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. RECEIVED MAR - 2 2016 FACILITY STANDARDS	

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

Jennifer Cole | Executive Director | 2/26/16

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.

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F 000	Continued From page 1 SW = Social Worker TID = Three Times a Day UA = Urinalysis UTI = Urinary Tract Infection	F 000		
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on Resident Council Meeting Minutes, Resident Group Interview, and resident and staff interview, it was determined the facility failed to resolve grievances regarding concerns of running out of food. This affected 10 of 10 residents in the Group Interview, one random resident (#24) and potentially any resident dining in the facility and created the potential to negatively affect residents' nutritional status and psychosocial well-being related to unresolved concerns. Findings included: Resident Council Meeting Minutes documented the following: *11/18/15-Residents had concerns the facility ran out of food items during meals. The facility response included going to the store before running out of items, do a better job ordering food and determine how much alternative food to prepare, *12/21/15-Residents had concerns the facility ran out of food items during meals and the previous month's food concern had not been resolved. The	F 166	F166 1. Residents found to be concerned by this were interviewed and resolution to assuring appropriate food items are available was completed 2. All residents can be affected by this deficient practice. 3. Dietary manager will implement Par levels for appropriate food items consistent with menus that have been established in kitchen to ensure inventory stays consistent. Food Committee meeting will be held bi weekly and resident council will be held monthly. Residents will be encouraged to attend to gather their feedback and monitor progress 4. An audit of food inventory will be conducted weekly for 6 weeks. Minutes from Food Committee, resident council and audits will be reviewed and monitored monthly at Performance Improvement (PI) meetings.	3/10/16

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F 166	Continued From page 2 facility response included going to the store and educating staff to do better during the inventory process, and *1/18/16-Residents had food concerns and were referred to the Food Committee. There was not a facility response regarding the concerns. On 2/2/16 at 10:30 am, during the Resident Group Interview, 10 of 10 residents said the facility continued to run out of food items, such as milk, sausage and condiments, including butter and jam. On 2/3/16 at 2:15 pm, the Interim DM said he thought the food concerns had been resolved. When asked about the Food Committee Meeting Minutes for January 2016, he said he did not know he needed to keep minutes for the meeting. On 2/4/16 at 12:45 pm, Resident #24 said the facility ran out of cold cereal and bananas during breakfast that morning.	F 166		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to document the assessment and education for self-administration of medications for 1 of 18 sampled residents. This failed practice created	F 176	F176 1.Resident #9 has had the self-administration assessment completed and reviewed by the IDT. An MD order to self-administer NMT has been obtained. 2.An audit will be conducted to identify other residents who use NMT's in the facility. From this audit, residents will be interviewed to see if they express interest in self-administering NMT's. If interest is expressed then a self-administration assessment will be completed with the resident. The IDT will ensure that the resident is cognitively, physically and have the visual ability to carry out the responsibility. If resident is able then a MD order will be obtained.	3/10/16

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F 176	Continued From page 3 the potential for medication errors related to inappropriate self-administration of medications. Findings include: Resident #9 was admitted to the facility on 9/23/15 with diagnoses of COPD, anxiety, and depression. The MDS assessment, dated 12/31/15, documented the resident was cognitively intact with a BIMS score of 13. On 2/1/16 at 1:15 pm, Resident #9 was observed alone in her room receiving her NMT. The resident stated, "The nurse sets it up (NMT) and then I do it." While the NMT was running, the nurse came into the room, turned off the NMT machine, auscultated the resident's lungs, and administered oral medications. Resident #9 then asked to finish the NMT, which the nurse provided before leaving the room with the machine still running. The nurse had not returned to the room by the time the NMT finished, about 3 minutes later, and the resident turned off the machine. January 2016 physician's orders documented a 9/23/15 order for the NMT, but the resident's clinical record did not include a physician's order, documented assessment, or education for self-administration of the NMT. The facility's "Self-Administration of Medications" policy, dated June 2008, documented, "If the resident desires to self-administer medication, an order for self-administration will be obtained from the physician, and an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical and visual ability to carry out this responsibility."	F 176	3.Nursing management will review orders on a daily basis and will identify any new NMT orders. Follow-up with the residents with new orders will be done to see if there is interest in self-administration of NMT, and if so, then an assessment will be conducted. If favorable, MD orders will be obtained. LN's will receive education regarding the policy for self-administration of medications by the residents. 4.These audits will be reviewed monthly in Performance Improvement meeting to ensure compliance.	

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F 176	Continued From page 4 On 2/4/15 at 4:00 pm, the DON stated Resident #9 should have had a physician's order and been assessed before being allowed to self-administer the NMT.	F 176		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure physician orders were followed for 1 of 18 sample resident (#4) and 1 of 3 closed records reviewed (#21). Failure to complete a physician-ordered laboratory test placed Resident #4 at risk for undetected abnormal renal function and abnormal blood count. When Resident #21 received two doses of Levothyroxine in one day, this failure also created the potential for harm if the resident experienced complications or adverse side effects related to the medication. Findings included: 1. Resident #4 was admitted to the facility on 1/7/2016 with multiple diagnoses, including fracture of the left hip and muscle weakness. A physician's order, dated 1/20/16, directed a Renal panel, CBC and differential count to be	F 309	F309 1.Resident #4 lab orders were scheduled and obtained on 2/3/2016. MD was made aware of the delay in obtaining the labs as well as family. Resident #21 is no longer at the facility. 2.Upon receipt of any lab order, the LN will note the lab order in the lab binder under the specified draw date. The order will be faxed to [redacted] for scheduled draw. Nursing Management will audit lab binders on lab draw days to ensure that labs were drawn as ordered. Residents admitting with orders for synthroid will have last dose noted on MAR for LN's to be aware of. If hospital transfer forms do not note last dose then LN will contact hospital for information.	3/10/16

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F 309	Continued From page 5 performed on 1/25/16. Results of the 1/20/16 laboratory order were not found in Resident #4's medical record during the survey week of 2/1/16 through 2/5/16. On 2/2/16 at 3:50 pm, RCM #2 said the laboratory tests were not completed as ordered. 2. Resident #21 was admitted to the facility on 8/1/15 with diagnoses that included hypothyroidism. A hospital patient medication list, dated 8/22/15, documented an order for Levothyroxine 100 mcg daily, which was given at the hospital on 8/22/15 at 6:08 am. Facility Physician Orders, dated 8/22/15, documented the Levothyroxine 100 mcg was to be given daily at 8:00 pm. The August 2015 MAR documented LN #1 provided the resident with Levothyroxine 100 mcg on 8/22/15 at 8:00 pm. On 2/3/15 at 4:10 p.m., LN #1 stated another nurse reviewed the hospital information and transcribed the medication orders onto the MAR, including the Levothyroxine. LN #1 said she was not aware Resident #21 received Levothyroxine at the hospital on 8/22/15 at 6:08 am and again at the faclity at 8:00 pm until the resident told her on 8/23/15.	F 309	3.Nursing Management will audit new orders at stand-up meeting and will follow up on the correct procedures for handling lab orders. Orders and last doses of synthroid for new admits will be reviewed by two nurses and signed for verification. An audit of new admissions that have synthroid ordered will be conducted weekly x4 then monthly thereafter. LN's will receive education on following physician orders on lab draws and verifying last doses of synthroid at the time of admission. 4. These audits will be reviewed monthly in the QAPI committee to ensure system is effective and compliance is sustained.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323	F323 1.No residents were found to be affected. Sani-cloths containers were securely stored in an area that was inaccessible by the residents.	3/10/16

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F 323	Continued From page 6 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure harmful chemicals were securely stored and inaccessible to residents. This was true for all independently mobile, cognitively impaired residents on the 100- and 200 hallways and any similar resident in the facility who could access the unsecured chemicals. Failure to safely store harmful chemicals created the potential for residents to experience skin, eyes, respiratory tract and gastric irritation. Findings included: On 2/1/16 at 9:45 am, and on 2/2/16 at 8:40 am and at 4:25 pm, a container of Sani Cloth HB Germicidal Disposable Wipe was observed unattended on top of an isolation cart outside of rooms 212 and 115 respectively. The label read, "Causes moderate eye irritation. Harmful if absorbed through skin. Avoid contact with skin, eyes or clothing." At 4:32 pm, LN #10 said the Sani cloth container should be inside the isolation cart drawer and not left unattended.	F 323	2. All residents have the potential to be affected by this. 3. Staff were inserviced at all-staff meeting on 2/17 regarding proper storage of sani-cloths. A C.NA meeting will be held on 2/23 & 2/24 as well as and LN meeting on 3/3 & 3/4. An audit will be conducted 3 times weekly for 6 weeks to ensure compliance. 4.Results from audits/trainings will be monitored monthly at Performance Meetings.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329	F329 1.Resident #3 will have a review of medication regime by MD and will have specified rationale for duplicated antidepressant therapy as well as antipsychotic. Behavior tracking will continue being documented for this resident. Resident #9 will be reviewed for medication regime by attending MD as well as Hospice MD and has been reviewed in the behavior management meeting and behavior monitoring is in place for Haldol.	3/10/16

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F 329	Continued From page 7 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. 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents' medications were not duplicated and included an indication for use. These failures created the potential for harm if residents were to receive unnecessary medications and/or to experience adverse consequences related to duplicate therapy. This was true for 2 of 18 (#s 3 & 9) sampled residents. Findings included: 1. Resident #3 was admitted to the facility on 11/10/15 with multiple diagnoses including depression.	F 329	2. Residents who are on psychoactive medications will be identified and reviewed for unnecessary medication practices and will be addressed with MD. Communication practices will be addressed with the Hospice personnel and nursing staff at LCC of PF. Conversations and consultations will be documented going forward for resident care Residents who receive psychoactive medications have the potential to be affected. Audits will be done on residents who are receiving multiple psychoactive medications to ensure	

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F 329	Continued From page 8 The resident's November and December 2015, and January and February 2016 MAR documented orders for daily use of Bupropion [Wellbutrin], Zoloft, and Aripiprazole [Abilify] for depression. The resident's care plan, dated 11/10/15, documented, "Alteration in mood state as evidenced by sad/negative statements. Evaluate the possibility of psychotropic drug reduction as indicated. Document findings." The record did not include a clinical rationale for the duplicative antidepressant therapy or the use of an antipsychotic [Abilify] as a third antidepressant medication. Resident #3's Behavior/Intervention monitors documented "sad/negative statements" occurred during the following: -November 2015: 9 of 62 shifts; -December 2015: 6 of 74 shifts; -January 2016: 8 of 76 shifts; and -February 2016: 0 of 6 shifts. The resident's 11/20/15 Psychotropic Behavioral Management Summary documented the three medications were for depression. IDT recommendations documented, "No change at this time due to recent admission on 11/10/2015. Resident adjusting to facility placement and routine. Resident presents with multiple episodes of depressive symptoms evidenced by documentation in behavior tracking in current MAR..." Under the physician response was a checked box that documented, "I do not wish to taper at this time," and which was signed by the physician on 11/23/15.	F 329	that either clinical rationale for use is present or reduction of medication occur. Audit will be done on hospice residents to ensure that any psychoactive medications are necessary to treat a specific condition as diagnosed, that behavioral monitoring is in place. At the time a resident elects hospice services, nursing management will meet with hospice representative to establish expectations regarding the use of antipsychotic medication and to present the Psychotropic Medication Administration Mental Health Referral Consultation Policy. Residents who receive psychoactive medications will receive on-going reviews in the behavior management meetings. Conversations and consultations will be documented going forward for resident care.	

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F 329	Continued From page 9 The resident's 12/8/15 Psychotropic Behavioral Management Summary documented the three medications were for depression. IDT recommendations documented, "See attached medication review from pharmacy." There was not an attached pharmacy review found in the record. Under the physician response was a checked box which documented, "I do not wish to taper at this time," and was signed by the physician on 12/16/15. On 2/4/16 at 10:25 am, SW #11 said she was unable to locate the clinical rationale in the record for the duplicate anti-depressant medications and use of an antipsychotic for antidepressant therapy. 2. Resident #9 was admitted to the facility on 9/23/15 with diagnoses that included COPD, anxiety disorder, and major depressive disorder. The 12/31/15 MDS assessment documented the resident was cognitively intact with a BIMS score of 13. January 2016 physician's orders documented the resident was to receive Haldol 0.5 mg three times daily for anxiety disorder effective 11/29/15; Ativan 0.5 mg twice daily and as needed for respiratory abnormalities effective 9/23/15. hospice services were initiated on 9/23/15. Resident #9's medical record included an 11/3/15 hospice order for Haldol 0.5 mg every hour as needed for anxiety. The resident received one PRN dose of this medication on 11/29/15 and the order was discontinued for "non-use" on 12/8/15. A 10/27/15 hospice order for the scheduled	F 329	3. Social Services and Licensed Nurses will receive education including the Psychotropic Drug Reduction Program Policy, Medication Administration Mental Health Referral Consultation Policy. C.N.A's will receive in-servicing to include how to recognize and report behaviors and this will be ongoing in orientation. 4. These audits will be reviewed monthly in the QAPI committee to ensure system is effective and compliance is sustained.	

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F 329	Continued From page 10 Haldol was continued due to "delirium related to terminal illness under hospice care, for symptom management of paranoia/anxiety/hallucinations not adequately managed by Ativan alone ..." Progress notes, dated 9/23/15 through 2/4/16, documented Resident #9 experienced multiple episodes of anxiety and two separate incidents of delirium/hallucinations prior to the start of Haldol, as well as when scheduled and PRN Ativan had been given with documented effectiveness. Progress notes documented that on 10/6/15 Resident #9 experienced hallucinations of people in her room and facility staff trying to hurt her. A hospice nurse administered scheduled Morphine ER and Ativan at 10:40 pm and the resident "slept through the night." On 10/1/15 Resident #9's facility physician adjusted the Morphine ER to 45 mg every eight hours and increased the Ativan to 0.5 mg three times daily. A progress note, dated 10/7/15, documented, "Physician suggested changing morphine to a lower dose and less frequent to help clear her mind, and increase Ativan to help alleviate anxiety ..." A physician "Quick Note," dated 10/7/15, documented the resident was experiencing "altered mental status with increasing paranoia/agitation, likely related to medications..." A 10/9/15 progress note documented the resident had "no hallucinations or concerns voiced so far and resident had complaints of burning at the catheter insertion area; physician notified with new orders to obtain urine dip/UA with culture if indicated ..." A 10/10/15 progress note documented, "UA results positive and new orders for Cipro 500 mg BID for seven days, Pyridium 200 mg TID for 3	F 329		

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F 329	Continued From page 11 days; resident reports burning and discomfort near the bladder area and groin ..." A 10/16/15 progress note documented the resident received a "last dose of Cipro ... [was]voiding without difficulty since Foley (catheter) removal, [and] denies any urinary complaints ..." Progress notes from 10/16/15 to 10/28/15, when the Haldol was ordered, documented no further incidents of anxiety, delirium or hallucinations. The October 2015 MAR documented the results of seven PRN doses of Ativan between 10/2/15 and 10/19/15 as "effective." The November 2015 MAR documented the results of 10 PRN doses of Ativan between 11/2/15 and 11/25/15 were "effective." A 12/30/15 physician's note documented the resident "stated that she had been having vertigo for the past 3-4 weeks, states she has been having a spinning sensation when she turns head quickly, particularly when she's laying flat and turns her head suddenly as she sits up." The physician's note documented Resident #9 with "anxiety, [but] stable on current regime of Ativan, [staff to] monitor ..." The 2015 Nursing Drug Handbook documented Haldol's potential "adverse reactions for central nervous system" included "vertigo." The September 2015 Behavior/Intervention Monthly Flow Record documented monitored behaviors included "SOB manifested by hyperventilation or hyper focusing," for which the resident received "medication" one time that month.	F 329		

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F 329	Continued From page 12 The October 2015 Behavior/Intervention Monthly Flow Record documented monitored behaviors included "SOB related to anxiety/hyper focusing," for which the resident was treated with "medication" nine times that month. The November 2015 Behavior/Intervention Monthly Flow Record documented monitored behaviors included "SOB/anxiety/hyper focusing," for which Resident #9 was treated with "medication" three times that month. On 2/2/16 at 3:00 pm, the SSD stated she was unaware the resident was started on Haldol, and noted the resident's use of Haldol had not been discussed in behavior management meetings or the facility's daily morning meetings. On 2/4/16 at 3:00 pm, the DON stated she was aware the resident received Haldol. The DON stated that when she became aware of the scheduled and PRN Haldol, she contacted the hospice physician, who then agreed to discontinue the PRN Haldol, but "vehemently refused to discontinue the scheduled Haldol." When asked for evidence of this conversation, the DON stated the conversation was not documented. On 2/4/16 at 4:15 pm, during an interview with the DON, RDCS and the resident's attending physician at the facility, the RDCS stated the facility called the hospice agency in December 2015 to discuss the PRN Haldol "but it's [phone conversation] not documented anywhere." The RDCS stated the facility called the hospice agency "multiple times" in December 2015 to discuss the scheduled Haldol use, "but, again, it's	F 329		

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F 329	Continued From page 13 not documented anywhere." On 2/4/16, when asked about the correlation of a UTI in early October 2015 and the resident's delirium/hallucinations at that time, Resident #9's facility physician stated, "I didn't see the symptoms as related to each other; they were two separate concerns." The clinical record contained no documentation the UTI was considered as a potential contributing factor to the resident's delirium/hallucinations in October 2015. The physician stated she consulted with the hospice physician about the Haldol, but those consultations were not documented. On 2/14/16 at 10:00 am, the RCM stated a hospice nurse told her the Haldol was ordered "due to quality of life issues with [Resident #9]" and that "all other means had proved ineffective." No related documentation was found in the resident's clinical or hospice records. The facility's Psychotropic Medication Administration Mental Health Referral Consultation policy documented, "Upon receipt of a 'new' order for a psychotropic medication, the nurse who signs off the order and transfers onto the MAR will also be responsible for documentation in the nurses notes the specific behavior/diagnosis for the medication. At the same time, the same nurse must also initiate [a] 'new' Behavior Monitoring Record and the side effects [are] to be monitored to the MAR." Resident #9's progress notes did not contain documentation when the Haldol was initiated or a Behavior Monitoring Record for Haldol. The policy also documented "any new orders for psychotropic medications and/or mental health	F 329		

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F 329	Continued From page 14 referrals will be reviewed in daily monitoring meetings," and "any resident on psychotropic medications will be reviewed in weekly interdisciplinary meetings." Resident #9's clinical record did not contain documentation that the scheduled- or PRN Haldol orders were reviewed in weekly interdisciplinary meetings as required by the facility's policy and procedure.	F 329	F332 1.Resident #22 will have medications administered in an appropriate time period. 2. Residents who receive synthroid or protonix can be affected. Medication administration pass audits will be randomly conducted 3 times weekly for 4 weeks then 2 times weekly for 4 weeks to ensure the appropriate administration of protonix and synthroid. Licensed nurses will receive medication administration pass audits during orientation, yearly and prn. 3. Licensed Nursing staff will be in-serviced on the medication administration time policy and the importance of giving protonix and synthroid per manufacture's recommendation. 4. Medication administration audits will be reviewed monthly in the PI committee to ensure system is effective and compliance is sustained.	3/10/16
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, it was determined the facility failed to ensure residents were free of medication errors exceeding a rate of 5-percent. This was true for 2 of 30 medication administrations observed with 11 residents between 2/1/16 and 2/3/16. This 6.6-percent medication error rate created the potential for residents to receive the wrong medications, wrong time of administration, wrong dosage, and/or wrong route of administration. Findings include: Random Resident #22 was admitted to the facility with diagnoses that included hypothyroidism and acute peptic ulcer. Physician Orders, dated 1/13/16, documented the resident was to receive Protonix 40 mg delayed release at 7:30 am and 8:00 pm for chronic peptic ulcer. A 1/27/16 physician order documented the	F 332		

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F 332	Continued From page 15 resident was to receive Levothyroxine 100 mcg daily at 7:30 am and Protonix 40 mg daily at 7:30 am and 8:00 pm. On 2/2/16 at 8:35 am, LN #4, stated she was waiting for Resident #22 to finish breakfast to administer his/her medications. LN #4 stated breakfast on the resident's unit was served between 8:00 am and 8:30 am. On 2/2/16 at 8:45 am, LN #4 was observed giving Resident #22 his/her 7:30 am Levothyroxine and Protonix and other 8:00 am medications. The facility's 2013 "Medication Administration Times Policy" documented staff were to begin medication administration within 60 minutes of designated times, and complete administration within 60 minutes of the designated administration times. The "Medication Administration Times Policy" specified staff were to administer pre-meal medications approximately 30 minutes before meals. On 2/4/16 at 10:00 am, the DON stated LN #4 did not follow the facility's "Medication Administration Times Policy."	F 332		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced	F 364	F364 1. Residents found to be concerned by this were interviewed and resolution regarding food palatability and food temperatures was completed. 2.Other residents in the facility were interviewed to receive their feedback in regards to food palatability and food temps. 3. The kitchen system to prepare coffee for service was evaluated and determined that the staff were preparing the coffee too early thus affecting the temperature of the coffee at service. System put in place with the kitchen staff to prepare the coffee close to the same time the meal service will begin and ensure the temperature is appropriate. Kitchen staff inserviced and trained on the process. Meal service was	3/10/16

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F 364	Continued From page 16 by: Based on facility grievances, individual interview, Resident Group interview, test tray evaluation and staff interview, it was determined the facility failed to serve food at a palatable temperature. This affected two random residents (#s 23 & 24) and 10 of 10 residents who attended the Resident Group interview, and had the potential to affect all residents who dined in the facility. This failed practice created the potential to negatively affect residents' nutritional status and psychosocial well-being related to unpalatable food. Findings included: Grievances dated 12/10/15 and 12/15/15 documented resident concerns of poor food quality; the facility response was to work with the dietary department to improve food quality. *On 2/1/16 at 9:50 am, Resident #23 said the food was "cold" and "gross," *On 2/1/16 at 1:00 pm, a resident, who wished to remain anonymous said the food was "terrible" and hot foods were not hot, and *On 2/4/16 at 12:35 pm, Resident #24 said he had reviewed the last recertification survey related to cold foods and said the facility still had issues with cold food. He stated the coffee was cold again that day. On 2/2/16 at 10:30 am, during the Resident Group interview, 10 of 10 residents said the food was not hot and the coffee was "always" cold and unpalatable. On 2/4/16 at 12:20 pm, a lunch meal test tray was evaluated by the survey team and the Interim DM. The test tray included black coffee with a temperature of 116-degrees F. The DM said the	F 364	evaluated and determined that issues with cold food are related to the timing to getting trays served to residents. Establishment of serving timeframes were reviewed, system with staff put in place to assure staffing is allocated appropriately during meal times and training and education provided on the importance of quickly delivering the meals. Test trays will be conducted 3 times/week on various meals. Food Committee meeting will be held twice monthly to monitor progress and gather suggestions. Resident Council meeting will be held monthly to gather feedback/suggestions. 4.Results from test trays,Food Committee meeting, and Resident council minutes will be review monthly at performance improvement meeting for continued compliance.	

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F 364	Continued From page 17 coffee was a little above "luke warm." The coffee was determined to be not hot enough to be palatable.	F 364		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to ensure 2 of 21 sampled Residents (#s 5 and 13) and 11 random residents (#s 25 - 35) had physician orders for eye medications that included the number of drops to be administered to each resident. Findings include:	F 425	F425 1.Residents # 5, 13, and 25 to 35 were reviewed for eye drop medication and clarification of specific number of drops were obtained from physicians. 2.A complete listing of medication orders for eye drops was obtained and orders that did not have quantitative order for drops were clarified by physicians. 3.Orders will be reviewed on a routine basis by DON and RCM's and will be appropriately clarified prior to administration. Education will occur on order and administration of eye medications with LN's at March meeting as well as ongoing by SDC. Audits will be conducted monthly for appropriate orders and administration. 4.Audits/training with be monitored/reviewed monthly at Performance Improvement Meetings	3/10/16

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F 425	Continued From page 18 Physician Orders for Resident #5, dated 6/9/15, included Latanoprost 0.005 % eye drops "instill 2 both % eyes intraocular daily at bedtime and artificial tear eye drops instill into eyes intraocular as need." Physician Orders for Resident #13, dated 10/15/14, included Dorzolamide-timolol eye drops "2% - 5% in a dropperette instill into right eye intraocular twice per day." Physician Orders for Resident #13, dated 12/23/14, included, "Artificial drops intraocular to the right or left eye 4 times a day prn." Physician Orders for Resident #25, dated 12/16/15, included, "Artificial tear eye drops intraocular twice a day prn." Physician Orders for Resident #26, dated 11/15/14, included, "Artificial tear eye drops intraocular 3 times per day." Physician Orders for Resident #33, dated 1/9/16, included, "Timolol maleate 0.5 % eye drops to left eye intraocular daily." The above eye medication orders did not contain the number of eye drops to be instilled in the residents' eyes. Eight additional random residents (#s27 - 35) also had eye medication orders that did not specify the number of eye drops to be instilled in their eyes. On 2/2/16 at 3:00 pm, 3:05 pm, and 3:10 pm respectively, the facility's RCM, LN#3, and LN #4 stated all eye medication orders should include the number of drops to be instilled in residents' eyes.	F 425		

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F 425	Continued From page 19 On 2/4/16 at 10:00 a.m., the DON said all eye medication orders were to include the number of drops to be instilled in residents' eyes. The DON reviewed medication orders and said some of residents' eye medication orders did not contain the number of drops to be instilled per facility protocol. On 2/4/16 at 10:00 am, the Pharmacist Consultant stated eye drop medication orders must specify the number of eye drops to be instilled in residents' eyes.	F 425		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure that a drug regimen review was completed monthly by the pharmacy consultant for 5 of 21 residents (#s 5, 8, 9, 12 and 15) sampled for monthly drug regimen reviews and resulted in the potential for adverse medication reactions. Findings include:	F 428	F428 1. Resident #5, 8,9,12 and 15 have had a drug regimen review completed and will be done monthly on-going by the pharmacy consultant and potential for adverse medication reactions will be identified and acted upon. 2. Residents who receive medications have the potential to be affected. An audit of resident's charts has been completed to ensure that a drug regimen review has been completed. Pharmacist from [redacted] will conduct medication regime reviews on a monthly basis and will document same. 3. The pharmacist will give a copy of the pharmacist's review and recommendations and will be kept in the DON office monthly. DON will audit census to review to ensure all residents have received a review. 4. Results of pharmacy review and census comparison audit will be reviewed monthly in the PI committee to ensure system is effective and compliance is sustained.	3/10/16

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F 428	Continued From page 20 Resident #5 was admitted to the facility on 6/9/15 and had one Pharmacist Drug Regimen Review in August 2015. That Review was not signed by the pharmacist. Resident #8 was admitted to the facility on 5/19/15. Three Pharmacist Drug Regimen Reviews were completed since the resident's admission - September, October, and November 2015 - none of which were signed by the pharmacist. Resident #9 was admitted to the facility on 9/23/15. One Pharmacist Drug Regimen Review was completed in November 2015. No Pharmacist signature was noted on the review. Resident #12 was admitted to the facility on 8/13/14. Five Pharmacist Drug Regimen Reviews were completed since his/her admission to the facility - September, October, and November 2014, September and November 2015 - none of which were signed by the pharmacist. Resident #15 was admitted to the facility on 8/19/14. Five Pharmacist Drug Regimen Reviews were completed since admission - October and December 2014, January, February, and October 2015. No Pharmacist signature was noted on the reviews. On 2/4/16 at 3:00 pm, the DON stated the pharmacy consultant performed monthly record reviews at the facility and attended monthly Behavior Management meetings. The DON said she was unaware the monthly drug regimen reviews were not completed. The facility's Psychotropic Medication	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 21 Administration Mental Health Referral Consultation policy documented, "Pharmacy consultants will review the drug regimen for each resident monthly, making recommendations as necessary."	F 428	F441 1.TB tests on residents #5, 8, 9, 12 and 15 were completed and read per policy and procedure. Nebulizer masks and mouthpieces were covered on residents #9, 12. 2. All residents admitted to the facility have the potential to be affected. An audit was conducted of remaining residents to ensure TB tests were conducted appropriately and corrected if not. Another audit was conducted on residents with nebulizer treatments to ensure equipment was covered when not in use.	3/10/16
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 22 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure that initial tuberculin tests were completed and read for five residents (#s5, 8, 9, 12 and 15) of 21 sampled residents reviewed for tuberculin testing. The facility also failed to ensure that nebulizer masks and mouthpieces were kept covered when not in use for two (#s9 and 12) of five sampled residents reviewed for breathing treatment use. These failed practices resulted in the potential for tuberculosis to go undetected and uncovered breathing treatment equipment to become contaminated. Findings include: 1. Resident #5 was admitted to the facility on 6/9/15. The Resident TB Screening and Immunization Record documented the resident was given her admission step one tuberculin test on 6/10/15, which was determined to be negative on 6/13/15. The results of a second tuberculin test given on 6/28/15 was not documented in the resident's record. Resident #8 was admitted to the facility on 5/19/15. The Resident TB Screening and Immunization Record documented the resident was given his admission step one tuberculin test on 5/19/15, which was determined to be negative on 5/22/15. The resident's record did not include documentation that the second tuberculin test	F 441	3. Licensed Nursing staff will be in-serviced to the Tuberculosis Control Plan. Both Licensed Nurses and C.N.A's will be in-serviced to the facility's procedure for cleaning nebulizer equipment policy. Medical records will audit new admission documentation to ensure that the tuberculin tests were completed and documented with the 14 day chart audit and 30 day chart audit. Audits will be conducted weekly for 6 weeks of nebulizer equipment in resident rooms to ensure compliance with on-going routine audits. 4. Audit results will be reviewed monthly in the QAPI committee to ensure system is effective and compliance is sustained.	

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F 441	Continued From page 23 was administered. Resident #9 was admitted to the facility on 9/23/15. The resident's clinical record did not contain an immunization record or that an admission step one or step two tuberculin test was performed. Resident #12 was admitted to the facility on 8/13/14. The Resident TB Screening and Immunization Record documented the resident was given her admission step one tuberculin test on 8/14/14 with no documented result. The resident's record did not include documentation that the second tuberculin test was administered. Resident #15 was admitted to the facility on 8/19/14. The Resident TB Screening and Immunization Record documented the resident was given her admission step one tuberculin test on 8/19/14 with no documented result. The clinical record did not contain documentation that the second tuberculin test was administered. On 2/4/16 at 10:00 am, the RCM stated all new admissions were to receive a two-step tuberculin test. That test and its results were to be documented on the immunization record. The RCM stated Resident #9's immunization record could not be located and there was no documentation on the MAR of the admission tuberculin test being completed. The facility's Tuberculosis Control Plan, Admission of Residents and Follow-Up policy, dated4/1/15, documented, "All first time residents will be screened for infection with tubercle bacilli on admission. Skin testing will employ the two-step procedure."	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 24 2. On 2/1/16 at 9:45 am in the rooms of Resident #9 and Resident #15, surveyors observed breathing treatment equipment that had not been kept covered when not in use. On 2/1/16 at 1:45 pm, surveyors obsered Resident #9's breating equipment mouthpiece had been left uncovered. On 2/2/16 at 10:00 am, the breathing equipment in Resident #9's and Resident #15's rooms were observed uncovered while not in use. On 2/3/16 at 2:10 pm, breating equipment in Resident #9's and Resident #15's rooms were observed uncovered while not in use. On 2/4/16 at 11:45 am and 4:00 pm in Resident #9's and Resident #15's room, surveyors observed breathing treatment equipment had been left uncovered while not in use. Resident #9 used a mouth piece for her breathing treatments and Resident #15 used a nebulizer mask. The facility's "Procedure for Cleaning Nebulizer Equipment" policy, dated August 2011, documented, "Cover nebulizer equipment when not in use." Surveyors observed plastic bags attached to Resident #9's and Resident #15's nebulizer machines for protection from 2/1/16 to 2/4/16.	F 441		

IDAHO DEPARTMENT OF
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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

February 22, 2016

Valari Zahiri, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Ms. Zahiri:

On **February 5, 2016**, an unannounced on-site complaint survey was conducted at Life Care Center of Post Falls. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from February 1, 2016 to February 5, 2016. The following observations were completed:

- Six residents with oxygen were observed for proper liter flow; and,
- Residents were observed for wet and soiled briefs throughout the survey.

The following documents were reviewed:

- The medical record of the identified resident;
- Thirteen other residents' records were reviewed for Quality of Care Concerns;
- The facility's Grievance file from 2015 to 2016;
- Resident Council minutes from November 2015 to January 2016;
- The facility's Incident and Accident reports for November and December 2014 and August 2015 to February 2016; and,
- The facility's Allegation of Abuse reports from August 2015 to February 2016.

The following interviews were completed:

- Five residents were interviewed regarding Quality of Care concerns;
- Two family members were interviewed regarding Quality of Care concerns;

- Ten Residents in the Group Interview were asked about Quality of Care concerns;
- The Director of Nursing was interviewed regarding transmission of clinical information;
- Two nurses were interviewed regarding oxygen administration; and,
- CNAs were interviewed regarding brief changes.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006832

ALLEGATIONS #1:

The Reporting Party said an identified resident was transported to a local clinic without his/her oxygen turned on.

FINDINGS:

The identified resident was no longer residing in the facility when the complaint was investigated. Six residents with oxygen were observed for proper liter flow and no concerns were identified. The medical record of the identified resident was reviewed and no oxygen concerns were found. The medical records of six residents receiving oxygen therapy were reviewed and there were no concerns identified. Ten Residents in the Group Interview said oxygen liter flow was not a concern. Two nurses said residents received proper oxygen liter flow.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

An identified resident was sent to a local clinic without enough clinical documentation.

FINDINGS #2:

The identified resident was no longer residing in the facility when the complaint was investigated. The medical record of the identified resident documented the resident's power of attorney gave the local clinic the information needed to treat the resident.
Thirteen other residents' records were reviewed for physician and clinic communication and no concerns were identified. The Director of Nursing said residents were sent to and from the facility with adequate clinical information.

Based on record review and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATIONS #3:

An identified resident's adult brief had not been changed and was found wet and soiled.

FINDINGS #3:

The identified resident was no longer residing in the facility when the complaint was investigated. Residents were observed for wet and soiled briefs throughout the survey and no concerns were identified. The medical record of the identified resident was reviewed and no concerns were found regarding brief changes. Eight other residents' records were reviewed for incontinence care and no concerns were identified. Resident Council minutes from November 2015 to January 2016 did not identify concerns with brief changes. Three residents were interviewed regarding incontinence needs and they said their needs were met. Ten Residents in the Group Interview said there were no concerns with incontinence needs. CNAs said briefs were changed according to the residents' care plans.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

David Scott, R.N., Supervisor
Long Term Care

DS/lj

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February 22, 2016

Valari Zahiri, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Ms. Zahiri:

On **February 5, 2016**, an unannounced on-site complaint survey was conducted at Life Care Center of Post Falls. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from February 1, 2016 to February 5, 2016.

The following observations were completed:

- Call light accessibility was observed throughout the survey;
- Several staff members were observed to place residents' call lights where they were accessible; and,
- Four residents were observed for therapy concerns.

The following documents were reviewed:

- The medical record of the identified resident;
- Thirteen other residents' records were reviewed for Quality of Care concerns;
- Six other residents' admission records;
- The facility's Grievance file from 2015 to 2016;
- Resident Council minutes from November 2015 to January 2016;
- The facility's Incident and Accident reports for November and December 2014 and August 2015 to February 2016; and,
- The facility's Allegation of Abuse reports from August 2015 to February 2016.

The following interviews were completed:

- Five residents were interviewed regarding Quality of Care concerns;
- Two family members were interviewed regarding Quality of Care and admission concerns;
- Ten Residents in the Group Interview were asked about Quality of Care and call light concerns;
- The Director of Nursing was interviewed regarding Quality of Care and admission concerns;
- The Assistant Director of Rehabilitation and one Physical Therapist were interviewed regarding therapy and therapy discharge concerns; and,
- Two CNAs and two Physical Therapists were interviewed regarding call light accessibility concerns.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006918

ALLEGATION #1:

The Reporting Party said the facility did not have enough clinical information for an identified resident upon admission.

FINDINGS:

The identified resident was no longer residing in the facility at the time the complaint was investigated. The resident's admission paperwork was reviewed and clinical information was received by the facility via fax on the day of admission. Six other residents' admission paperwork was reviewed and no concerns were identified. Two family members of residents said they had no concerns regarding admission paperwork or the admissions process. The Director of Nursing said the paperwork for the identified resident was sufficient enough to admit the resident, and said if a resident came to the facility without proper clinical information then the facility would immediately request information from the admitting physician and/or the transferring health care facility.

Based on record review, and family and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

An identified resident was left by a therapy staff member in his/her room without the call light accessible, fell out of his/her wheelchair and sustained a fractured bone.

FINDINGS:

The identified resident was no longer residing in the facility at the time the complaint was investigated. Call light accessibility was observed throughout the survey with no concerns. Several staff members were observed to place residents' call lights where they were accessible to the resident. The identified resident's medical record and an incident and accident report were reviewed and they documented the call light was accessible to the resident. Five other residents were reviewed for falls and no concerns were identified. Resident Council minutes from November 2015 to January 2016 were reviewed and no fall or call light accessible issues were identified. Five residents and two family members said falls and call light accessibility were not concerns. Ten residents in the Group Interview said call light accessibility was not a concern. Two CNAs and two Physical Therapists said before leaving a resident's room they ensure the call light is accessible to the resident. The Director of Nursing said the fall investigation documented the resident's call light was accessible and the resident did not fall due to facility negligence; and staff have been trained to ensure call lights are accessible to residents at all times.

Based on observation, record review, and resident, family and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

An identified resident did not receive adequate therapy services before being discharged.

FINDINGS #3:

The identified resident was no longer residing in the facility at the time the complaint was investigated. Four residents who received therapy were observed to receive appropriate therapy services. The identified resident's medical record was reviewed for therapy and discharge orders and no concerns were identified. Eight other residents were reviewed for therapy and no concerns were identified. Five residents and two family members had no concerns regarding therapy. One Physical Therapist was interviewed and said when residents were discharged from the facility and needed more therapy, he recommends the resident receive outpatient therapy or

home health therapy to meet any further goals. The Assistant Director of Rehabilitation said residents receive appropriate therapy services while in the facility and if they need further services upon discharge, they are encouraged to follow up with their physicians prior to discharge for home therapy or outpatient therapy orders.

Based on observation, record review, and resident, family and staff interview, it was determined the allegation could not be substantiated.

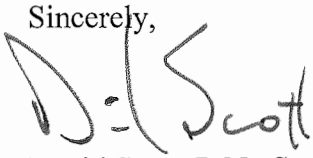
CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



David Scott, R.N., Supervisor
Long Term Care

DS/lj

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February 22, 2016

Valari Zahiri, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Ms. Zahiri:

On **February 5, 2016**, an unannounced on-site complaint survey was conducted at Life Care Center of Post Falls. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from February 1, 2016 to February 5, 2016.

The following observations were completed:

- Wound dressings for two residents were observed, and
- Medication pass was observed.

The following documents were reviewed:

- The medical record of the identified resident;
- Twenty-one other residents' records were reviewed for medication administration concerns;
- The records of four other residents with wounds;
- The records of five other residents were reviewed for tuberculosis tests;
- The facility's Grievances file from 2015 to 2016;
- Resident Council minutes from November 2015 to January 2016;
- The facility's Incident and Accident reports for November and December 2014 and August 2015 to February 2016; and,
- The facility's Allegation of Abuse reports from August 2015 to February 2016.

The following interviews were completed:

- The identified nurse was interviewed regarding Quality of Care concerns,
- Two other nurses were interviewed regarding wound dressing procedures, and
- The Infection Control Nurse was interviewed regarding tuberculosis testing procedures.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007144

ALLEGATION #1:

The Reporting Party said an identified nurse cleansed the wound of an identified resident with alcohol swabs and would blow on the wound afterwards.

FINDINGS:

The identified resident was no longer residing in the facility at the time the complaint was investigated. Wound dressings for two residents were observed and the nurses did not use alcohol swabs and did not blow on the wound. The medical record of the identified resident did not indicate improper wound dressing changes. The medical records of four other residents with wounds were reviewed and no concerns were identified. The identified nurse was interviewed and he/she said wound cleaning cloths come in a package which look similar to alcohol wipes and he/she did not blow on wounds. Two other nurses said they use proper wound techniques.

Based on the observations, record review and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

An identified nurse tried to perform an unnecessary tuberculosis test on an identified resident.

FINDINGS:

The identified resident was no longer residing in the facility at the time the complaint was investigated. The medical record of the identified resident documented the resident received appropriate tuberculosis testing. The records of five other residents were reviewed for tuberculosis tests and no concerns were identified. The identified nurse said he/she administered the appropriate tuberculosis testing. The Infection Control Nurse said nurses used the proper tuberculosis testing procedures.

Based on record review and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATIONS #3:

An identified nurse administered an unnecessary dose of medication to an identified resident.

FINDINGS:

The identified resident was no longer residing in the facility at the time the complaint was investigated. Medication pass was observed and two medication errors were committed. The medical record of the identified resident documented a medication error. Twenty-one other residents' records were reviewed for Medication administration concerns. The identified nurse said he/she was unaware the medication was given earlier in the day when he/she administered another dose to the identified resident.

Based on the observations, record review and staff interview, it was determined the allegation was substantiated and was cited at F309.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Davide Scott, R.N., Supervisor
Long Term Care

DS/lj