



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
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**CERTIFIED MAIL: 7007 3020 0001 4044 7281**

April 23, 2013

Tim J. Needles, Administrator  
Life Care Center of Boise  
808 North Curtis Road  
Boise, ID 83706

Provider #: 135038

Dear Mr. Needles:

On **April 12, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Life Care Center of Boise by the Department of Health & Welfare, 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, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should

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sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 6, 2013**. Failure to submit an acceptable PoC by **May 6, 2013**, may result in the imposition of civil monetary penalties by **May 28, 2013**.

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

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
  - a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
  - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
  - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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.

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

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

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 **May 17, 2013 (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 **May 17, 2013**. A change in the seriousness of the deficiencies on **May 17, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 17, 2013** includes the following:

Denial of payment for new admissions effective **July 12, 2013**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, 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 **October 12, 2013**, 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, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; 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.

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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 **April 12, 2013** 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 noncompliance 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 **May 6, 2013**. If your request for informal dispute resolution is received after **May 6, 2013**, 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, please contact us at (208) 334-6626.

Sincerely,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor  
Long Term Care

LKK/dmj  
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>135038</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE:  <b>4/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF BOISE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>808 NORTH CURTIS ROAD BOISE, ID</b>	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>F 514</b>	<p><b>483.75(1)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</b></p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to maintain clinical records that were complete and accurate. This affected 1 of 5 (#8) sampled residents reviewed for moderate/severe pain. Findings included:</p> <p>Resident #8 was admitted to the facility on 7/12/12 with multiple diagnoses including rheumatoid arthritis, urostomy, diabetes, and lumbago.</p> <p>Resident #8's 1/2/13 Quarterly MDS coded received both scheduled and PRN pain medication in the last 5 days.</p> <p>Resident #8's care plan addressed the problem "At risk for pain r/t Osteoporosis, Rheumatoid Arthritis, Lumbago, chronic pain, allergies."</p> <p>Resident #8's physician/telephone order dated 11/14/12, documented in part, "Norco 5/325 1 tab PO 0500 (5:00 AM), 1300 (1:00 PM)..."</p> <p>Resident #8's 4/13 Physician's Orders/Recapitulation documented: -12/28/12, Hydrocodone-Acetaminophen 5 MG-325 MG tablet, Norco, Take 1 tab by mouth twice daily (0500 and 1300) [5:00 AM &amp; 1:00 PM]. However, the hour column, documented the medication was to be administered at 8:00 AM and 8:00 PM.</p> <p>NOTE: The physician's original order directed staff to administer the medication at 5:00 AM and 1:00 PM, however the medication administration times were incorrect on the Recapitulation orders, 8:00 AM and 8:00 PM.</p> <p>Resident #8's 4/13 MAR documented: -Hydrocodone-Acetaminophen 5 MG-325 MG Tablet, Norco, Take 1 tab by mouth twice daily (0500 and 1300) NOTE: The hour column on the MAR indicated the administration times were 8:00 AM and 8:00 PM. The MAR contained handwritten entries as follows: 8:00 AM and 8:00 PM were lined out, 5:00 AM &amp; 1:00 PM</p>		

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

The above isolated deficiencies pose no actual harm to the residents

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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AH  
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  135038	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 4/12/2013
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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 514	<p>Continued From Page 1 were written in the hour column.</p> <p>Although the original 11/14/12 physician order for Norco directed staff to administer the medication at 5:00 AM and 1:00 PM, the 4/13 Physician's Orders/Recapitulation orders and 4/13 MAR contained in the hour columns, the wrong medication administration times for the scheduled pain medication, Norco.</p> <p>During observation of medication administration on 4/9/13 at 1:30 PM, LN #4 administered a Norco 5 mg-325 mg tablet to Resident #8. The surveyor asked the LN which times were accurate, the 5:00 and 1:00 times, or the 8:00 and 8:00 times. The LN indicated the 5:00 and 1:00 were the accurate times the medication was to be given.</p> <p>On 4/10/13 at 3:45 PM, the DON and LN Unit Manager, were interviewed. The DON stated, "We have tried to get the pharmacy to change the times on the recap (recapitulation) orders but they still haven't changed it. We have written the right times in on the MAR."</p> <p>On 4/11/13 at 4:30, the DON and Administrator were informed of the medical records issue for Resident #8. No other documentation was provided.</p>
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PRINTED: 04/17/2013  
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  C 04/12/2013
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	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the annual recertification and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were: Karen Marshall, MS, RD, LD Team Coordinator Bradley Perry, BSW, LSW Karla Gerleve, RN</p> <p>Survey Definitions: BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide DNS/DON = Director Nursing Services/Director of Nursing HS = At Bedtime LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligram PD = Peritoneal Dialysis PRN = As Needed PPM = Parts Per Million RN = Registered Nurse R/T = Related To TAB = Tablet TAR/TR = Treatment Administration Record</p>	F 000	<p>Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies</p> <p>F 242 <b>What corrective actions will be accomplished for those residents/issues found to have been affected by the deficient practice.</b></p> <p>Resident #16 name on the plaque outside her room was changed to the name she preferred to be called.(Residents middle name) <b>How you will identify other residents/issues having the potential to be affected by the same deficient Practice.</b></p> <p>All residents names were evaluated on doors and on communication systems within the facility to assure that the names they prefer to be called are displayed.</p>		
F 242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p>	F 242			

FACILITY STANDARD

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE Administrator (X6) DATE 5/6/2013

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 242	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to use the name the resident preferred to be addressed as on the name plaque outside the resident's room. This affected 1 of 1 (#16) random residents. This practice created the potential to affect the resident's self-esteem regarding personal choices of her life. Findings included:  Random Resident #16 was originally admitted to the facility on 10/22/07, and most recently readmitted on 3/16/13, with multiple diagnoses including generalized muscle weakness and gout.  The resident's 2/26/13 Quarterly MDS coded cognition intact, no delirium signs or symptoms, and minimal depression.  On 4/8/13 at 9:22 a.m., Random Resident #16 was in her room and appeared to be reading a book. The surveyor entered the room and addressed the resident by the name on the name plaque outside the room. The resident adamantly stated with vocal agitation, "Do not call me by that name. I do not like that name. I prefer to be called by my middle name." The resident then stated the name she preferred to be called. The surveyor asked the resident what her preference was for her name plaque by the door outside the room. The resident stated, "I prefer to have [Resident #16's middle name] on my name plaque outside the room."  On 4/8/13 at 9:55 a.m., the surveyor informed the	F 242	<b>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</b>  Upon Admission, the Admission coordinator will ask each resident if they prefer a specific name to be called. The Admission Coordinator will communicate to the appropriate depts which name they prefer. Medical Records will keep a log of preferred names and will assure that the Plaques on Doors and other communication systems denote the name the resident prefers to be called.  <b>How the corrective actions will be monitored to ensure the deficient practice will not recur.</b>	

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F 242	Continued From page 2 Unit Manager (UM) of the above conversation with Random Resident #16. The UM smiled and stated, "Oh, she told you. Yes, she does want to be called by her middle name."  On 4/11/13 at 2:53 p.m., CNA #1 stated, "[Random Resident #16] told all of us she prefers to be called by her middle name, not her first name."  On 4/12/13 at 11:30 a.m., the Administrator and the DON were informed of the finding. The facility did not provide any additional information.	F 242	Starting on May 13th 2013: Weekly for 4 weeks, every other week for 3 months, then Monthly for two months the Medical Records Director will audit name preferences and door plaques to assure that the names are appropriately displayed. Monthly in Quality Assurance/Performance Improvement Committee Medical Records Director will report audit results to monitor the system.  F 253 <b>What corrective actions will be accomplished for those residents/issues found to have been affected by the deficient practice.</b>  1. Bathrooms in residents rooms 102, 106, 122, 126, 201, 203, 206 and 208 were cleaned, sanitized and the old caulking removed with new caulking installed around the base of each toilet.		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to ensure a sanitary and comfortable environment was provided in residents bathrooms and a shower room. This was true for 16 of 26 bathrooms examined and 1 of 3 shower rooms examined. This had the potential to harm the residents in these rooms due to possible spread of germs. Findings included:  1. During the initial tour on 4/8/13 from 8:35 AM to 9:55 AM and a follow up tour from 1:01 PM to 2:38 PM, bathrooms in resident rooms 102, 106, 122, 126, 201, 203, 206, and 208 had what appeared to be a build up of yellowish and brown	F 253			

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F 253	<p>Continued From page 3</p> <p>colored waste matter. The build up was observed around the base of the toilets in each room. In each of the identified rooms the base of the toilets had missing, cracked, or disintegrating caulking, making the surface uneven and non-cleanable surfaces.</p> <p>2. During the two above stated tours, bathrooms in resident rooms 102, 116, 122, 126, 205, 209, 212, 214, 217, 221, and 223 had toilet floor bolts exposed without a plastic covering over them, creating a gap where debris could be trapped between the bolt and the toilet, creating a non-cleanable surface.</p> <p>3. During the initial tour on 4/8/13 from 8:35 AM to 9:55 AM, bathroom floors in rooms 201 and 206 were observed to be stained and dingy in appearance.</p> <p>4. On 4/10/13 at 3:15 PM, the shower room across from resident room #118 was observed. On the South side of the shower, where the tiled floor and the tiled wall met there was a 12 inch section of what appeared to be black molded caulking. On the East side of the shower was a three foot long section of the tile in the same condition.</p> <p>On 4/10/13 from 2:04 PM to 2:30 pm, during a tour of the facility environment with the Director of Maintenance (DM), the bathroom caulk issue was brought to his attention. The DM said regarding the condition of the caulk in room 106, "[I] see a little dirt down there" and in room 116 he stated, "We'll just check them all." (referring to all resident bathrooms in the facility). He said all the toilets in the facility would be checked and would</p>	F 253	<p>2. Bathrooms in residents rooms 102, 116, 122, 126, 205, 209, 212, 214, 217, 221 and 223 where the floor bolts were exposed had appropriate caps installed at the base of each toilet which covered the bolts and provided a cleanable surface.</p> <p>3. Bathroom floors in rooms 201 and 206 were stripped of all wax, scrubbed and rewaxed to provide a shiny clean appearance.</p> <p>4. The Shower room across from resident room #118 on the south side of the shower, where the tiled floor and the wall met and the East side of the shower in the three foot long section, the caulking was removed and new caulking installed as appropriate.</p> <p><b>How you will identify other residents/issues having the potential to be affected by the same deficient Practice.</b></p> <p>All bathrooms and Shower rooms were evaluated by Housekeeping and Maintenance Supervisor. Any other areas identified as having caulking needing replaced, exposed bolts around the toilets or dirty or dingy bathroom floors were cleaned and/or repaired.</p> <p><b>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</b></p>		

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F 253	Continued From page 4 be re-caulked. The toilet bolt issue was also brought to his attention and the DM said, "we can cover those up." The bathroom floors in room 201 and 206 were observed and the DM stated, "It could use a cleaning...caulking, strip and wax it and put caps (toilet bolt coverings) back on (room 201)" and, "It could use a shine (room 206)."  On 4/10/13 at 3:17 PM, the DM was interviewed regarding the condition of the shower and he stated, "[it] needs re-caulking...strip the old caulking out and put new caulking in."  On 4/11/13 at 4:35 PM, the Administrator, DON, and Regional Director of Clinical Service were informed of the maintenance and housekeeping issues. No other information was received from the facility.	F 253	Bathroom and shower room cleaning procedure implemented to ensure bathrooms and showers are cleaned, caulked and toilet caps to cover bolts are in place. Housekeeping Staff inserviced on the procedure and the importance of cleaning and up keep of the bathroom and showers.  <b>How the corrective actions will be monitored to ensure the deficient practice will not recur.</b>		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279	Starting on May 13th 2013: Weekly for 4 weeks, every other week for 3 months, then Monthly for two months the Housekeeping Supervisor will audit the bathrooms and shower rooms. Monthly in Quality Assurance/Performance Improvement committee meeting the Housekeeping Supervisor will report the findings of the audits in order to monitor the system.  F 279 <b>What corrective actions will be accomplished for those residents/Issues found to have been affected by the deficient practice.</b>		

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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF BOISE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>808 NORTH CURTIS ROAD BOISE, ID 83706</b>		
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F 279	<p>Continued From page 5</p> <p>due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to address a resident's anxiety needs on his interim care plan, and failed to individualize a resident's care plan for peritoneal dialysis. This affected 2 of 13 (#s 3 &amp; 9) sampled residents reviewed for their plan of care. This created the potential for harm for Resident #3's anxiety needs to be unmet and Resident #9's peritoneal dialysis to not be monitored and performed accurately. Findings included:</p> <p>1. Resident #3 was admitted to the facility on 10/7/10 and was readmitted from a hospital stay on 4/6/13. He had multiple diagnoses which included Rieter's Syndrome, chronic arthritis, diabetes, anxiety, colostomy and a feeding tube.</p> <p>Resident #3's most recent Quarterly MDS, dated 1/22/13, coded the resident cognitively intact with a BIMS of 15. He had received anti-anxiety medications 7 days out of the last 7 days.</p> <p>Resident #3's Admission orders dated 4/6/13 indicated: Buspar 5 mg P.O. (by mouth) every Q (every) AM for Anxiety and Buspar 7.5 MG P.O. QPM for Anxiety.</p> <p>Resident #3's 4/13 MAR indicated: Buspar 5 mg P.O. every AM at 8:00 AM for anxiety and Buspar 7.5 mg P.O. every PM at 6:00 PM for anxiety.</p>	F 279	<p>Resident #3 careplan updated to include anxiety. Resident #9 was careplanned for specific approaches for Peritoneal Dialysis and included a plastic tub for barrier protection.</p> <p><b>How you will identify other residents/issues having the potential to be affected by the same deficient Practice.</b></p> <p>Residents with Anxiety or Peritoneal Dialysis. Residents with peritoneal dialysis and Anxiety have been reviewed and care plans updated.</p> <p><b>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</b></p>		

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F 279	<p>Continued From page 6</p> <p>On 4/8/13 at 1:15 PM, during observation of care for Resident #3 in the resident's room, CNA #3 indicated the resident would be medicated for pain before transfer into his wheelchair. NOTE: The resident was medicated for pain before he was transferred via a Hoyer lift.</p> <p>Resident #3's "Interim Care Plan" dated 4/6/13, did not address the resident's anxiety. NOTE: The resident's previous care plan initiated on 4/30/12 included a problem "He has a fear of falling and movement is painful at times therefore is anxious with cares and mobility and will call out when moved or transferred."</p> <p>On 4/10/13 at 10:00 AM, the RN Unit Manager for the 200 Unit was interviewed. The Unit Manager indicated the interim care plan in the resident's chart, and not the previous care plan, was in place for Resident #3 since his latest admission from the hospital. The surveyor informed the RN there was not a problem for anxiety in Resident #3's care plan and the resident received Buspar for anxiety. The RN acknowledged anxiety was a concern for Resident #3 and had not been care planned, but indicated the Social Worker had added the anxiety problem to the resident's care plan just that morning.</p> <p>On 4/11/13 at 4:30 PM, the DON and Administrator were informed of the care plan issue for Resident #3. No other documentation was provided.</p> <p>2. Resident #9 was admitted to the facility on 2/25/13 with multiple diagnoses including aftercare for traumatic fracture healing and end</p>	F 279	<p>IDT team and Licensed Staff inserviced that residents with Anxiety diagnosis of anti anxiety medication or has signs or symptoms of anxiety must have a care plan to address their needs. Residents with peritoneal dialysis must have specific approaches including pink tub for barrier.</p> <p><b>How the corrective actions will be monitored to ensure the deficient practice will not recur.</b></p> <p>Care plan audits will be done on Admission Interim Care plans to ensure anyone on anxiety medication signs or symptoms of anxiety are care planned and anyone on Peritoneal Dialysis has a specialized careplan. Audits to be completed by the MDS Nurse and Director of Nursing starting on May 13th 2013 and will be weekly for the first month, every other week for three months and monthly for two months. Audits results will be reviewed monthly by the Quality Assurance Performance Improvement Committee to monitor the system.</p>		

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F 279	<p>Continued From page 7 stage renal disease (ESRD).</p> <p>The resident's 3/4/13 Admission MDS coded cognition intact, minimal depression, and dialysis.</p> <p>The resident's 2/25/13 admission orders included, in part, "...daily PD [peritoneal dialysis] per [name of the local dialysis center's medical doctor]."</p> <p>The resident's April 2013 physician orders (recapitulation) contained the 3/20/13 order, continue with dialysis.</p> <p>The resident's ESRD care plan identified, 2/25/13, alteration in health maintenance due to ESRD and 2/25/13 alteration in health maintenance secondary to dialysis treatments due to ESRD. The only problem approach related to PD was, "Resident peritoneal dialysis will stay on schedule (please see mars for schedule) any AE's [adverse effects/events] will be reported to MD immediately."</p> <p>On 4/8/13 at 10:55 a.m., the Station One Unit Manager (UM) stated, "The resident is on peritoneal dialysis and the nurses do the dialysis."</p> <p>On 4/9/13 at 1:35 p.m., the surveyor spoke with the DON and the UM about the resident's ESRD care plan. The DON stated, "The care plan does not provide specific approaches for PD such as the use of the pink plastic tub for barrier protection." The DON indicated the care plan would be updated.</p> <p>NOTE: Please refer to F441 as it related to the dialysate bag laying in direct contact with the floor without barrier protection.</p>	F 279			

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F 279	Continued From page 8 On 4/10/12 at 11:00 a.m., the surveyor reviewed the resident's ESRD care plan. The facility updated the care plan to include many different approaches for the dialysis the resident received including barrier protection for the dialysate bag.  On 4/12/13 at 11:30 a.m., the Administrator and the DON were informed of the finding. The facility did not provide any additional information.	F 279			
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility did not	F 280	<b>F 280</b> <b>What corrective actions will be accomplished for those residents/Issues found to have been affected by the deficient practice.</b>  Resident #2 careplan updated to read transfer pole in room for safe transfers assist; with therapy only. Resident #4 careplan was updated to address pain. Resident #7 careplan was updated to read allow resident to keep door closed for privacy and honor his preference to remain naked in his room. Outdated approaches were deleted. Resident #8 care plan was revised to delete eye shield.  <b>How you will identify other residents/issues having the potential to be affected by the same deficient Practice.</b>		

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F 280	<p>Continued From page 9</p> <p>revise care plans for 4 of 13 sampled residents (#s 2, 4, 7, &amp; 8). Care plans did not reflect revisions for a resident transfer pole, privacy needs, pain medication, and cataracts. This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in the care plan. Findings included:</p> <p>1. Resident #2 was admitted on 1/13/09 with multiple diagnoses including muscle weakness and history of falls.</p> <p>During the initial tour on 4/8/13 from 8:35 AM to 9:55 AM, Resident #2's room was observed with a transfer pole in his room, next to his bed.</p> <p>A facility Incident Follow-Up and Recommendation Form dated 3/21/13, documented under interventions, following a fall on 3/21/13, "therapy to screen and eval[uate] for transfer pole." The form also documented, "Date care plan reviewed and updated 3/21/13."</p> <p>A facility Rehabilitation Services Multidisciplinary Screening Tool dated 3/22/13, documented, "Assessed for transfer pole transfer."</p> <p>The resident's mobility/safety care plan had a handwritten note for approaches dated 4/9/13, documented, "Transfer pole in room for safe transfers with assist." NOTE: The new approach did not document who would assist with pole transfers or if the resident was independent with using the transfer pole.</p> <p>On 4/10/13 at 10:37 AM Unit Manager #5 was interviewed regarding the transfer pole and he stated, "Therapy [staff] has been using it with</p>	F 280	<p>Other residents with specific needs such as transfer poles, cataracts, pain medication and privacy requests have the potential to be affected. Care plans have been reviewed and updated for interventions for pain, cataracts, transfer poles and privacy needs. Conflicting information has been deleted.</p> <p><b>What measures will be put into place or what systematic changes you will make to ensure that the definet practice does not recur;</b></p> <p>MDS nurses have been inserviced that if pain is triggered on MDS section V, there must be a careplan problem for pain. MDS nurses to review previous care plan to ensure new interventions do not conflict with prior interventions. License staff inserviced that when adding new interventions it must be care planned and any specific intervention must be added to the careplan. Any new intervention specific to a certain discipline must be included on approach. Licensed staff and MDS inserviced to ensure discontinued orders and outdated approaches are removed from careplan.</p>		

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F 280	<p>Continued From page 10</p> <p>him." He said his staff was not using the pole with the resident because they had not been trained by therapy yet."</p> <p>On 4/10/13 at 10:55 AM, the Therapy Manager was interviewed regarding the transfer pole and said only therapy staff was to assist the resident until the nursing staff were trained and then, "We add it (to the care plan) when they are ready for (nursing) staff...but probably should not have been added to the care plan yet."</p> <p>On 4/10/13 at 11:37 AM, the DON was interviewed about the care plan. She said she added the care plan note but, "I should have written, assist with therapy, maybe."</p> <p>The facility failed to specify who was allowed to assist the resident with his transfer pole.</p> <p>2. Resident #7 was admitted to the facility on 7/18/2011 with multiple diagnoses including dementia and delusional disorder.</p> <p>During the initial tour on 4/8/13 from 8:35 AM to 9:55 AM, Resident #7's room door was observed to be closed and was also observed closed throughout much of the day from 4/8/13 through 4/11/13.</p> <p>The resident's cognition care plan dated 7/18/11, documented in the approach section, "Keep door open and observe for problems each time room is passed." The resident's mood/behavior care plan dated 8/1/12, documented in the approach section, "Allow [Resident] to keep his door closed for privacy and honor his preferences to remain naked in his room."</p>	F 280	<p><b>How the corrective actions will be monitored to ensure the deficient practice will not recur.</b></p> <p>Audit 25% of care plans per MDS schedule to include any identified pain triggering in section V, any conflicting information not applicable to the patients current care needs, interventions updated with discipline specifics and interventions accurate with cataracts and ensure that they are updated as appropriate in the care plan. Audit will be completed by the Director of Nurses, Unit Managers and MDS Nurses starting the week of May 13th 2013 and will be completed weekly for 4 weeks, every other week for 3 months then every month for two months. Director of Nurses will report findings of Audit monthly in Quality Assurance Performance Improvement committee meeting.</p>	

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F 280	Continued From page 11  On 4/10/13 at 10:15 AM, the MDS Coordinator was interviewed regarding the conflicting care plans. After reading the care plans, she stated, "I do see the discrepancy." She said the cognition care plan was completed when the resident first came to the facility, but it had not been updated since then.  The facility failed to remove an outdated cognition care plan approach. 3. Resident #4 was admitted to the facility on 8/8/12 with diagnoses of personality disorder, depressive psychosis, hemiplegia, chronic pain, and back spasms.  Resident #4's most recent 1/22/13 Quarterly MDS coded the resident experienced pain, received a scheduled pain medication, received a PRN pain medication in the last 5 days, and a BIMS score of 15 cognitively intact.  Resident #4's most recent 4/30/12 Annual MDS coded the resident experienced pain almost constantly, experienced pain over the last 5 days, limited his day to day activities, and a 10 the worst pain you can imagine. Pain was triggered and the MDS Section V documented a new care plan was started.  Resident #4's most recent care plan dated 3/22/13 did not address a pain issue.  Resident #4's 4/13 MAR documented: -Lidoderm 5% 700 MG ADH Patch, Apply 1 patch topically to back, Change every day for pain. Lower mid back. -Lidocaine Cream 5% 4x (4 times) a day to liver	F 280			

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F 280	<p>Continued From page 12</p> <p>area</p> <p>-Oxycodone HCL 5 MG Tablet, Take 1 tab by mouth every 4 hours as needed.</p> <p>-Oxycodone HCL 5 MG Tablet, Take 2 tabs by mouth every 4 hours as needed for pain.</p> <p>NOTE: The MAR documented Resident #4 received PRN Oxycodone, April 1, 5, 6, 8, and 9, 2013, five (5) days.</p> <p>-Pain Level every shift using 0-10 pain scale</p> <p>NOTE: The MAR documented Resident #4 experienced a pain level of 2-5 on each of the following days April 2, 5, 6, 7, 9, and 10, 2013, six (6) days.</p> <p>On 4/10/13 at 10:15 AM, Resident #4 indicated he experienced pain in his left foot, and it could be compared to "kidney stones". He indicated when he received the pain medication it relieved the pain.</p> <p>On 4/10/13 at 10:25 AM, the LN Unit Manager was asked if pain was addressed on Resident #4's care plan. The LN acknowledged Resident #4 received scheduled and PRN pain medication but the LN could not locate pain anywhere on the resident's care plan.</p> <p>On 4/11/13 at 4:40 PM, the DON and Administrator were informed of the care plan issue for Resident #4. No other documentation was provided.</p> <p>4. Resident #8 was admitted to the facility on 7/12/12 with multiple diagnoses that included rheumatoid arthritis, a urostomy, lumbago, depression, and diabetes.</p> <p>Resident #8's most recent 1/2/13 Quarterly MDS,</p>	F 280			

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F 280	<p>Continued From page 13</p> <p>coded the resident had adequate vision and saw fine detail such as regular print in newspaper and books, she used corrective lenses, and a BIMS score of 15, cognitively intact.</p> <p>Resident #8's care plan dated 1/16/13, had a problem for, "At risk for injury from falls related to pain, cataracts, use of high risk meds, wears right eye shield at bedtime." One of the approaches listed was "shield to right eye at bedtime."</p> <p>On 4/8/13 at 1:45 PM, in Resident #8's room, the resident stated, "I had cataract surgery and it was successful. I had it right after I got here." The resident had glasses on her bedside table and indicated she used them for reading.</p> <p>On 4/10/13 at 10:10 AM, in Resident #8's room, the resident indicated again, she had cataract surgery shortly after coming to the facility in August of 2012. She indicated she had never worn an eye shield over her eyes.</p> <p>Resident #8's most recent 4/13 MAR and 4/13 Physician's Orders/Recapitulation did not indicate the resident had cataracts or was to wear a shield to her right eye.</p> <p>During interview with the LN Unit Manager, on 4/10/13 at 10:25, the LN was asked about the eye shield and the cataracts on the care plan for Resident #8. The LN stated, "I can go ahead and discontinue those on the care plan, they were fixed." He also indicated the resident "probably" never wore the eye shield and he would remove it from the care plan.</p> <p>On 4/11/13 at 4:40 PM, the DON and</p>	F 280			

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F 280	Continued From page 14 Administrator were informed of the care plan issue for Resident #8. No other documentation was provided.	F 280	F 356 <b>What corrective actions will be accomplished for those residents/issues found to have been affected by the deficient practice.</b>	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION  The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.  The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.  The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.  The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.  This REQUIREMENT is not met as evidenced	F 356	A wipe board was installed on the wall in which staffing is posted to include the Facility Name, the Current Date, the total number and the actual hours worked by RN's, LPN's, CNA's and the Resident Census.  <b>How you will identify other residents/issues having the potential to be affected by the same deficient Practice.</b>  All Residents are affected by this deficient practice.  <b>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</b>	

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F 356	Continued From page 15 by: Based on observation and staff interview, it was determined the facility failed to ensure nursing staffing data was posted. This affected 13 of 13 (#s 1-13) sampled residents, 1 of 1 (#16) random residents and all residents who resided in the facility. Findings included:  On 4/8/13 at 10:50 a.m., two surveyors asked the DON where the staffing was posted. The DON stated, "It is not on the wall where we normally have staffing posted. I will take care of that."  On 4/9/13 at 8:40 a.m., the Administrator stated, "When the facility was painted, the sign was taken down and never put back up. I know it is a requirement to post staffing for each shift and day."	F 356	Daily at the beginning of each shift the Staffing Coordinator or designee will post the staffing data.  <b>How the corrective actions will be monitored to ensure the deficient practice will not recur.</b>		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure the sanitizing solutions in 1 of 2 buckets evaluated maintained the correct parts per million	F 371	Starting on May 13th 2013: Weekly for 4 weeks, every other week for 3 months, then Monthly for two months the RN Unit Manager will audit the staff posting for completeness and accuracy. Monthly in Quality Assurance/Performance Improvement committee meeting the RN Unit Manager will report the findings of the audits in order to monitor the system.  F 371  <b>What corrective actions will be accomplished for those residents/Issues found to have been affected by the deficient practice.</b>		

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F 371	Continued From page 16 (ppm). This affected 13 of 13 (#s 1-13) sampled residents and had the potential to affect residents who dined in the facility. This practice created the potential for cross-contamination of food and exposed residents to potential sources of pathogens. Findings included:  On 4/8/13 at 8:20 a.m., the Dietary Manager (DM) accompanied the surveyor during the initial tour of the facility kitchen. - At 8:24 a.m., two red plastic buckets containing quaternary sanitizing solution were evaluated for ppm. The test strip for one of the sanitizing buckets did not appear to change in color to indicate 150 ppm. The surveyor asked the DM what the ppm for the sanitizing solution was. The DM stated, "The test strip indicates 100 ppm. The ppm should be 150." The surveyor asked, "Are you sure?" The DM stated, "Yes."  On 4/12/13 at 11:30 a.m., the Administrator and the DON were informed of the finding. The facility did not provide additional information.	F 371	The identified bucket with the sanitizing solution outside acceptable limits, was immediately discarded and refilled. It was tested and was found to be ">150 & <300 ppm". <b>How you will identify other residents/issues having the potential to be affected by the same deficient Practice.</b>  All residents in the facility had the potential to be affected by the sanitizing solution. Certified Dietary Manager evaluated all areas where the sanitizing solution is used and ensured that the were found to be within the acceptable limits. <b>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</b>	
F 441 SS=D	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,	F 441	All red sanitizing buckets will be filled from the appropriate chemical dispenser. The dispenser is set by Ecolab and monitored by the Ecolab technician on routine visits as well as the Certified Dietary Manager during weekly sanitation audits. Kitchen staff will test buckets prior to use to make certain that they are at the proper PPM concentration. All kitchen staff will be re-educated on proper cleaning & sanitizing techniques and the importance of the proper concentration of sanitizing solution.	

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

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F 441	<p>Continued From page 17</p> <p>should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews, it was determined the facility failed to ensure infection control precautions were implemented for a peritoneal dialysis (PD) dialysate bag when the resident received PD. This affected 1 of 2 (#9) residents sampled for dialysis. This practice placed the resident at risk for harm due to the potential transmission of disease causing pathogens. Findings included:</p>	F 441	<p><b>How the corrective actions will be monitored to ensure the deficient practice will not recur.</b></p> <p>Starting on May 13th 2013: Weekly for 4 weeks, every other week for 3 months, then Monthly for two months the Certified Dietary Manager will audit the Sanitized Solution in the kitchen by testing the PPM's. Monthly in Quality Assurance/Performance Improvement committee meeting the Certified Dietary Manager will report the findings of the audits in order to monitor the system.</p> <p>F441</p> <p><b>What corrective actions will be accomplished for those residents/issues found to have been affected by the deficient practice.</b></p> <p>Resident #9 dialysis bag is kept in pink tub for barrier protection. Pink tub for barrier protection is care planned.</p> <p><b>How you will identify other residents/issues having the potential to be affected by the same deficient Practice.</b></p>		

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F 441	<p>Continued From page 18</p> <p>Resident #9 was admitted to the facility on 2/25/13 with multiple diagnoses including aftercare for traumatic fracture healing, end stage renal disease (ESRD), and renal dialysis status.</p> <p>The resident's 3/4/13 Admission MDS coded cognition intact, minimal depression, and dialysis.</p> <p>The resident's 2/25/13 admission orders included, in part, "...daily PD per [name of the local dialysis center's medical doctor]."</p> <p>The resident's April 2013 physician's orders (recapitulation) contained the 3/20/13 order, continue with dialysis.</p> <p>The resident's ESRD care plan identified the 2/25/13 problem of alteration in health maintenance due to ESRD. One of the problem approaches was, "resident's peritoneal dialysis (PD) will stay on schedule (please see MARs for schedule) any adverse events/effects will be reported to MD immediately."</p> <p>On 4/8/13 at 10:55 a.m., the Station One Unit Manager (UM) stated, "The resident is on peritoneal dialysis and the nurses do the dialysis."</p> <p>On 4/8/13 at 12:45 p.m., the resident stated, "I have a dialysis machine at home. Here, nurses do the dialysis and the dialysis is every 2 hours or so."</p> <p>On 4/8/13 at 1:15 p.m., the resident was in bed. The dialysate bag contained a yellow colored fluid and was laying in direct contact with the floor. The bag was connected to the PD tubing, connected to the resident.</p>	F 441	<p>Other residents with ESRF doing Peritoneal Dialysis will have the potential to be affected.</p> <p><b>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</b></p> <p>Licensed staff to be responsible to assure the Dialysate Bag is in the appropriate barrier on all Peritoneal Patients. Licensed Staff were inserviced on the need to keep the Dialysate Bag in the appropriate container for proper barrier.</p>		

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F 441	<p>Continued From page 19</p> <p>NOTE: The surveyor did not observe a barrier between the bag and the floor. Neither did the surveyor observe a pink plastic tub in the room.</p> <p>On 4/8/12 at 1:42 p.m., the Station One UM, RN #2, and the surveyor observed the dialysate bag filled with yellow colored fluid. At this time, the dialysate bag was in a pink plastic tub. Both the UM &amp; RN #2 stated, "The dialysate bag should be in the pink plastic tub, not on the floor. The tub is used for barrier protection."</p> <p>On 4/9/13 at 11:35 a.m., the resident was in bed. The PD tubing was connected to the resident and to the dialysate bag. The dialysate bag was laying in direct contact with the floor. The pink plastic tub was located on the floor approximately 2 inches from the dialysate bag. The surveyor then asked the DON and RN #2 to observe the resident's room. The RN stated, "I placed the bag in the plastic tub earlier today." The surveyor informed the DON and the RN, this observation was the second observation of the dialysate bag laying in direct contact with the floor while connected to the resident.</p> <p>On 4/9/13 at 1:35 p.m., the surveyor, the DON, and the UM reviewed the resident's ESRD care plan for use of the pink plastic tub. The DON stated, "The care plan does not provide specific approach information such as barrier protection for the dialysate bag." Note: Please refer to F279 as it related to the resident's ESRD care plan.</p> <p>On 4/12/13 at 11:30 a.m., the Administrator and the DON were informed of the finding. The facility did not provide any additional information that</p>	F 441	<p><b>How the corrective actions will be monitored to ensure the deficient practice will not recur.</b></p> <p>Starting the week of May 13th 2013 the Unit manager will audit Peritoneal Dialysis patients 5 times weekly for 4 weeks, twice weekly for 4 weeks, then weekly for 2 months to assure Licensed staff are appropriately maintaining the barrier. Director of Nursing will report findings to the Quality Assurance Performance Improvement committee monthly to monitor the system.</p>	

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F 441	Continued From page 20 resolved the finding.	F 441			

Bureau of Facility Standards

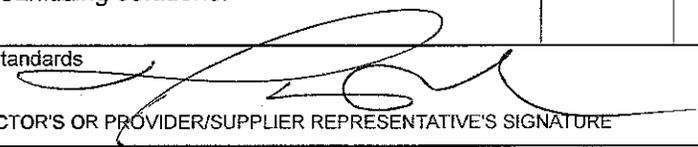
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001380</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/12/2013</b>
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C 000	16.03.02 INITIAL COMMENTS  The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the State licensure survey of your facility.  The surveyors conducting the survey were: Karen Marshall, MS, RD, LD, Team Coordinator Bradley Perry, BSW, LSW Karla Gerleve, RN	C 000	Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies  C 125 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F242.	
C 125	02.100,03,c,ix Treated with Respect/Dignity  ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please refer to F242 as it related the resident's preference to be addressed by her middle name not her first name.	C 125	C325 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F371.  C362 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F253.	
C 325	02.107,08 FOOD SANITATION  08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F371 as it related to the ppm of 1 of 2 sanitizing solutions.	C 325	C669 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F441.  C779 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F279.	

FACILITY STANDARDS

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Bureau of Facility Standards

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



TITLE

*Administrator*

(X6) DATE

*5-6-2013*

Bureau of Facility Standards

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C 362	Continued From page 1	C 362		
C 362	02.108,07,a Interior Surfaces Kept Clean & Sanitary  a. Floors, walls, ceilings, and other interior surfaces, equipment and furnishing shall be kept clean, and shall be cleaned in a sanitary manner. This Rule is not met as evidenced by: Refer to F253 regarding bathroom and shower cleanliness.	C 362	C782 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F280.	
C 669	02.150,03 PATIENT/RESIDENT PROTECTION  03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Please refer to F441 as it related to protecting a resident from the potential transmission of disease causing pathogens.	C 669		
C 779	02.200,03,a,i Developed from Nursing Assessment  i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Please refer to F279 as it related to a resident's care plan.	C 779		
C 782	02.200,03,a,iv Reviewed and Revised  iv. Reviewed and revised as needed to reflect the current needs of	C 782		

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C 782	Continued From page 2  patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 regarding care plan revisions.	C 782			



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

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

April 30, 2013

FILE COPY

Tim J. Needles, Administrator  
Life Care Center of Boise  
808 North Curtis Road  
Boise, ID 83706

Provider #: 135038

Dear Mr. Needles:

On **April 12, 2013**, a Complaint Investigation survey was conducted at Life Care Center of Boise. Karen Marshall, R.D., Bradley Perry, L.S.W. and Karla Gerleve, R.N. conducted the complaint investigation. The complaint was investigated in conjunction with an annual Recertification and State Licensure survey.

Financial statements for the identified resident and four other residents were reviewed. Copies of checks made out to the resident were reviewed. The surveyors reviewed the resident's dedicated funds account detail on the facility's computer software program.

Interviews were conducted with the Administrator and the Business Office Manager.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00005476**

ALLEGATION #1:

The complainant stated an identified resident's funds were placed in the facility's general fund.

Tim J. Needles, Administrator  
April 30, 2013  
Page 2 of 2

FINDINGS:

A check in amount of one thousand, nine hundred, twenty dollars and no cents (\$1,920.00) dated October 11, 2011, in the identified resident's name came to the facility. The facility established a separate account for the resident to deposit the funds. The resident's facility account was credited the money. Statements on November 20, 2011, December 20, 2011, January 20, 2012 and February 20, 2012, were sent to the resident, each showed a credit of one thousand, nine hundred, twenty dollars and no cents (\$1,920.00). On or about March 23, 2012, the Business Office Manager received a telephone call requesting payment of funds. The Business Office Manager contacted the corporate office and the corporate office issued the resident a check in the amount of one thousand, nine hundred, twenty dollars and no cents on March 23, 2012.

Federal guidelines state the facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. It also states the system must preclude any commingling of resident funds with facility funds.

It was determined the facility was in compliance with federal guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor  
Long Term Care

LKK/dmj



IDAHO DEPARTMENT OF  
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April 30, 2013

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Life Care Center of Boise  
808 North Curtis Road  
Boise, ID 83706

Provider #: 135038

Dear Mr. Needles:

On **April 12, 2013**, a Complaint Investigation survey was conducted at Life Care Center of Boise. Karen Marshall, R.D., Karla Gerleve, R.N. and Bradley Perry, L.S.W. conducted the complaint investigation. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey.

The closed records of the identified resident and another sampled resident were reviewed for transfers.

Interviews were conducted with station two's Licensed Nurse (LN), Dietary Manager, Licensed Social Worker, Resident Support Services, the LN who was on duty at the time of the resident's discharge and the Director of Nursing (DoN).

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00005710**

**ALLEGATION #1:**

The complainant stated an identified resident was discharged without due cause.

**FINDINGS:**

The identified resident exhibited verbal outbursts more than once. The day the resident left the

Tim J. Needles, Administrator  
April 30, 2013  
Page 2 of 3

facility; the resident had a verbal altercation with another resident, while in the facility's dining room and was verbally threatening to the facility's population as a whole. An LN had to intervene and redirect the resident.

The LN on duty at the time the resident left the facility and the DoN both said that in addition to the resident verbally threatening the population as a whole, there was concern for the resident's health. The resident's face was bright red, and he was breathing extremely heavily. The LN called the resident's physician, explained to the physician what happened and the resident's appearance. The physician ordered the facility to transfer the resident to a local hospital emergency room (ER) for a seventy-two (72) hour psychiatric evaluation.

The LN called the local emergency medical technicians (EMTs) and a close family member of the resident. When the EMTs arrived, the resident refused to leave the facility. When the family member arrived, the EMTs were still in the facility and the resident agreed to allow the family member to drive him to the local hospital ER.

According to the facility staff, the facility offered to drive the resident to the local hospital ER; however, the resident refused and adamantly stated he would not be returning to the facility.

The resident left the facility accompanied by the family member.

Federal guidelines require facilities to permit each resident to remain in the facility and not transfer the resident from the facility unless the transfer is necessary for the resident's welfare, the resident's needs cannot be met in the facility, the safety of individuals in the facility are endangered and the health of individuals in the facility would otherwise be endangered.

It was determined the facility was in compliance with federal guidelines.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

The complainant stated that the identified resident left the facility to go to a local hospital Emergency Room (ER) without any paperwork. The complainant stated a family member had to return to the facility to obtain the resident's paperwork; such as medications and discharge summary.

#### FINDINGS:

The LN stated that after conferring with the resident's physician, she called the local emergency medical technicians (EMTs) and a close family member of the resident. The LN stated she

Tim J. Needles, Administrator  
April 30, 2013  
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prepared a Resident Transfer Record and obtained copies of the resident's current medication administration record, physician's order for the seventy-two hour (72) transfer, treatment record, the most recent nurses' notes, the resident's history and physical and recent laboratory results. The LN said the intent of preparing and obtaining these documents was to give the paperwork to the EMTs who would provide the local hospital ER with the paperwork, once the EMTs delivered the resident to the ER.

However, when the EMTs arrived, the LN said the resident refused to leave the facility. When the family member arrived, the resident agreed to allow the family member to drive him to the local hospital ER. The LN said that as the family member and the resident were leaving the facility, she provided the family member with the resident's paperwork that was originally prepared for the EMTs to provide to the local hospital ER.

Current accepted standards of practice indicate a health care facility should provide to the receiving institution, the resident's current orders, the most recent medication administration record and other communication necessary to allow for the resident's continuity of care.

Since it is one person's word against the others, it could not be determined exactly when the appropriate paperwork was provided for the resident's discharge; however, it was determined that the paperwork had been copied and made available for discharge.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, somewhat stylized font.

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor  
Long Term Care

LKK/dmj