



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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May 25, 2016

Joe Rudd, Administrator
Life Care Center Of Boise
808 North Curtis Road
Boise, ID 83706-1306

Provider #: 135038

Dear Mr. Rudd:

On **May 11, 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.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 4, 2016**. Failure to submit an acceptable PoC by **June 4, 2016**, may result in the imposition of civil monetary penalties by **June 27, 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*.

As noted in the Bureau of Facility Standards' letter of **February 25, 2016**, following the survey of **February 5, 2016**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **August 5, 2016**, if substantial compliance is not achieved by that time.

Joe Rudd, Administrator
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The findings of non-compliance on **May 11, 2016**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **March 30, 2016**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **May 5, 2016**
- Civil money penalty, 5,600.00 .

Due to facility's continued non-compliance cited, we are recommending that CMS impose the following remedy(ies), in addition, to the remedy(ies) that were previously mentioned to you in the originating survey letter of **February 25, 2016**:

An additional 'per instance' civil money penalty of **Federal Civil Money Penalty**

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.

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>

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

- BFS Letters (06/30/11)

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

This request must be received by **June 4, 2016**. If your request for informal dispute resolution is received after **June 4, 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, LSW, Supervisor
Long Term Care

NS/pmt
Enclosures

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: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/11/2016
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}	INITIAL COMMENTS The following deficiency was cited during the federal recertification and complaint follow-up survey from May 10 to May 11, 2016. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Sylvia Creswell, LWS, QIDP 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 staff interview and record review, it was determined the facility failed to ensure the physical needs of residents were recognized and thoroughly addressed to maintain their highest practicable physical well-being. This was true for 1 of 7 residents (#17) reviewed during the on-site follow-up survey. The deficient practice resulted in harm to Resident #17, when he did not receive continued antibiotic treatment for severe sepsis, and was again hospitalized with severe sepsis. Findings included: On 4/11/16 Resident #17 was transported to an Emergency Room, where he was diagnosed with severe sepsis. Resident #17 was treated at the hospital with IV antibiotics and fluids and returned	{F 000}			
F 309 SS=G		F 309	This Plan of Correction is 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 specifically denied. The submission of this Plan of Correction does not constitute an agreement by the facility that the Surveyors findings and/or conclusions, constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied. Definitions: Daily = Monday through Friday with regard	5/26/16	

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

TITLE

(X6) DATE

Electronically Signed

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 309	<p>Continued From page 1</p> <p>to the facility on 4/12/16 after refusing admission to the hospital.</p> <p>On 4/20/16, Resident #17 was admitted to the hospital with severe sepsis and re-admitted to the facility on 4/23/16 with multiple diagnoses, including severe sepsis, urinary tract infection, and urinary retention.</p> <p>Resident #17's Nurses Notes (NN), Nurse Practitioner (NP) notes, lab results, Emergency Room (ER) records, and hospital records from 4/8/16 to 4/24/16 documented:</p> <p>* NN - 4/7/16 at 11:34 pm: Increased lethargy late in the afternoon, decreased oxygen saturation, and difficulty staying awake. Resident #17 refused transport to the ER twice and the physician (MD) was notified. Vital signs were not documented.</p> <p>* NP #1 - 4/8/16 - "Nursing staff report ... that [Resident #17] had an issue on 4/7/16 where he was very somnolent and he was having difficulty staying aroused. The resident stated he was extremely sleepy and had felt some chills before this had come on. [On 4/7/16] the resident was noted to have hypotension with a blood pressure of 86/42." Resident #17's BP was later rechecked and was 118/70.</p> <p>* NN - 4/9/16 at 10:44 pm: Resident #17, who had been "lethargic" and sleepy all day, was observed sleeping in his w/c "slumped over" with his chin against his chest. He became verbally aggressive towards staff when they offered assistance. Resident #17 dropped his nightly medication and had to be wakened 5 times within a 3-4 minute time span to finish the medications.</p>	F 309	<p>to 24 Hr. Report Process</p> <p>Corrective Action:</p> <ol style="list-style-type: none"> Resident #17 has continued to be assessed and treated by the facility Medical Director for infections and any other issues as they are presented. The facility requested and received documentation from visits Resident #17 made to outside health care providers. Orders included in that documentation have been addressed as per facility policy. <p>Identification:</p> <ol style="list-style-type: none"> Resident leaving the facility to receive services from outside health care providers are identified as being potentially affected by this deficient practice identified in this 2567. Facility staff will request documentation from outside health care providers, which provide services to facility residents, within 24 hours, if not received when the resident returns to or admits to the facility. Orders and/or treatments received in documentation to be carried out per facility policy and procedure. <p>Systemic Changes:</p> <ol style="list-style-type: none"> Facility Licensed Nurse and Medical Records staff have received inservice regarding facility policy for requesting documentation from outside health care providers within 24 hours after a resident returns to or admits to the facility after receiving services from that provider. 		

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F 309	<p>Continued From page 2</p> <p>His vital signs, except blood pressure, were assessed; oxygen saturation was 72% on room air, but rose to 88% after he was provided with oxygen at 2 liters/minute. The MD was contacted and ordered staff to monitor Resident #17 and hold any pain medication if sedation continued.</p> <p>* NN - 4/10/16 at 3:07 am: Resident #17 was sitting in his bathroom at 12:00 am and when the nurse approached the resident to offer assistance, "he stated he was ok, he was fine, and did not need help." Resident #17 remained in the bathroom through most of the shift and when his oxygen was checked it was 74% on room air. He was provided with a portable oxygen tank, and remained in the bathroom. The nurse documented, "[nursing staff] will check oxygen saturation after the resident is out of the bathroom and back where saturation can be checked." Will continue to monitor. Vital signs were not documented and there was no documentation the MD was notified.</p> <p>* NN - 4/11/16 at 7:00 am: Resident #17, who was sitting in the bathroom, became verbally aggressive towards staff and refused their offers of assistance. Resident #17 presented with tremors, involuntary movement, incontinence of bowel and bladder, confusion with decreased level of consciousness, difficulty following directions, and was unable to stand or bear weight. Vital signs included: Temperature 101.8 F, pulse 108/bpm, respiratory rate 24/minute, blood pressure 93/54 mmHg, and oxygen saturation 74% on room air. The nurse administered Tylenol at 4:00 am and documented at 7:00 am that Resident #17 was afebrile, the NP was notified, and an order was received to monitor the resident.</p>	F 309	<p>2. Resident appointments to outside health care providers will be reviewed during the facility's 24 Hour Report process to ensure documentation from the respective providers has been requested if not received from those providers when the resident returns or is admitted to the facility.</p> <p>Monitor:</p> <p>1. Director of Nursing Services / Unit Managers to conduct audit of clinical record for residents seeing outside health care providers to ensure documentation from the respective providers has been received. Audit also to include ensuring that orders and/or treatments in documentation received are carried out per facility policy and procedure.</p> <p>Audits to be conducted at the following frequencies: Weekly x eight (8) weeks Monthly x three (3) months</p> <p>2. Administrator to review audits</p> <p>3. Findings to be reported to QA Committee</p>		

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F 309	Continued From page 3 * NP - 4/11/16: Nurse Practitioner was asked by staff to assess Resident #17, who was described as "being very drowsy, not waking up, having bowel and bladder incontinence." NP #1 was told Resident #17 received Tylenol for a temperature of 101.8 F and that he stated he had "some fevers and chills but is feeling fine now." Vital signs included: Blood pressure of 98/45 mmHg, pulse of 108 bpm, respiratory rate of 24/min., and a temperature of 101.8 F. NP #1 documented, "It seems [Resident #17] is developing signs and symptoms of sepsis with his febrile illness, hypotension and tachycardia, but I am not certain as to the source of this yet and Stat [immediate] laboratory studies were ordered." * NN - 4/11/16 at 4:30 pm: Resident #17 was observed with shakes, chills, had returned to his confused state, continued to be incontinent, continued to "nod off frequently," and had a temperature of 94.6 F. NP #1 was contacted and Resident #17 was transported to the ER for a blood draw, evaluation, and treatment. * An Emergency Room report, dated 4/11/16, documented: - 1:51 pm - Blood pressure of 128/64 mmHg, pulse of 109/bpm, respiratory rate of 22/minute, oxygen saturation of 93% on 3 liters, and a temperature of 103.1 F. - 1:55 pm - Multiple blood tests were drawn, including blood cultures. - 2:25 pm to 3:00 pm - The hospital lab reported to the ER physician that Resident #17 had critical potassium and lactic acid levels, additional blood	F 309			

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F 309	<p>Continued From page 4 cultures were pending.</p> <p>- 3:00 pm - The ER physician documented, "It was at this point the resident was identified as having shock secondary to sepsis."</p> <p>- 3:17 pm - The ER physician and the facility MD discussed Resident #17's history, diagnostic assessments, findings, and diagnosis. The ER physician stated Resident #17 was "adamant that he does not want to stay in the hospital and wants to be sent back to the facility." Resident #17 stated he was willing to accept the antibiotics that were prescribed and some IV fluids in the ER, but did not want continued therapy in the hospital. The ER physician told Resident #17 that should he discharge him back to the facility "there is strong possibility he could die secondary to sepsis." The ER physician noted the facility MD "felt that the patient should be discharged back to the facility ... and asked that the IV remain in and the IV antibiotics and fluids be given prior to the patient being sent back."</p> <p>- 3:42 pm - Resident #17 received antibiotic Vancomycin via IV.</p> <p>- 4:27 pm - Resident #17 received antibiotic Zosyn via IV.</p> <p>- 6:30 pm - The IV was removed from Resident #17.</p> <p>* NN - 4/11/16 at 7:50 pm: Resident #17 returned to the facility with orders to follow-up with his primary physician. The hospital reported he had a diagnosis of severe sepsis, hyperkalemia, and received IV antibiotics and fluids.</p>	F 309			

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F 309	<p>Continued From page 5</p> <p>* An Emergency Room note, dated 4/12/16 at 6:07 am, documented the facility was contacted and staff were informed that Resident #17's blood cultures showed signs of infection. Facility staff stated Resident #17's POST stipulated he was to receive comfort care only with no antibiotics. Resident #17's facility record did not include documentation of this contact.</p> <p>* On 4/13/16, NP #2 documented, "Staff noted the resident has a POST form for comfort only with no antibiotics and no IV fluids but the resident has been pursuing active treatment and they would like to have a discussion with him." The assessment/plan section of the note stated the POST was discussed with Resident #17. He stated he wanted to be DNR but did want antibiotics and IV fluids and would fill out a new POST form. The note also stated, "[There are] also concerns over whether or not he should be on continued antibiotics." The note did not document whether NP #2 addressed continued antibiotic treatment.</p> <p>* A Emergency Room note, dated 4/14/16, documented:</p> <p>- 7:29 am - Blood cultures were positive for Extended Spectrum Beta-Lactamase Escherichia coli infection and included a list of antibiotics for treatment of the infection.</p> <p>- 10:09 am - Hospital staff documented the facility was contacted and was aware of the positive blood cultures.</p> <p>Resident #17's clinical record did not include documented assessments by an NP, MD, or nursing related to the infection, monitoring vital</p>	F 309			

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F 309	<p>Continued From page 6</p> <p>signs, and follow-up on the positive blood cultures from 4/14/16 until 4/18/16.</p> <p>* On 4/18/16, NP #1 documented Resident #17 was diagnosed with severe sepsis at the Emergency Room on 4/11/16, received IV antibiotics and fluid boluses in the hospital, and returned to the facility. NP #1 noted, "It was believed the antibiotic would be continued at the facility."</p> <p>* A NN, dated 4/20/16, documented Resident #17 was transported to the hospital per his request due to a temperature of 103.1 F and a pulse of 122 bpm, and was admitted for sepsis.</p> <p>* A hospital History and Physical, dated 4/20/16, documented Resident #17 had severe sepsis with an underlying cause related to Extended Spectrum beta-Lactamase bacteremia Escherichia coli based on blood cultures from 4/11/16. The History and Physical documented, "As far as I can tell, he was not on medications to treat this. The patient meets severe sepsis criteria and is at risk for progression to septic shock or death."</p> <p>* A hospital Discharge Summary, dated 4/23/16, documented, "On 4/11/16 the patient presented to the Emergency Room with shaking, chills, a cough, and met the criteria for severe sepsis. The Emergency Room was notified by the lab and subsequently documented a call on 4/12/16 at 6:07 am to the facility staff to notify them of the finding of positive blood cultures. Actions thereafter are unknown, as review of nursing progress notes from the facility for that day do not document the call. Regardless, the patient eventually returned to the Emergency Room on</p>	F 309			

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F 309	<p>Continued From page 7</p> <p>4/20/16 for tachycardia, oxygen desaturation, fever, and altered mental status."</p> <p>* On 4/25/16, NP #1 documented, "Nursing staff reported the hospital was quite angry as we had not provided treatment for [Resident #17] ... after his last Emergency Room visit. Nursing staff inform me that [they] were never informed the resident had an infection by the Emergency Room, we never received a phone call or follow-up on his labs."</p> <p>On 5/11/16 at 11:10 am, NP #2 was asked about the reason Resident #17 was not administered antibiotics for the positive blood cultures. NP #2 stated, "The Emergency Room did not inform the facility that further antibiotic treatment was needed." The NP stated it was the hospital's responsibility to notify the facility of positive lab results and/or critical lab values. NP #2 stated it was determined on 4/13/16 that Resident #17 did not require antibiotics. When asked if she had reviewed the Emergency Room report for Resident #17, NP #2 stated she had not because the facility "did not have it."</p> <p>On 5/11/16 at 4:00 pm, NP #2 was asked if the facility had a policy and procedure for following up on Emergency Room reports, hospital records, and/or lab results. NP #2 stated the facility did not have such a policy.</p> <p>On 5/11/16 at 4:15 pm, the facility MD was asked about Resident #17's 4/11/16 Emergency Room visit. The MD stated the Emergency Room had not informed him that blood cultures were drawn on Resident #17. The MD stated the Emergency Room physician informed him only that Resident #17 did not want to be admitted to the hospital</p>	F 309			

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F 309	<p>Continued From page 8</p> <p>nor was there any reason to admit him. The MD stated the Emergency Room physician informed him that Resident #17 would receive some fluid and then return to the facility. The MD stated he was not sure if he was even informed about Resident #17 needing antibiotics. The Emergency Room report was then read to the MD. The MD stated none of that information had been reported to him. When asked if he was informed on 4/14/16 of the positive blood cultures for Resident #17, the facility MD stated he was not provided with the results. When asked if Resident #17 should have received antibiotic treatment based on the positive blood culture results, the MD stated it depended on whether the resident was symptomatic or not and he would need to look at the resident to determine whether the antibiotics were necessary. The physician stated the NP saw Resident #17 on 4/13/16 and determined the resident was asymptomatic. When asked what the facility's policy and procedure was for following up on Emergency Room visits and/or hospital admission, the MD stated he participated in the development of policies and procedures for the facility, but was not aware of one related to the transfer of information between the facility and the hospital. When asked if he saw Resident #17 after the 4/11/16 Emergency Room visit and/or the 4/20/16 hospital admission, he stated his NP, rather than him personally, saw Resident #17 at those times. Resident #17's facility record did not include documentation by the facility's MD regarding his discussion with the ER physician.</p> <p>On 5/11/16 at 4:45 pm, the DNS was asked how the facility received and processed verbal or faxed information from outside providers. The DNS stated Medical Records staff delivered faxes to the nurse on the floor for review. She stated</p>	F 309			

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

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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 R 05/11/2016
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
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F 309	<p>Continued From page 9</p> <p>the nurse reviewed and noted the faxed information and any pending labs were documented in a book for follow-up by the facility. She stated critical labs or positive cultures were reported to the physician for orders.</p> <p>On 5/11/16 at 5:00 pm, Medical Records Staff #1 was asked how the facility received and processed faxed information from outside providers. Medical Records Staff #1 stated providers/hospitals were given "a few days" to generate the report(s), which were then given to the DNS for review. Medical Records Staff #1 stated she did not recall when Resident #17's ER/hospital/lab report were requested or received.</p> <p>The facility failed to develop and implement written policies and procedures to ensure communication with other healthcare providers was received, documented, and follow up on. Resident #17 was harmed when he failed to receive necessary treatment for severe sepsis, culminating in another ER visit and admission to the hospital.</p>	F 309			