



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

CERTIFIED MAIL: 7007 3020 0001 4044 6871

June 6, 2013

Joe F. Rudd Jr., Administrator
Marquis Care at Shaw Mountain
909 Reserve Street
Boise, ID 83712

FILE COPY

Provider #: 135090

Dear Mr. Rudd:

On **May 24, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Marquis Care at Shaw Mountain 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 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, 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.) **Please provide ONLY ONE completion date for each federal and state tag in column X5 Complete Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION.

Joe F. Rudd Jr., Administrator
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After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 19, 2013**. Failure to submit an acceptable PoC by **June 19, 2013**, may result in the imposition of civil monetary penalties by **July 9, 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.

Joe F. Rudd Jr., Administrator
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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*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 24, 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, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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)

Joe F. Rudd Jr., Administrator
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2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **June 19, 2013**. If your request for informal dispute resolution is received after **June 19, 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,

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
Enclosures

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

PRINTED: 06/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2013
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NAME OF PROVIDER OR SUPPLIER MARQUIS CARE AT SHAW MT	STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification and complaint investigation of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW Karla Gerleve, RN Arnold Rosling RN, BSN, QMRP</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CAD=Coronary Artery Disease CNA = Certified Nurse Aide CVA=Cerebral Vascular Accident DNS = Director of Nursing Services EMR= Electronic Medical Record IDHW= Idaho Department of Health & Welfare LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MI= Myocardial Infarction PO=By mouth PRN = As Needed Q=Every RN=Registered Nurse R/T=Related to TAR=Treatment Administration Record TID=Three times a day UCM=Unit Care Manager</p>	F 000	<p>This plan of correction constitutes the facility's written allegation of compliance for the deficiencies cited in the CMS 2567. However, the submission of this plan is not an admission that a deficiency exists. The Plan of Correction is prepared and executed solely because it is required by federal and state law. This response and Plan of Correction does not constitute an admission or agreement by the provider of the facts alleged or set forth in the statement of deficiencies.</p> <p>Survey Definitions:</p> <p>"Daily" as used in Monitors = Monday - Friday FH = Friendship House IDT = Interdisciplinary Team LN = Licensed Nurse LSW = Licensed Social Worker PASRR - Pre-Admission Screening and Resident Review RCM = Resident Care Manager. Also referred to as UCM in 2567. UDA = User Defined Assessment (Incident Report)</p>	
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in</p>	F 241	<p>Corrective Action:</p> <ol style="list-style-type: none"> Catheter bag for Resident #7 has been replaced with a model that has a built in cover. Care Plan for Resident #7 has been updated to include monitoring of leg bag covering. 	

RECEIVED
JUN 19 2013
FACILITY STANDARDS

RECEIVED
JUN 19 2013
DIV. OF MEDICAID

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>J. F. [Signature]</i>	TITLE Administrator	(X6) DATE 6/19/2013
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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 241	<p>Continued From page 1 full recognition of his or her individuality.</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 ensure a resident's dignity was protected related to the use of a urinary catheter leg bag. This had the potential of causing low self-esteem and psychological harm to the resident. This was true for 1 of 3 (#7) sampled residents reviewed for indwelling urinary catheters.</p> <p>Resident #7 was admitted to the facility on 12/5/12 with diagnoses of diabetes, urinary retention, incontinence, and dementia.</p> <p>Resident #7's 12/12/12 Admission MDS documented in part: -moderately impaired cognitive skills for daily decision making -indwelling catheter -occasionally incontinent of bowel</p> <p>Resident #7's 4/7/13 Care Plan documented a focus area of "Indwelling catheter characterized by inability to control urination or bowel movements related to urinary retention." It documents interventions in part: -"utilize leg bag as opposed to foley bag" -"catheter care with soap & water every shift" -"secure catheter tubing to prevent pulling/trauma" NOTE: This focus area did not indicate the urinary catheter leg bag should be covered and/or kept out of sight to others.</p>	F 241	<p>Identification:</p> <ol style="list-style-type: none"> All residents in using catheter bags are identified as potentially being affected by this deficiency. An audit of other residents with catheter bags has been completed and no further issues were found. <p>Systemic Changes: Nursing staff received in-service regarding resident dignity, specifically with ensuring that catheter leg bags are covered appropriately, and documenting residents refusals to keep catheter bags from view of others</p> <p>Monitor:</p> <ol style="list-style-type: none"> RCMs to conduct audit of residents with catheter leg bags for appropriate placement and exposure to others. This audit to begin on 06/19/2013 and will continue at the following frequency: <ul style="list-style-type: none"> Weekly x four (4) weeks Q two (2) weeks x four (4) weeks Monthly x three (3) months DNS to review audits and report findings to QA Committee. 	6/25/2013

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F 241	Continued From page 2 On 5/20/13 at 1:30 pm and 5/21/13 at 7:50 am while sitting at the dining table in Friendship House, Resident #7 was observed with a urinary catheter leg bag, entirely below her pant line. The bag was uncovered and strapped around her ankle where it was visible to others. On 5/21/13 at 12:15 pm, Resident #7 was accompanied by her son down the hall to the dining room on Friendship House. Her urinary catheter leg bag g was down around her ankle and was visible to others. Then again at 2:35 pm the same day, Resident #7 was observed ambulating out of her room down the hall toward the dining room on Friendship House with the uncovered urinary catheter leg bag resting on top of her foot. On 5/22/13 at 8:00 am and 5/23/13 at 8:00 am at the dining table in Friendship House, Resident #7 was observed with her uncovered urinary catheter leg bag down below her pant line near her ankle in full view to others. On 5/22/13 at 10:45 am, the Friendship House UCM #5 was asked about Resident #7's urinary catheter leg bag being visible to others. The UCM #5 replied, "She moves the leg bag sometimes and she sits where her pant leg goes above the bag." On 5/23/13 at 2:10 pm, the Administrator and DNS were notified of the dignity issue of having the urinary catheter leg bag being visible to others. No documentation was provided that resolved this issue.	F 241			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	Continued on p. 4		

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F 280	<p>Continued From page 3</p> <p>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.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure resident care plans addressed resident needs related to pain and the application of TED hose (also known as compression stockings). This was true for 2 of 13 sampled residents (#4 & 7) whose care plans were reviewed. This created the potential for unmet pain needs and a possible embolism (blood clot). Findings included:</p> <p>1. Resident #4 was admitted to the facility on 1/12/12 with diagnoses of bipolar disorder, macular degeneration, Menier's disease (inner</p>	F 280	<p>Corrective Action:</p> <ol style="list-style-type: none"> Care Plan for Resident #4 has been updated to include staff interventions, with medication and without medication, to address pain and gastrointestinal issues. Care Plan for Resident #7 has been updated with regard to Physician Order to wear TED hose as prescribed, and the resident's possible refusal to wear them. <p>Identification: All residents are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes:</p> <ol style="list-style-type: none"> Nursing and IDT staff have received in-service regarding completion and updating of comprehensive care plans, which also includes the resident's possible refusal of cares. <p>Monitor:</p> <ol style="list-style-type: none"> Care Plan updates will continue to be reviewed daily during the facility's 24 Hour Report process. RCMs to conduct audit of random residents Care Plan to ensure they are complete, comprehensive, and individualized. Audits to begin on 6/19/2013 and will continue at the following frequency: <ul style="list-style-type: none"> Weekly x four (4) weeks Q two (2) weeks x four (4) weeks Monthly x three (3) months DNS to review audits and report findings to QA Committee. 	6/25/2013	

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F 280	<p>Continued From page 4</p> <p>ear disorder that affects hearing and balance and causes episodes of dizziness, nausea and hearing loss), esophageal reflux, dementia, and anxiety.</p> <p>Resident #4's most recent 1/19/13 Annual MDS documented in part: -BIMS Score of 3 (Cognitively impaired) -Received scheduled pain medication -Received non medication intervention for pain -Yes, Have you had pain or hurting at any time in the last 5 days -Vocal complaints and facial expressions of pain -Indicator of pain or possible pain observed 1 to 2 days The CAA (Care Area Assessment) Summary MDS Section V documented pain was triggered and would be care planned. The actual 2/2/13 CAA stated pain would be care planned.</p> <p>Resident #4's most recent 4/21/13 Quarterly MDS documented in part: -Moderately impaired for cognitive skills for daily decision making -Yes, received scheduled pain medication regimen. -Frequently experienced pain -Moderate, resident's verbal descriptor of pain.</p> <p>Resident #4's April & May 2013 MARs documented in part: -Acetaminophen 325 mg (2 tablets) every 6 hours for generalized pain - discontinued on 5/16/13 -Ibuprofen 400 mg tablet every 6 hours PRN -Ranitidine HCL Capsule 15 mg twice a day for esophageal reflux -Tums (Calcium Carbonate antacid) chewable tablet 500 mg by mouth for GI (gastrointestinal)</p>	F 280			

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F 280	<p>Continued From page 5</p> <p>discomfort or distress, 1-2 tablets PO every 2-4 hours PRN (as needed) not to exceed 7000 mg in 24 hours</p> <p>-APAP Tablet 650 mg 4 x a day, related to generalized pain - started on 5/16/13</p> <p>Resident #4's care plan did not have a focus area for pain. The care plan did not address the scheduled pain medication or non-medication interventions for pain or how these would be monitored. The care plan did not include how staff should intervene in the event that non-medication interventions were ineffective.</p> <p>On 5/20/13, Resident #4 was moved from the 300 Hall to the Friendship House. Earlier in the day, during the initial tour of the facility at 9:30 am, the 300 Hall UCM #6 said Resident #4 experienced pain. She indicated the resident also had problems with indigestion and esophageal reflux and Resident #4's pain could be related to some of her GI issues. UCM #6 also indicated Resident #4 would be moved over to the Friendship House due to her wandering concerns.</p> <p>On 5/22/13 at 10:45 am, the Friendship House UCM #5 was asked about Resident #4's pain, and where that issue was addressed on the resident's care plan. The RCM replied, "I'm not finding it on the care plan where I think it should be. I don't know [Resident #4's name] that well. She just moved over here Monday."</p> <p>On 5/23/13 at 2:10 pm, the Administrator and DNS were notified of the care plan issue for pain for Resident #4. No documentation was provided which resolved this issue.</p>	F 280			

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F 280	Continued From page 6 2. Resident #7 was admitted to the facility on 12/5/12 with diagnoses of dementia, edema, hypertension, diabetes, and urinary retention. Resident #7's May 2013 Medication Review Report (Active Orders/Recapitulation) read, "TED hose on AM and Off PM." It documented a start date of 3/1/13. Resident #7's March, April, and May 2013 TARs read, "TED hose on AM and PM, Start date 03/01/2013." The TARs documented the treatment was provided twice daily and was initialed as completed with the exception of 5 days during the three month period. Resident #7's 4/7/13 Care Plan documented focus areas of concerns in part: -"Requires assistance for bathing, personal hygiene(combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hand and perineum) related to: CVA, cognitive impairment, poor coordination/balance" -"Requires assistance for dressing related to CVA, cognitive deficit" -"Potential for injury related to anti-thrombolytic therapy r/t CVA" -"Impaired cardiac function related to: CAD, history of MI, hypertension" NOTE: None of the focus areas or interventions on the care plan mentioned TED hose. On 5/20/13 at 2:00 pm, 5/21/13 at 7:50 am and 2:35 pm, and 5/22/13 at 8:00 am, Resident #7 was observed in the Friendship House without TED hose on.	F 280			

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F 280	Continued From page 7 There was no documentation in the EMR that Resident #7 refused or removed the TED hose on 5/20/13 or 5/21/13. There was documentation on 5/22/13 the resident refused the TED hose, but this was after UCM #5 was notified of the observation of the resident without them on. On 5/22/13 at 10:45 am, UCM #5 confirmed Resident #7 had a physician's order for TED hose.	F 280			
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--	F 285	Corrective Action: As noted in the 2567, the PASRR for the residents identified were corrected on 6/25/2012. The facility appropriately identified the incorrect form used by Hospice and the missing level II from the hospital upon resident admission to facility. Facility contacted the state PASRR agency to obtain correct forms and to ensure follow up completed, as noted in the 2567. Additionally, facility has been proactive in providing PASRR education to other providers based on the newly released Idaho PASRR forms and requirements, to ensure that ongoing processes were in place. Not only improving PASRR compliance for the facility, but benefiting other providers associated with the Hospice and Hospitals. Identification: All residents admitting to the facility are identified as possibly being affected by this deficiency. Systemic Changes: IDT received in-service and review of the State's PASRR requirements.		

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F 285	<p>Continued From page 8</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a Level II pre-admission screening and resident review (PASRR) was completed prior to admitting residents to the facility. This was true for 2 of 2 closed records sampled (#s 14 and 15). This created the potential for residents to not receive required Level II services to meet their mental health needs. Findings include:</p> <p>1. Resident #14 was admitted to the facility on 6/22/12 with diagnoses of prostate cancer, diabetes, anxiety and congestive heart failure.</p> <p>The facility received a Level I PASRR from the hospice agency dated 6/21/12. The agency used a PASRR form that had been discontinued so the facility generated the correct form on the day of</p>	F 285	<p>Monitor:</p> <ol style="list-style-type: none"> 1. LSW or designee to review each PASRR prior to resident admission. Admission will not be confirmed, unless appropriate PASRR has been sent and verified by facility. 2. DNS or designee to conduct audit of PASRR review to ensure compliance. Audit to begin on 6/19/2013 and will continue at the following frequency: <ul style="list-style-type: none"> • Weekly x four (4) weeks • Q two (2) weeks x four (4) weeks • Monthly x three (3) months 3. Administrator to review audits and report findings to QA Committee. 	6/25/2013	

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F 285	Continued From page 9 admission. The resident triggered for a Level II PASRR to be completed. This was done on 6/25/12, three days after admission. The DNS and social service designee (SSD) were interviewed on 5/22/13 at 1:45 p.m. The SSD indicated that they initiated the correct form after the resident was admitted to the facility. She was aware of the new form but the Hospice agency was not. The resident expired on 9/1/12. No further information was provided. 2. Resident #14 was admitted to the facility on 6/21/12 with diagnoses of congestive heart failure, depressive disorder, and atrial fibrillation. The resident's Level I PASRR, dated 6/22/12, triggered the need for a Level II PASRR to be completed. This was not completed until 6/25/12. The DNS and SSD were interviewed 5/22/13 at 1:45 p.m. The SSD said there was some confusion with Level II PASRR criteria by the discharge planner at a local hospital. The discharge planner at the hospital completed the form but when IDHW was contacted for the Level II PASRR, there was a delay in completing it. The resident would have had to stay in the hospital for three more days while waiting for IDHW to allow her to go to the nursing home.	F 285			
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309	Continued on p. 11		

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F 309	<p>Continued From page 10 and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined that the facility failed to ensure physician's orders were followed and hospice services were effectively coordinated. This was true for 2 of 13 sampled residents (#7 and 13) and 3 random residents (#s 17, 18, and 19). The failure to follow physician's orders and ensure coordination of hospice services of care had the potential to negatively impact residents' health. Findings include:</p> <p>NOTE: Interpretive Guidance for F 309 states: The facility's services must be consistent with the plan of care developed in coordination with the hospice (i.e., the hospice patient residing in a facility should not experience any lack of services or personal care because of his/her status as a hospice patient); and the facility must offer the same services to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit. As such, the facility continues responsibility for providing the resident's overall care and comfort. For example, the facility should continue to provide general medical and nursing care, assist with ADLs, administer medications, give personal care, provide activities, if desired, and maintain the cleanliness of the resident's room.</p> <p>1. Resident #13 was admitted to the facility on 12/9/08 with diagnoses of unspecified anemia, senile dementia, secondary parkinsonism and</p>	F 309	<p>Corrective Action:</p> <ol style="list-style-type: none"> Resident # 7 – See F 280 Care Plans for Residents #13, 17, 18, and 19 have been updated to reflect coordination of services with hospice providers, specifically with regard to the resident's bathing needs. End of Life Care Plans to reflect services to be provided by hospice staff. Care Plans will also reflect that facility staff will continue to provide additional bathing services to maintain the resident's hygiene, if desired by or requested by resident. <p>Identification: All hospice residents are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes:</p> <ol style="list-style-type: none"> Nursing Staff have received in-service regarding coordination of care with Hospice and changes in Care Plans to reflect resident needs. <p>Monitor:</p> <ol style="list-style-type: none"> DNS to conduct audit of random Residents Hospice Care Plans to ensure compliance. Audits to begin on 6/19/2013 and will continue at the following frequency: <ul style="list-style-type: none"> Weekly x four (4) weeks Q two (2) weeks x four (4) weeks Monthly x three (3) months Administrator to review audits and report findings to the QA Committee. 	6/25/2013

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F 309	<p>Continued From page 11 depressive disorder.</p> <p>The most recent Quarterly MDS assessment, dated 4/19/13, documented the resident:</p> <ul style="list-style-type: none"> - had short and long term memory problems, - had moderate impairment for decision making skills, - require assistance of one to two staff for transfers, dressing, eating, personal hygiene and bathing, and - was frequently incontinent of bowel and bladder. <p>Resident #13's facility care plan for Resident Care Standards, dated 9/2/10 and revised 1/1/12, documented a goal of, "Resident will receive quality care per [facility]." The interventions were:</p> <ul style="list-style-type: none"> - Bath/shower - CNA 2X/WK. [bath or shower to be given 2 times a week by the CNA], and - Care provided per resident Care Plan Kardex & standard of care. CNA QShift. <p>NOTE: The Care Plan Kardex is the CNA assignment sheets that are in the EMR.</p> <p>The hospice care plan documented their staff would bathe the resident two times a week. According to the resident's bathing records for April and May 2013, the resident received a bath twice a week. The bathing records documented that hospice agency staff gave the baths.</p> <p>CNA #7 and CNA #8 were interviewed on 5/23/13 at 9:00 a.m. They said they did not bath any residents receiving hospice services because the hospice CNAs gave the baths.</p> <p>Facility staff did not assist the resident with a bath twice a week as care planned.</p>	F 309			

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F 309	<p>Continued From page 12</p> <p>2. Resident #17 was admitted to the facility on 7/10/12 with diagnoses of diabetes mellitus without complications, cerebrovascular accident (CVA) and post traumatic seizures.</p> <p>The most recent Significant Change MDS dated 2/2/13, documented the resident:</p> <ul style="list-style-type: none"> - had short and long term memory problems, - had moderate impaired decision making ability, - required extensive assistance for transfers, dressing, personal hygiene and bathing. <p>The facility care plan had a focus of Resident Care Standards, dated 7/17/12. Interventions included:</p> <ul style="list-style-type: none"> - Bath/Shower, CNA, 2X/Wk. - Care provided per resident Care Plan Kardex & standard of care, CNA, QShift. <p>The hospice care plan documented their staff would bathe the resident two times a week. According to the resident's bathing records for April and May 2013, the resident received a bath twice a week. The bathing records documented that hospice agency staff gave the baths. Facility staff did not assist the resident with a bath twice a week as care planned.</p> <p>3. Resident #18 was admitted to the facility on 6/9/11 with diagnoses of senile dementia unspecified, depressive disorder and anxiety state.</p> <p>The most recent Significant Change MDS, dated 3/8/13, documented the resident;</p> <ul style="list-style-type: none"> - had severe cognitive impairment with a BIMS of 2, - required extensive assistance for transfers, 	F 309			

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F 309	<p>Continued From page 13</p> <p>dressing, eating, personal hygiene and bathing, and</p> <p>- was frequently incontinent of urine.</p> <p>The resident had an order for hospice service dated 2/28/13. The facility care plan had a focus dated 3/4/13 that documented, "End of life care related to diagnosis of End Stage Dementia." The interventions were:</p> <ul style="list-style-type: none"> - Coordinate aspects of resident's care with Hospice and MD, - DME per hospice care plan, - Hospice services provided by: (name of agency). <p>The facility care plan had a focus of "Resident Care Standards" dated 6/8/11. Interventions included:</p> <ul style="list-style-type: none"> - Bath/Shower, CNA, 2X/Wk. - Care provided per resident Care Plan Kardex & standard of care, CNA, QShift. <p>The hospice care plan documented their staff would bathe the resident two times a week. According to the resident's bathing records for April and May 2013, the resident received a bath twice a week. The bathing records documented that hospice agency staff gave the baths. Facility staff did not assist the resident with a bath twice a week as care planned.</p> <p>4. Resident #19 was admitted to the facility 5/6/13 with diagnoses of ulcerative colitis and adult failure to thrive.</p> <p>The most recent Admission MDS assessment, dated 5/13/13, documented the resident:</p> <ul style="list-style-type: none"> - had severe cognitive impairment - BIMS = 7, 	F 309			

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F 309	<p>Continued From page 14</p> <p>- needed extensive assistance for transfers, dressing, personal hygiene, and bathing</p> <p>The facility care plan had a focus of Resident Care Standards, dated 5/6/13. Interventions included:</p> <ul style="list-style-type: none"> - Bath/Shower, CNA, 2X/Wk. - Care provided per resident Care Plan Kardex & standard of care, CNA, QShift. <p>The hospice care plan documented their staff would bathe the resident two times a week. According to the resident's bathing records for April and May 2013, the resident received a bath twice a week. The bathing records documented that hospice agency staff gave the baths. Facility staff did not assist the resident with a bath twice a week as care planned.</p> <p>The DNS was interviewed 5/23/13 at 1:40 p.m. about the coordination of care and the care plan information. The DNS did indicate that hospice staff attended the care conferences for residents. No further information was obtained.</p> <p>5. Resident #7 was admitted to the facility on 12/5/12 with diagnoses of dementia, edema, hypertension, diabetes, and urinary retention.</p> <p>Resident #7's 12/12/12 Admission MDS documented in part:</p> <ul style="list-style-type: none"> -Moderately impaired cognitive skills -Rarely/never understood -Rarely/never understands others -Rejection of care occurred 1-3 days -Wandering occurred 4 to 6 days, but less than daily -Required assistance of one person for dressing 	F 309			

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F 309	<p>Continued From page 15</p> <p>-Indwelling catheter</p> <p>NOTE: Resident #7's primary language was a language other than English and only understood some basic English words.</p> <p>Resident #7's 3/14/13 Quarterly MDS documented in part:</p> <ul style="list-style-type: none"> -Sometimes is understood -Sometimes understands -No rejection of care present -Wandering occurred 1 to 3 days -Required extensive assistance of one person for dressing -Indwelling catheter <p>Resident #7's current May 2013 Medication Review Report (Active Orders/Recapitulation) read, "TED hose on AM and Off PM." It documented a start date of 3/1/13. NOTE: TED hose are also known as compression stockings.</p> <p>Resident #7's March, April, and May 2013 TARs read, "TED hose on AM and PM, Start date 03/01/2013." The TARs documented the treatment was provided twice daily and was initialed off as completed with the exception of 5 days during the three month period. The days the TED hose were refused or removed by Resident #7 were documented as follows:</p> <ul style="list-style-type: none"> -March 18 2013, refused -April 8 2013, refused; April 17 2013, resident took them off, and April 30, 2013, resident took them off. -May 22 2013, refused. <p>Resident #7's 4/7/13 Care Plan documented focus areas of concerns in part:</p>	F 309			

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F 309	<p>Continued From page 16</p> <p>- "Requires assistance for bathing, personal hygiene (combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hand and perineum) related to: CVA, cognitive impairment, poor coordination/balance"</p> <p>- "Requires assistance for dressing related to CVA, cognitive deficit"</p> <p>- "Potential for injury related to anti-thrombolytic therapy r/t CVA"</p> <p>- "Impaired cardiac function related to: CAD, history of MI, hypertension"</p> <p>NOTE: None of the focus areas on the care plan mentioned TED hose.</p> <p>On 5/20/13 at 2:00 pm, 5/21/13 at 7:50 am and 2:35 pm, and 5/22/13 at 8:00 am, Resident #7 was observed in the Friendship House without TED hose on.</p> <p>NOTE: There was no documentation Resident #7 refused or removed the TED hose on 5/20/13 or 5/21/13. There was documentation on 5/22/13 the resident refused the TED hose, but this was after the UCM #5 was notified of the observation of the resident without them on.</p> <p>On 5/22/13 at 10:45 am, UCM #5 was asked why Resident #7 was observed without TED hose, on the above days and times. The UCM #5 stated Resident #7 would sometimes take the TED hose off and the staff would put them back on.</p> <p>NOTE: Resident #7's Care Plan and MDS documented the resident required assistance with many ADLs, including dressing. The MDS documented, "No rejection of care present." This resident also had a urinary catheter leg bag which was observed down around the resident's ankle which would appear more difficult to remove the TED hose once they were on (Refer to F241).</p>	F 309		

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F 309	Continued From page 17	F 309			
F 314 SS=G	<p>On 5/23/13 at 2:10 pm, the Administrator and DNS were notified of the issue of TED hose not being provided to Resident #7. No documentation was provided that resolved this issue.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure residents did not acquire pressure sores for 2 of 3 residents sampled for pressure sores (#3 & #9). Resident #3 was harmed when he acquired three successive Stage II pressure sores on his upper right thigh and the facility failed to provide appropriate interventions after the first two sores to prevent a third sore from developing. Resident #9 was harmed when he acquired a Stage II pressure sore on his right ischial tuberosity and an unstageable blister on his right heel which healed and then reoccurred. Findings include:</p> <p>1. Resident #3 was admitted to the facility on</p>	F 314	<p>We are respectfully submitting a request for Informal Dispute Resolution and requesting this tag be removed from the 2567.</p> <p>Corrective Action:</p> <ol style="list-style-type: none"> Care Plan for Resident #3 has been updated to include the following interventions: <ul style="list-style-type: none"> "Skin Prep" product to be applied to skin areas that areas that are assessed to be "at risk". Facility changed catheter bag strap product which may reduce potential for skin issues. Current Assessment, treatment, and Care Plan for Resident #9 have been reviewed and are appropriate for current wound status. Resident #9 is being followed by [REDACTED] MS, RN, NP-C from [REDACTED] on a weekly basis. He has reviewed assessments, plan of care, and treatment of wounds and has noted all to be appropriate for the current wound status. Prevalon Boots being applied as per Resident #9's Care Plan. <p style="text-align: right;">Continued on p. 19</p>		

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F 314	<p>Continued From page 18</p> <p>5/11/12 and readmitted on 12/9/12 with multiple diagnoses including sepsis, urinary tract infection (UTI), and muscle weakness.</p> <p>The resident's Medicare 5 day MDS dated 12/16/12, coded the resident as: *Having an indwelling catheter. *Moderately cognitively impaired. *Does not have pressure sore.</p> <p>The resident's Care Plan (CP) dated 12/9/12, documented under Interventions for the Focus of Resident Care Standards, "Weekly Skin at Risk Assessment."</p> <p>The resident's CP dated 12/11/12, documented under Interventions for the Focus of Potential to Restore Function: Foley Catheter due to Urinary Retention, "Maintain closed drainage system/secure catheter tubing to prevent pulling/trauma..."</p> <p>The resident's CP dated 5/11/12, documented under Interventions for the Focus of Resident Skin Impairment, "Pressure reduction on bed" and "Pressure reduction on Chair: w/c (wheelchair) cushion."</p> <p>The resident's Skin/Wound Integrity Admission Assessment dated 12/9/12 documented the resident did not have pressure sores or blisters. The assessment also documented under Pressure Ulcer Definitions, "3. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister."</p>	F 314	<p>Identification: All residents are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes:</p> <ol style="list-style-type: none"> 1. LN staff to receive in-service regarding skin care policy and procedure. 2. Nursing staff to receive in-service regarding following care plan interventions 3. Consultation visits by [REDACTED], MS, RN, NP-C form [REDACTED] on weekly basis. 4. Continue to review UDA, skin events, during facility 24 Hour Report process. <p>Monitor:</p> <ol style="list-style-type: none"> 1. RCMs to conduct audit of random resident's Care Plans, specifically the Skin Focus Area to ensure compliance. Audits to begin on 6/19/2013 and to continue at the following frequency: <ul style="list-style-type: none"> • Weekly x four (4) weeks • Q two (2) weeks x four (4) weeks • Monthly x three (3) months 2. Skin Event UDA will continue to be reviewed daily in the facility 24 Hour Report process. 3. DNS to review audits and report findings to the QA Committee 	6/25/2013

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/24/2013
NAME OF PROVIDER OR SUPPLIER MARQUIS CARE AT SHAW MT		STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712		
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F 314	<p>Continued From page 19</p> <p>The resident's Progress Notes dated 12/11/12 at 4:03 PM and signed by RN#2, documented, "Blister found to residents right upper thigh by groin area during cath[eter] care this shift. Blister in [sic] unopened, fluid filled, 1.5 cm x (by) 1 cm. Covered area with clear film dressing and faxed MD (Medical Director)...Updated care plan and TAR. Resident put on alert charting. Will continue to monitor."</p> <p>The resident's Skin Event Assessment dated 12/11/12 and signed by UCM #1 on 12/14/12, documented in the Conclusion/Investigative Findings section, "...Catheter tubing likely caused blister due to rubbing against skin. Resident does use a catheter securing device on his leg, which is his right leg. Skin is thin and fragile due to age. Resident hasn't had other blisters in the past due to catheter though on 10/17/12, he did develop an abrasion on his leg which was thought to be caused by catheter port. Will treat as ordered by MD and monitor for s/sx (signs and symptoms) of malhealing. Will continue with current POC (plan of care) for catheter use as ordered by MD." NOTE: The pressure sore was resolved on 1/1/13.</p> <p>On 12/18/12 a new blister was found on the resident's upper right thigh near the groin area and the resident's Skin Event Assessment dated 12/18/12 and signed by UCM #1 on 12/21/13, documented: *The Skin Issue section, "Size 1.2 x 1.2 cm...Blister is intact, has serous fluid in it." *The form documented a history of a similar issue was found. *The Preliminary Findings section, "Resident currently has another blister approx[imately] 6 cm</p>	F 314		

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F 314	<p>Continued From page 20</p> <p>away from this blister. It may have been caused by his catheter rubbing against his skin" and "Placed clear dressing over blister. No changes to care plan at this time."</p> <p>*The Conclusion/Investigative Findings section, "Blister caused by catheter tubing. Foley catheter is in place due to urinary retention. Resident has another blister to R (right) thigh which was noted on 12/11/2012. CP includes intervention to secure catheter tubing and resident is compliant with this. Other than 12/11/12 blister, no hx (history) of blisters noted r/t (related to) catheter. Will treat as ordered by MD and monitor for signs of malhealing." Note: The pressure sore was resolved on 1/1/13.</p> <p>On 1/8/13 a new blister was found on the resident's upper right thigh near the groin area and the resident's Skin Event Assessment dated 1/8/13 and signed by UCM #1 on 1/11/13, documented:</p> <p>*The Skin Issue section, "Size .5 x .5 cm...Blister itself is yellowish in color & fluid filled."</p> <p>*The form documented a history of a similar issue was found.</p> <p>*The Conclusion/Investigative Findings section, "This is the third blister that resident has had to his right thigh r/t catheter. Previous blisters were noted on 12/11/12 and 12/18/12. Resident has been using an adhesive leg strap that "tapes" to the leg and it is likely that strap doesn't hold catheter tubing off of leg well enough. Resident previously used a Velcro strap, though this has not been available in the facility, and no hx of blisters noted until recently. A request has been made to central supply to order these Velcro straps as when in use, resident didn't develop blisters [sic]." Note: The pressure sore was</p>	F 314			

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F 314	<p>Continued From page 21 resolved on 2/12/13.</p> <p>The resident's Progress Notes dated 1/15/13 at 12:07 PM and signed by RN#3, documented, "Placed new catheter strap around resident's right leg and attached catheter to strap."</p> <p>The DNS and UCM #1 were interviewed on 5/22/13 at 10:50 AM regarding the skin issues. When asked other than medical treatment and securing the catheter tubing, why the facility did not implement interventions after the first pressure sore was discovered, UCM #1 stated, "It seemed like an isolated event."</p> <p>When asked why there were no interventions after the second pressure sore was discovered, UCM #1 stated, "The adhesive strap looked like it kept it (tubing) off the skin...so we continued to use the same holder (strap)...there weren't any options."</p> <p>When asked what had caused the third pressure sore, UCM #1 stated, "After looking at it...it was the adhesive leg straps." She indicated it was the same issue with the other pressure sores as well. When asked to clarify why it took three pressure sores to finally discover the problem, the DNS stated, "If we don't have a source, what interventions do we put into place when we don't know the cause?" He also said the facility discovered their supplier switched catheter securing products from a Velcro strap to an adhesive strap.</p> <p>Although the facility medically treated the pressure sores, it failed to find and implement appropriate interventions before two more Stage II pressure sores were discovered, causing harm to the resident.</p>	F 314		

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F 314	<p>Continued From page 22</p> <p>On 5/23/13 at 2:10 PM, the Administrator and DNS were informed of the pressure sore issue. No further documentation was provided by the facility.</p> <p>2. Resident #9 was admitted to the facility on 1/26/1995 and readmitted most recently on 8/23/11. The admission diagnoses were paraplegia, depressive disorder, Encephalopathy, unspecified schizophrenia, diabetes without complications and decubitus ulcer (8/17/10).</p> <p>The most recent annual MDS assessment, dated 6/13/12, documented the resident:</p> <ul style="list-style-type: none"> - had severe memory impairment with a BIMS of 3, - required extensive assistance with transfers, dressing, eating, personal hygiene and bathing, - had a catheter, - had 2 unstageable pressure sores (M0300F1), that were not present on admission (M0300F2), - the sore had necrotic eschar tissue covering it (M0700 = 4), and - the sore measured 0.8 by 0.5 cm in size. <p>The 6/13/12 CAA Worksheet for Pressure Sores documented, "Resident has a history of multiple pressure ulcers and does remain at risk for future pressure ulcer development. Goals and interventions directed toward reduction of risk factors to be addressed in skin integrity focus. As resident does have two unstageable pressure areas on right foot, pressure focus will be addressed in resident's plan of care with goals directed toward resolution of ulcers."</p>	F 314			

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F 314	<p>Continued From page 23</p> <p>The most recent quarterly MDS assessment, dated 3/16/13, documented the resident:</p> <ul style="list-style-type: none"> - had a catheter, - did not have a pressure sore, - had moisture associated skin damage [MASD] (M1040H), and - had pressure reducing device in wheelchair and bed. <p>The resident's care plan dated 4/8/13 documented: Focus: "Resident at risk for actual skin impairment/pressure ulcer related to: History of prior pressure ulcer, diabetes, immobility, incontinence." The interventions were:</p> <ul style="list-style-type: none"> "- Do not push broda chair through doorways/over thresholds, please pull chair through instead to avoid injury to resident's feet [initiated: 3/29/12], - Ensure bedding is not touching resident's feet; ensure foot cradle is in place at all times when resident is in bed [initiated: 6/7/12], - Ensure that resident is one of the last residents up before meals and one of the first residents down after meals [initiated: 2/6/11], - Foot buddy to wheelchair to prevent injury[initiated: 6/7/12], - Foot cradle to foot of bed [initiated: 6/7/12], - Glove to left hand at all times: check for placement every 2 hours[initiated: 1/25/13], - Provide nail care once a week...[initiated: 4/3/13], - Refer to mobility plan of care for positioning [initiated: 9/9/11], - Resident to spend limited time up in wheelchair until resolution of pressure ulcers; new turning/positioning schedule until resolution of pressure ulcers, refer to schedule posted in resident's room...[initiated: 5/25/12], - Pressure reduction on bed; full air mattress 	F 314		

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F 314	<p>Continued From page 24 [initiated: 6/14/10], - Pressure reduction on chair; Keen contour cushion [initiated:6/14/10], - Float heels: Utilize Prevalon foam boots at all times to float heels [initiated: 2/6/13], - Moisture barrier to buttocks and scrotum after each incontinence episode....[initiated: 6/14/10]."</p> <p>The care plan for mobility, initiated 9/9/11, documented: "Reposition resident with assistance of 2 staff members, turn and reposition every 2 hours."</p> <p>The resident's sores that were coded on the annual MDS dated 6/13/12, were resolved by September 2012. During the survey it was found the resident had two separate areas of pressure sores. One was on the right ischial tuberosity (NOTE: Sometime described as gluteal fold in the documentation) and the other was on the right heel. NOTE: The two will be described separately below.</p> <p>a) On 9/21/12 the facility completed a Skin Event Assessment that documented the resident had a MASD of the right gluteal fold. The size was documented as: 2.5 cm x 2 cm x 0.1 cm. The wound bed was described as, "75% slough, without drainage, surrounding skin looks healthy and pink." The Preliminary Finding for the sore was: "Resident is obese, with decreased mobility. He is diaphoretic with frequent bowel incontinence. Resident also has a history of skin issues." The facility documented Risk/Contributing Factors of: "Resident is at an increased risk for skin impairment as well as for development of pressure ulcers. Resident does have a history of previous pressure ulcers, as</p>	F 314			

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F 314	<p>Continued From page 25</p> <p>well as a history of similar skin impairments in the same area as this impairment." The resident was noted to be, "Compliant with the plan of care."</p> <p>Facility Progress Notes documented a dressing change on 9/25/12 then nothing was documented about the sore until:</p> <p>On 10/2/12 at 8:04 p.m. an LN documented, "Late entry: [NOTE: no date for the late entry] Residents [sic] coccyx dressing changed. Wound seems [to] have gotten worse since last dressing change. Feces was in dressing and interrupted with [sic] healing process. Wound was cleansed well with wound cleanser and redressess[sic] with foam dressing."</p> <p>NOTE: There was no documentation provided by the facility that described the wound progress or deterioration between 10/2/12 and progress note documentation by the physician assistant (PA) on 12/31/12.</p> <p>On 12/31/12 at 1:51 pm and 1:57 pm the PA documented, "Subjective: Pt [patient] doing well overall, nursing has no concerns. Pressure ulcer on buttocks has healed, as have the ulcers on heels [with] boots and cares. Pt reports mood is happy today... Objective: skin: heel ulcers are healed, now grade 1 with some erythema of skin... Plan: 4. skin ulcers, improved w/wound care, air boots. Continue current care, special bed..."</p> <p>On 1/8/13 at 10:13 p.m. the LN documented, "...We are currently treating and monitoring an abrasion to his inner gluteal fold as well as ones to his right toes, all of which appear to be healing</p>	F 314		

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F 314	<p>Continued From page 26 without issues..."</p> <p>NOTE: It is unclear if this was the same wound that the PA documented was healed on 12/31/12 or if it was a new wound on the right gluteal fold. In addition, there was no description of the wound on the gluteal fold since the PA documented it was healed.</p> <p>On 2/22/13 at 3:07 a.m. the LN documented, "Dressing to resident's right gluteal fold became removed during peri care this shift. Wound is open with red irritated skin around. Faxed MD requesting change in dressing orders...."</p> <p>NOTE: There was no documentation about the open gluteal fold wound between 2/22/13 and 3/26/13.</p> <p>On 3/26/13 at 6:28 a.m. the LN documented, "Wound to [right] gluteal fold has macerated tissue approx 4 cm x 4 cm [with] 2 open areas. Open areas have red wound bed that has occasional bloody drainage. D/t [due to] maceration..." NOTE: The Mosby Medical Encyclopedia describes maceration as the softening and break down of skin from prolonged exposure to moisture.</p> <p>On 4/1/13 at 3:11 p.m. the LN documented, "Late entry...for 3/28/13 note that gluteal wound...area of approx. 3 x 3 [cm] of red macerated skin with a scab in middle of wound, cleansed and dressing applied. skin surrounding wound was white in color, area in center pink and viable, area outside of wound blanchable..."</p> <p>On 4/1/13 at 1:14 p.m. the LN documented, "Area</p>	F 314		

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F 314	<p>Continued From page 27</p> <p>of right gluteal, Measures at 3.2 x 3 [cm] with healthy skin surrounding, area inside pink and bloody with a noted 1.1 [cm] eschar area in middle of wound, notified RCM [UCM] and will continue to turn pt side to side...." Interpretive Guidance for F314 describes eschar is described as thick; leathery, frequently black or brown in color, necrotic (dead) or devitalized tissue that has lost its usual physical properties & biological activity.</p> <p>On 5/16/13 at 3:06 p.m. the LN documented, "Pressure ulcer to right gluteal fold assess[ed] by this nurse; pressure ulcer no longer noted to be unstageable. No slough/eschar present. Wound bed has opened to reveal stage II pressure sore measuring 2 cm x 2.5 cm. Wound edges noted with epithelial tissue accounting for approximately 10% of the wound granulation tissue comprising the remaining 90% of the wound bed..."</p> <p>On 5/21/13 at 8:30 a.m. LN#3 was observed while doing a dressing change to the sore on the right ischial tuberosity. [NOTE: This is the same sore that was identified as being located in the gluteal fold]. The sore was a stage II and measured 1.7 cm x .8 cm. It had depth, but the LN did not measure it. The sore was pink and no redness or slough was noted. The dressing was applied and the resident was positioned to the left side.</p> <p>b) A Skin Event Assessment, dated 1/28/13, documented a blister on the right heel. The blister measured 4 cm x 5 cm and was described as being, "blue, purple, fluid filled, no drainage, no s/sx [sign/symptoms] of infection, intact." The Preliminary Finding of the investigation</p>	F 314		

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F 314	<p>Continued From page 28</p> <p>documented: "unable to give possible cause...Resident has current orders to float heels in bed, foam boots when out of bed, and skin prep to heels BID [twice a day]. With that noted, pressure to heels is a possible cause." The Risks/Contributing Factors were, "Resident has a significant history of poor tissue tolerance. Resident has a history of multiple pressure ulcers. Resident is at increased risk for development of skin impairment secondary to immobility as well as obesity. Friction as well as shear continue to remain risk factors as well." The Conclusion was, "It is likely that friction is the causative factor in the development of the blister. It is likely that resident's heel rubbed against an object, likely the mattress, thereby causing the blister." The Plan of Prevention was to place a, "protective dressing over blister. Plan of care updated to include that Prevalon boots are to be worn when resident is in bed to alleviate the possibility of friction between the resident's feet and the mattress."</p> <p>On 3/22/13 at 2:28 p.m., Facility Progress Notes documented, "This nurse also assessed blister to right heel. Blister is no longer intact; pink, healthy tissue noted. Dressing to site discontinued as treatment is no longer indicated. Skin to right heel continues to appear fragile; will continue to float bilateral heels when in bed as well as apply skin prep twice daily for additional protection."</p> <p>A Skin Event Assessment, dated 4/14/13, described a blister to the right heel. It measured 4 cm by 5 cm and was a, "fluid filled blister, red and purple with some white color r/t moisture. Blister is weeping." The Risk/Contributing Factors were documented as, "Resident is at an increased risk</p>	F 314		

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F 314	<p>Continued From page 29</p> <p>for development of skin impairment. Resident does currently have an unstageable pressure ulcer to his right gluteal fold, and does have a history of previous pressure ulcers." The Conclusion/investigation Findings were, "Blister is likely the result of friction between the resident's foot and the mattress. It was noted that Prevalon foam boots were not in place which likely would have protected resident's foot from friction."</p> <p>On 5/21/13 at 11:10 a.m. LN#3 was observed to remove the dressing from the right heel of Resident #9. The sore was 2 cm x 1.5 cm and had pink granulated tissue. There was no depth to the sore and it was almost healed. The LN replaced the dressing and put the Prevalon boots on.</p> <p>The DNS and UCM were interviewed on 5/22/13 at 1:50 p.m. They indicated that the wound on the resident's gluteal fold was unavoidable because it was caused by moisture from the resident sweating and his incontinence of stool. However, the resident had a suprapubic catheter that aided in moisture prevention. The pressure sore on the right heel was healed and broke down a second time because a staff member did not apply the Prevalon boots as care planned. No further information was provided.</p> <p>The resident was harmed due to a history of skin breakdown and then having a new pressure ulcers develop. The facility had the resident on a every 2 hour turning schedule since 9/9/11 and the resident continued to have skin breakdown. In addition, a right heel stage II pressure sore developed then healed, but when staff failed to apply Prevalon boots, it reoccurred in the same</p>	F 314		

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F 314	Continued From page 30 area.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that a resident who was incontinent of urine was assessed to determine if a toilet training program would be beneficial and assist in restoring the resident's continence. This was true for 1 of 13 sampled residents (# 6). This placed the resident at risk for skin breakdown and urinary tract infections. Findings include: Resident #6 was admitted to the facility 2/17/09 with diagnoses of anxiety state, paralysis agitans, depressive disorder, and dementia. The most recent annual MDS assessment, dated 2/17/13, documented the resident: - had severe cognitive impairment with a BIMS of 4, - required limited assistance of one staff for transfers, dressing, personal hygiene and bathing,	F 315	Corrective Action: Urinary Incontinence Assessment for Resident #6 has been completed and Care Plan updated. Identification: 1. All residents are identified as possibly being affected by this deficiency. 2. An audit to be conducted of current resident's medical records, to ensure that the Urinary Incontinence Assessment has been completed. Further Assessments will be completed by RCM, based on audit findings. Systemic Changes: RCM staff have received in-service regarding Incontinence Assessments policy and procedure. Monitor: 1. DNS to conduct audit of random resident's medical record to ensure compliance. Audits to begin on 6/19/2013 and to continue at the following frequency: • Weekly x four (4) weeks • Q two (2) weeks x four (4) weeks • Monthly x three (3) months 2. Administrator to review audits and report findings to the QA Committee.	6/25/2013

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: 135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/24/2013
NAME OF PROVIDER OR SUPPLIER MARQUIS CARE AT SHAW MT		STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	<p>Continued From page 31</p> <p>- was occasionally incontinent of bowel and bladder.</p> <p>The resident's comprehensive care plan, dated 3/19/13, documented a Focus of, "Mixed bladder incontinence related to use of diuretics and prostate cancer, as evidenced by functional incontinence. Resident is continent of bowel." The interventions were:</p> <p>"- Toileting: one person supervision and physical assist for safety i.e.. adjusting clothing/wash hands/pericare with barrier cream provided or brief change with occasional incontinence.</p> <p>- Incontinence program: Toilet upon rising, [before] and [after] meals, mid afternoon, bedtime, and at night if awake. [Resident's name] will often use his urinal at night.</p> <p>- Place urinal at bedside and assure that it is within reach at nights. Provide transfer pole in bathroom for increased safety in transfers..."</p> <p>The resident's medical record did not include any documentation that the resident's incontinence had been assessed. There was no documentation to show if there was a specific time when the resident was incontinent and a plan developed to assist the resident in achieving a higher level of continence. The record did not include a thorough assessment of factors that may predispose the resident to having urinary incontinence such as the type of incontinence, prior history of urinary incontinence, voiding patterns, review of medications that might affect continence, patterns of fluid intake, environmental factors & assistive devices that may restrict or facilitate a resident's ability to access the toilet, etc.</p>	F 315		

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F 315	Continued From page 32 The DNS and UCM were interviewed on 5/21/13 at 1: 50 p.m. They indicated that a comprehensive toileting assessment had not been completed for the resident. The resident's care plan included the facility's "standard of care" toileting program but was not specific to the resident based on a comprehensive assessment. The staff could not answer if the times were resident specific, nor would they agree that the resident potentially could be continent if he was assessed and found to have specific times to use the toilet/urinal.	F 315			
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 and staff interview, the facility failed to ensure that sanitary conditions were maintained during food preparation. This had the potential to affect 13 of 13 (#s 1 - 13) sampled residents and any resident in the facility who may find facial hair in their food. This unsanitary practice could create an unappetizing dining experience for residents. Findings include: The Food Code reference states: The 2009 FDA	F 371	Corrective Action: 1. As noted in 2567, staff identified as not having facial hair covered on 5/22/2013, did so immediately. 2. Specific "beard restraints" were purchased and made available to staff on 5/23/2013. 3. Both staff identified in 2567 reported to work on 5/23/2013 clean shaven. Note: While observing conditions in the kitchen area, the Survey Team member did don a hair net to cover the hair on his head. However, he also had facial hair, specifically a mustache, which was not covered. Identification: All residents are identified as possibly being affected by this deficiency. Systemic Changes: Dietary Staff have received in-service regarding sanitary condition requirements, specifically with regard to facial hair.		

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F 371	Continued From page 33 Food Code, Chapter 2, Part 2-4, Hygiene Practices, Hair Restraints, subpart 402.11, Effectiveness, indicates, "(A) Except as provided in ¶ (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. (B) This section does not apply to food employees such as counter staff who only serve beverages and wrapped or packaged foods, hostesses, and wait staff if they present a minimal risk of contaminating exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles." On 5/22/13 at 11:30 a.m. two male employees were observed in the kitchen preparing lunch. Both employees had facial hair and were observed to not have it covered. The CDM was immediately informed and both employees put nets on over the hair. No further information was obtained.	F 371	Monitor: 1. Dietary Manager to conduct random audits of staff to ensure compliance. Audits to begin on 6/19/2013 and will continue at the following frequency: <ul style="list-style-type: none"> • Weekly x four (4) weeks • Q two (2) weeks x four (4) weeks • Monthly x three (3) months 2. Administrator to review audits and report findings to QA Committee.	6/25/2013
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	Corrective Action: 1. Current Physician Order for Resident #16's Tramadol HCL 50 mg was transmitted to the pharmacy. 2. Label on current bubble pack of Resident #16's Tramadol HCL 50 mg. supply reflects current Physician Order. Identification: All residents are identified as possibly being affected by this deficiency. Continued on p. 35	

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F 431	<p>Continued From page 34</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to provide proper and accurate labeling of medications. This was true for 1 of 8 (#16) random residents reviewed during medication pass. This created the potential for the resident to receive more medication than was ordered by the physician. Findings included: Random Resident #16's MAR in the EMR read, "Tramadol HCL tablet 50 mg. Give 1 tablet by</p>	F 431	<p>Systemic Changes: LN Staff received in-service regarding proper notification to pharmacy of Physician Orders.</p> <p>Monitor:</p> <ol style="list-style-type: none"> RCMs to conduct audit of random resident's Physician Orders, specifically medications, to ensure compliance with labeling. Audits to begin on 6/19/2013 and will continue at the following frequency: <ul style="list-style-type: none"> Weekly x four (4) weeks Q two (2) weeks x four (4) weeks Monthly x three (3) months DNS to review audits and report findings to the QA Committee. 	6/25/2013	

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F 431	<p>Continued From page 35</p> <p>mouth three times a day for moderate pain, Start date 5/16/13."</p> <p>Random Resident #16's May 2013 Physician Orders in the EMR read, "Tramadol HCL 50 mg, Give 1 tablet by mouth three times a day for moderate pain."</p> <p>During a medication pass at 10:30 am on 5/23/13, LN #4 was observed punching out a Tramadol HCL 50 mg tablet from a bubble pack for Random Resident #16. The card read, "1 tablet by mouth 4 times daily." The bubble pack card was dated 5/5/13. LN #4 was asked about the different times the Tramadol was to be given. The bubble pack read 4 x a day and the MAR in the EMR read 3 x a day. LN #4 stated, "I go by the computer order. It says 3 times a day."</p> <p>On 5/23/13 at 12:15 pm, UCM # 6 was asked about the labeling issue for Random Resident #16's Tramadol order. The UCM #6 stated, "I don't know why, I'm looking into it. I can't explain it."</p> <p>On 5/23/13 at 2:10 the Administrator and DNS were notified of the labeling issue. No documentation was provided that resolved the issue.</p>	F 431		

Bureau of Facility Standards

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>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.</p> <p>The following deficiencies were cited during the annual State licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW Karla Gerieve, RN Arnold Rosling RN, BSN, QMRP</p>	C 000	<p>This plan of correction constitutes the facility's written allegation of compliance for the deficiencies cited in the CMS 2567. However, the submission of this plan is not an admission that a deficiency exists. The Plan of Correction is prepared and executed solely because it is required by federal and state law. This response and Plan of Correction does not constitute an admission or agreement by the provider of the facts alleged or set forth in the statement of deficiencies.</p>	
C 125	<p>02.100,03,c,ix Treated with Respect/Dignity</p> <p>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;</p> <p>This Rule is not met as evidenced by: See F241 regarding a urinary catheter bag in full view to others.</p>	C 125	<p>See F 241</p> <p style="text-align: center;">RECEIVED JUN 19 2013 FACILITY STANDARDS</p>	
C 325	<p>02.107,08 FOOD SANITATION</p> <p>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)."</p> <p>This Rule is not met as evidenced by: Refer to F371 as it relates to kitchen sanitation.</p>	C 325	<p>See F 371</p> <p style="text-align: center;">RECEIVED JUN 19 2013 DIV. OF MEDICAID</p>	

Bureau of Facility Standards

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

TITLE
Administrator

(X6) DATE
6/19/2013

Bureau of Facility Standards

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C 781	Continued From page 1	C 781			
C 781	02.200,03,a,iii Written Plan, Goals, and Actions iii. Written to include care to be given, goals to be accomplished, actions necessary to attain the goals and which service is responsible for each element of care; This Rule is not met as evidenced by: See F280 as it relates to the updating of care plans.	C 781	See F 280		
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: See F309 as it relates to not following physician's orders and the lack of hospice service coordination.	C 784	See F 309		
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 regarding pressure sores acquired while in the facility.	C 789	See F 314		

Bureau of Facility Standards

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C 795	Continued From page 2	C 795			
C 795	02.200,03,b,xi Bowel/Bladder Evacuation/Retraining xi. Bowel and bladder evacuation and bowel and bladder retraining programs as indicated; This Rule is not met as evidenced by: Refer to F315 as it refers to bladder retraining.	C 795	See F 315		
C 832	02.201,02,f Labeling of Medications/Containers f. All medications shall be labeled with the original prescription legend including the name and address of the pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.) This Rule is not met as evidenced by: Refer to F431 as it relates to labeling medications.	C 832	See F 431		



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
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June 6, 2013

Joe F. Rudd Jr., Administrator
Marquis Care at Shaw Mountain
909 Reserve Street
Boise, ID 83712

FILE COPY

Provider #: 135090

Dear Mr. Rudd:

On **May 24, 2013**, a Complaint Investigation survey was conducted at Marquis Care at Shaw Mountain. Bradley Perry, L.S.W., Karla Gerleve, R.N. and Arnold Rosling, R.N., Q.M.R.P. conducted the complaint investigation. The complaint investigation was conducted in conjunction with the annual Recertification and State Licensure survey.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005632

ALLEGATION #1:

The complainant stated the facility failed to ensure a Level 2 Pre-Admission Screening and Resident Review (PASRR) was completed prior to admitting two identified residents.

FINDINGS:

Based on records reviews and staff interviews, it was determined that PASRRs were not completed prior to admission for the two identified residents. The facility was cited at F285 for not ensuring completion of the PASRR prior to admission.

Joe F. Rudd Jr., Administrator
June 6, 2013
Page 2 of 2

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and cursive.

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

LKK/dmj