



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: 7012 1010 0002 0836 1567

June 26, 2014

Michael S. Crowley, Administrator
Life Care Center of Boise
808 North Curtis Road
Boise, ID 83706-1306

Provider #: 135038

Dear Mr. Crowley:

On **June 13, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Life Care Center of Boise by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies 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 sign both the 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 **July 9, 2014**. Failure to submit an acceptable PoC by **July 9, 2014**, may result in the imposition of civil monetary penalties by **July 29, 2014**.

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 will you make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice does 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 have 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 (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

Michael S. Crowley, Administrator
June 26, 2014
Page 3 of 4

- 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 **July 18, 2014 (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 **July 18, 2014**. A change in the seriousness of the deficiencies on **July 18, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 18, 2014** includes the following:

Denial of payment for new admissions effective **September 13, 2014**. [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 **December 13, 2014**, 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 Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; 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.

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 **June 13, 2014** and continue until substantial

Michael S. Crowley, Administrator
June 26, 2014
Page 4 of 4

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:

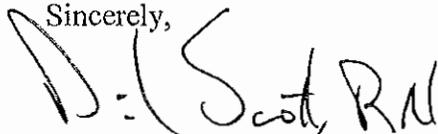
- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **July 9, 2014**. If your request for informal dispute resolution is received after **July 9, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj
Enclosures

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

PRINTED: 06/26/2014
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 06/13/2014
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>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification and complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Lauren Hoard, RN, BSN Linda Kelly, RN Linda Hukill-Neil, RN</p> <p>The survey team entered the facility on June 9, 2014 and exited on June 13, 2014.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed UM = Unit Manager</p>	F 000	<p><i>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</i></p>	
F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p>	F 164	<p>F164</p> <p>SPECIFIC RESIDENT</p> <p>Resident #5 no longer resides in the facility.</p> <p>OTHER RESIDENTS</p> <p>Residents with beds next to windows have the potential to be affected by this practice.</p>	7/16/14

RECEIVED
JUL - 8 2014
FACILITY STANDARDS

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

M. S.

TITLE

Administrator

(X6) DATE

7/8/14

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 164	<p>Continued From page 1</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure privacy was maintained during a coccyx wound care and dressing change. This was true for 1 of 9 sample residents (#5). This failed practice created the potential for a negative affect on the resident's psychosocial well-being. Findings included:</p> <p>On 6/10/14 at 3:30 p.m., LN #1 and CNA #3 were observed as they uncovered and repositioned the resident in bed. The LN changed the coccyx dressing while CNA #3 maintained the resident on her right side. After that, the staff turned the resident side to side to apply a new incontinent brief. During that time, the window blind was down. However, the blind slats were horizontal which allowed a clear view into the room from the courtyard and sidewalk.</p>	F 164	<p>SYSTEMIC CHANGES</p> <p>Staff was in-serviced on maintaining privacy and dignity for Residents including closing of the blinds.</p> <p>MONITORING</p> <p>SDC and or Designee will perform floor audits to include dignity issues twice a week times 4 weeks, then weekly times 4 weeks, then monthly times 3 months.</p> <p>Results of the Floor Rounds will be reviewed during monthly Performance Improvement (PI) meeting and adjustments and trainings provided as indicated.</p>		

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F 164	Continued From page 2 On 6/10/14 at 4:00 p.m., CNA #3 and CNA #4 were observed as they changed the resident's bed linens. The window blind was down and the slats were now closed. Immediately afterward, CNA #3 was asked when the blind slats were closed. The CNA stated, "I noticed the blind wasn't closed before. It was my fault." On 6/13/14 at 3:15 p.m., the Administrator and DNS were informed of the privacy issue. No other information was received which resolved the issue.	F 164		
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 observation and staff interview, it was determined the facility failed to ensure: a) Offensive odors were not present in the hallway on Unit 2; b) A sanitary and comfortable environment was provided in the Station 2 short hall shower room, and; c) Missing tiles were replaced in the Central Supply room. This had the potential to affect any resident or staff in the Unit 2 hallway and to decrease the quality of life for 1 of 13 (#1) sampled residents, 1 random resident (#18) and any resident who used the Station 2 shower room. Findings included: a) On 6/9/14 during the Initial Tour and throughout the survey process, two surveyors	F 253	F253 SPECIFIC RESIDENTS Residents #1 and #18 are provided showers in a clean, sanitized, and orderly shower room. Residents that utilize the Unit 2 shower room are showered in a clean, sanitized, and orderly shower room. Residents in room 207 were moved to other rooms and the floor was stripped and waxed, the curtains were changed, the mattresses were replaced, and the room was deep cleaned. There is no longer any order of urine. Personal belongings were removed from the unit 2 shower room and the shower room was deep cleaned and organized and the cabinet is kept locked. Tiles were installed in the northeast corner of the Central Supply Room.	7/16/14

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F 253	<p>Continued From page 3</p> <p>observed the smell of urine in the Unit 2 hallway by Rooms 207 and 208.</p> <p>On 6/11/14 at 10:05 AM, the DON was asked about the urine odor in the hallway of Unit 2. The DON stated the urine smell was an issue, had been investigated, and was determined to be coming from the tile in Room 207. She stated the facility had replaced the mattress and bedside rug in the room on 6/10/14, but there remained a urine smell in the hallway which was coming from Room 207. The DON stated the resident in Room 207 had a urostomy which staff thought had leaked onto the rug and seeped into the tiles. The DON stated, "The sticky area on the floor had been cleaned four times and buffed but the smell still remained." The DON stated the facility had addressed the smell concern with the resident, however, the resident had denied any concerns with urine odor. The DON stated the facility planned to replace the tiles as soon as possible and would replace the subflooring if needed.</p> <p>On 6/11/14 at 12:30 PM, the DON told the surveyor the tile man would come that evening to determine the number of tiles needed and the facility would then order the tiles. She stated she hoped the work would be finished in 2-3 weeks.</p> <p>b) On 6/11/14 at 11:30 AM, during the environmental tour of the facility with the Maintenance Director (MD), the following items were observed in the Station 2 short hall shower room: *Wet, used and crumpled washcloth on the shower room floor. *Dirty, empty coffee drinking mug on the counter top.</p>	F 253	<p>OTHER RESIDENTS</p> <p>Residents that reside on unit 2 are provided an environment free of urine odor and is clean, sanitary, and well organized. All Residents have the potential to be affected by this issue.</p> <p>SYSTEMIC CHANGES</p> <p>Staff were in-serviced on maintaining a clean, sanitary, odor free environment.</p> <p>Shower Aides were in-serviced on locking cabinets, maintaining a clean/sanitary environment and not having any personal items/food in the shower rooms.</p> <p>Staff was in-serviced on how to use the facilities Maintenance Request Forms for reporting environmental issues including missing tiles.</p> <p>MONITORING</p> <p>Environmental Audits to included offensive odors, shower room sanitation, and missing tiles will be done by either the Housekeeping Supervisor, Executive Director, and or Designee twice a week times 4 weeks, then weekly times 4 weeks, then monthly times 3 months.</p> <p>Results of audits will be reviewed during the monthly PI meeting and adjustments and training provided as indicated.</p>		

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F 253	Continued From page 4 Additionally the bottom shelf of the laundry bin which held clean, folded towels contained: An electronic device, similar in size to an I-Pad, single tampon container with 2 single sanitary napkin pads in a clear plastic zip lock bag, a plastic trash bag that contained trash, a Nutri Grain bar, personal hair brush, single unwrapped large Kotex, a resident handkerchief, and a wadded female camisole. The middle shelf of the laundry bin, which held clean, folded towels also contained: Cardboard stock coupons which were approximately 6" x 8" in size, a large electronic device which was approximately 4" x 6", a clear zip lock bag with 7 small note pads, two wrist blood pressure cuffs, a 6" x 9" spiral steno pad, a large dirty soup spoon, 3 Styrofoam cups, 2 disposable shoe covers and a dry dirty washcloth. In an unlocked black cabinet, located below the laundry bin, the following was observed: *The top shelf of the cabinet contained an open Tabasco jar, a dirty Thermos coffee pot in a plastic bag, and a dirty washcloth. A plastic tub contained clear plastic bags of resident's personal items with their names on the bags. These bags held talc powder, deodorants, shampoo, long cotton tipped swabs, razors and tape. Additionally, there was a roll of black duct tape. The bottom shelf of the black cabinet also contained a black gym bag with the following contents:	F 253		

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F 253	<p>Continued From page 5</p> <p>*An opened 11.2 ounce package of Keebler Sandies Cookies; *An opened 9 ounce package of Hot Limon Crunchy Cheetos; and, *An unopened 2.5 ounce package of Kellogg's fruit snacks.</p> <p>Additionally, during the initial environmental tour, the surveyor and MD observed: *A black purse hanging on a hook on the wall of the shower room. *A coat, poncho and large blue tote, full of personal items, was hanging on the back of the shower door.</p> <p>The wall by the shower door contained a list of the "Responsibilities of Shower Aids," which documented, "...Clean linens are to be covered in shower rooms...shower and tub mat are to be sanitized with disinfectant after each shower and scrubbed with bleach water at end of shift...once a week shower room is to be emptied and deep cleaned..."</p> <p>The MD stated that staff "need to go through the cabinet, the towels, everything." He informed the surveyor he would, "have a talk with staff and make sure staff kept their personal things in their car."</p> <p>c) On 6/11/14 at 12:10 PM, during the environmental tour of the facility, the MD and the surveyor observed the northeast corner of the Central Supply room had 4-5 missing tiles which revealed a rusted and grooved, dirty cement floor that was uncleanable. On top of the rusted floor 9 plastic bins were observed stacked one on top of the other. The MD stated, "The floor should be tiled." The Central Supply Director was asked</p>	F 253		

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F 253	Continued From page 6 how long the tiles had been missing and she stated the floor "has been that way since I started working here." When asked when she started working at the facility, the Central Supply Director stated, "Since September of 2013."	F 253			
F 279 SS=D	On 6/12/14 at 5:40 PM, the Administrator and the DON were informed of the above environmental concerns. No further information was provided by the facility. 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 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it	F 279	F279 SPECIFIC RESIDENTS Resident #1 now has a psychotropic drug care plan and the Physician has clarified the diagnosis for the Invega Sustenna. Resident #9 now has a care plan for delirium/cognitive loss. OTHER RESIDENTS Residents who trigger a CAA have the potential to be affected by this practice. SYSTEMIC CHANGES MDS/Clinical Compliance Coordinator and MDS Support Staff were in-serviced to ensure that all areas triggered by the Resident Assessment Instrument tool are care planned as indicated. Behavior Management Team (BMT) in-serviced to ensure all psychotropic medications have diagnosis on the recaps/MD orders. MDS Staff and BMT members in-serviced that psychotropic medications need a psychotropic drug careplan.	7/16/14	

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F 279	<p>Continued From page 7</p> <p>was determined the facility failed to ensure all areas triggered by the RAI (Resident Assessment Instrument) process, and identified by the facility as care planned, were actually care planned. This was true for 2 of 9 (#s 1 & 9) sampled residents. Resident #1's medical record did not include a Care Plan for psychotropic drug use and Resident #9's medical record did not include a Care Plan for cognitive loss. This failure created the potential for harm when staff did not have direction to meet the resident's needs related to psychotropic drug use, delirium and cognitive loss. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 3/20/07 with multiple diagnoses including cerebral degeneration, dysphagia, abnormal involuntary movements and muscle weakness.</p> <p>The resident's most recent Annual MDS assessment, dated 8/19/13, documented in the Care Area Assessment in Section V, a care plan decision for the problem of psychotropic drug use was triggered.</p> <p>The resident's clinical record documented an order for Clonazepam 0.125 mg daily, for the diagnosis of anxiety, dated 1/31/14. Additionally, there was an order for Invega Sustenna 117 mg monthly, dated 5/13/14. However, the order did not include a diagnosis.</p> <p>NOTE: None of the above identified medications contained a diagnosis on the MAR or on the Physician's Orders (Recapitulation Orders) for 6/1/14 through 6/30/14.</p> <p>Review of Resident #1's clinical record did not document a care plan for the problem of</p>	F 279	<p>MONITORING</p> <p>Either the Unit Manager, LSW, and or Designee will audit care plans post completion of MDSs weekly times 3 months them monthly times 3 months checking for triggered care plans and approach dates.</p> <p>Results of audits will be reviewed during the monthly PI meeting and adjustments and trainings provide as indicated.</p>		

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

PRINTED: 06/26/2014
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 06/13/2014
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F 279	<p>Continued From page 8 psychotropic drug use.</p> <p>On 6/12/14 at 11:20 AM, UM #7 was interviewed regarding the missing care plan and stated, "I don't see a care plan for psychotropics and the care plan should include a psychotropic care plan, especially with the medication changes." UM #7 explained the resident had been on three different psychotropic medications which had been discontinued after a successful trial of Invega Sustenna for the diagnosis of bipolar disorder. When questioned about the diagnosis for Invega Sustenna, UM #7 provided a Nurse Practitioner Progress Note, dated 5/7/14, which documented a diagnosis of bipolar disorder.</p> <p>2. Resident #9 was admitted to the facility on 5/6/11 and readmitted on 1/22/14 with multiple diagnosis including difficulty walking and paranoid type schizophrenia.</p> <p>The resident's most recent Annual MDS assessment, dated 3/19/14, documented in the Care Area Assessment in Section V, that care plan decisions for the problems of delirium and cognitive loss were triggered.</p> <p>Resident #9's clinical record did not include a care plan for the problems of delirium and cognitive loss.</p> <p>On 6/12/14 at 3:40 PM, UM #7 was interviewed regarding the missing care plan areas. He stated he had not seen problems with delirium or cognitive loss and the resident "had been at baseline quite a while, a couple of years now." UM #7 stated, "the care plan for psychosocial should be updated." He stated he would talk to the MDS Coordinator to see why there was a</p>	F 279			

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

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F 279	Continued From page 9 Care Area Assessment for these areas. On 6/13/14 at 9:50 AM, the MDS/Clinical Compliance Coordinator and UM #7 were interviewed regarding the missing care plan areas. The Clinical Compliance Coordinator stated there was a care plan for orientation which she felt had the same meaning as cognitive loss. After reviewing the care plan for orientation with the Clinical Compliance Coordinator she stated the care plan, "should be more addressed as cognitive loss versus orientation." When asked about the care plan for delirium, UM #7 stated the psycho-social care plan addressed the resident had a history of hallucinations but, "we will look at current delirium and create a care plan which addresses current issues with delirium." On 6/13/14 at 11:40 AM, the DON was made aware of the orientation versus cognitive care plan concern and stated, "I see it as an issue." When shown the resident's psychosocial care plan, the DON agreed the care plan for delirium should be revised and updated.	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	F 280	F280 SPECIFIC RESIDENTS Dates will be included for all new approaches in care plans for Resident #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13. The care plan for Resident #13 has been updated to include the use of a pommel cushion.	7/16/14

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	<p>Continued From page 10</p> <p>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 staff interview and record review, it was determined the facility failed to ensure care plans were revised to reflect current resident needs, and failed to provide dates when such revisions were made. This was true for 13 of 13 sampled residents (#s 1-13) and had the potential to affect all residents residing in the facility. This had the potential for harm if the residents did not receive appropriate care due to lack of direction in the care plan. Findings included:</p> <p>1. Resident #3 was admitted to the facility on 12/24/13 with multiple diagnoses which included osteoarthritis, diabetes and morbid obesity.</p> <p>The Impaired Skin Integrity Care Plan for Resident #3, dated 3/18/14, documented: * Problems - Alteration in skin integrity: suspected, deep tissue injuries to bilateral heels; * Approaches - Wound care as ordered...observe effectiveness of/response to treatment as ordered; Bariatric air bed with antishet [sic] surface; Encourage resident to wear prevalon boots; and Beneprotein per MD order.</p> <p>Note: The aforementioned approaches did not</p>	F 280	<p>OTHER RESIDENTS</p> <p>Residents have the potential to be affected by this practice. Residents will have dates of initiation of interventions carried over when care plans are updated.</p> <p>SYSTEMIC CHANGES</p> <p>Staff that participate in the creation of care plans will be in-serviced on writing the date when an approach is initiated on the care plan. MDS Staff will be in-serviced to ensure that the date is carried forwarded whenever the care plan is updated and reprinted.</p> <p>Staff will be in-serviced on dating the approaches when added to care plans and ensuring that care plans are updated with new equipment orders.</p> <p>MDS Staff will be in-serviced to ensure that the date on hand written approaches are carried over when care plans are reprinted.</p> <p>MONITORING</p> <p>Either the Unit Manager, LSW, and or Designee will audit care plans to include adaptive equipment post completion of MDSs weekly times 3 months then monthly times 3 months checking for triggered care plans and approach dates.</p> <p>Results of the care plan audits will be reviewed during monthly PI meeting and adjustments and trainings provided as indicated.</p>		

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

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F 280	<p>Continued From page 11 include dates of initiation.</p> <p>The Risk for Impaired Skin Integrity Care Plan for Resident #3, dated 12/24/13, documented: * Problems - At risk for impaired skin integrity r/t [related to] dx [diagnosis] of DM [Diabetes mellitus], restricted mobility, dx of difficulty in walking; * Approaches - Observe skin weekly and PRN [as needed], report any red or broken areas to nurse; Turn & reposition Q [every] 2 hours or more frequently as resident will allow. Resident has often refused to be turned.</p> <p>Note: The aforementioned approaches did not include dates of initiation.</p> <p>On 6/11/14 at 12:05 p.m., UM #7 was asked when the approach of Beneprotein was added to the care plan. He looked through the Physician's Orders and stated, "I'm looking for the order," then looked through nurses notes, but did not provide an answer.</p> <p>2. Resident #10 was admitted to the facility on 2/13/13, and readmitted on 7/16/13, with multiple diagnoses which included dementia with agitated behaviors, delirium, muscle spasms, and pain.</p> <p>Side rails were observed in the raised position on the resident's bed during the survey.</p> <p>The resident's recapitulation of Physician's Orders for June 2014 included, "11/18/13: 1/2 side rails X [times] 2...to aid in bed mobility."</p> <p>The resident's Care Plan (CP) included the problem area, "At risk for falls..." Approaches included, "1/2 siderails X 2 to aid in bed</p>	F 280			

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

PRINTED: 06/26/2014
FORM APPROVED
OMB NO. 0938-0391

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F 280	<p>Continued From page 12 mobility..." However, the date the side rails were implemented was not included in the CP.</p> <p>3. Resident #13 was admitted to the facility on 5/9/14 with diagnoses that included cerebrovascular accident (CVA, or stroke) and right-sided weakness.</p> <p>A recapitulation of the resident's June 2013 Physician's Orders included: * "05/14/14: 1/2 lap tray added to wheelchair;" and, * "05/14/14: 1/4 side rails X [times] 2. To bed to assist with bed mobility."</p> <p>A Telephone Order (TO), dated 6/6/14, documented, "Pt [patient] requiresommel cushion in w/c at all times to prevent forward thrust and to maintain adequate w/c positioning."</p> <p>The resident's Care Plan (CP), dated 5/9/14, included the problem area, "Self care deficit..." Approaches included, "1/2 lap tray to right side of w/c to provide for positioning of RUE [right upper extremity]."</p> <p>The CP also included the problem area, "At risk for falls..." Approaches included, "1/4 Side rail(s) as an enabler."</p> <p>None of the aforementioned CP approaches included the date they were implemented for the resident. In addition, theommel cushion was not included anywhere in the resident's care plan.</p> <p>On 6/13/14 at 3:15 p.m., the DNS and the Administrator were informed of the CP issues. No other information was received from the facility which resolved the issues.</p>	F 280			

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

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OMB NO. 0938-0391

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F 280	Continued From page 13 4. Resident #9 was admitted to the facility on 5/6/11, and readmitted on 1/22/14, with multiple diagnoses including difficulty walking and paranoid type schizophrenia. Review of the care plans in the clinical record documented the date the care plans were created, however, approach dates did not include the date they were initiated. On 6/12/14 at 3:40 PM, the surveyor interviewed UM #7 regarding the missing care plan approach dates. UM #7 stated, "I see they aren't dated." Similar results were found for sampled residents #s 1, 2, 4, 5, 6, 7, 8, 11, & 12. On 6/12/14 at 5:40 PM, the Administrator and DON were made aware of the concerns regarding care plan approach dates. On 6/16/14 the facility delivered a binder which contained a memorandum from the facility Resource Utilization Specialist which did not resolve the issue concerning care plan approach dates.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F309 SPECIFIC RESIDENT Resident #13 was provide a new brace that she is more compliant with wearing, however she continues to periodically choose to not wear the brace. Residents veritable compliance with wearing the brace has been care planned.	7/16/14	

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

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F 309	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure a right upper extremity brace was in place as ordered for 1 of 13 sample residents (#13) reviewed for quality of life. This failure created the potential for the resident to experience contracture(s) in the right hand and fingers. Findings included: Resident #13 was admitted to the facility on 5/9/14 with diagnoses that included cerebrovascular accident (CVA, or stroke) and right sided weakness. The resident's admission MDS assessment, dated 5/16/14, coding included: * Spoke a different language and needed or wanted an interpreter; * Sometimes able to make self understood; * Understood others; * Short and long-term memory problems; * Moderately impaired cognition; * Needed extensive assistance of 1 or 2 people for bed mobility, dressing, toileting, and personal hygiene; * Needed total assistance of 2 or more people for transfers; and, * Range of motion limitations in one upper and one lower extremity. A Telephone Order (TO), dated 6/1/14, documented, "RUE brace on in AM, off at HS [Right upper extremity brace on in the morning, off at bedtime]." The resident's Care Plan identified the problem,	F 309	OTHER RESIDENTS Residents that require the application of braces have the potential to be affected by this practice. SYSTEMIC CHANGES Nursing Staff and Therapy Staff will be in-serviced regarding the appropriate use of braces and correct protocols for when Residents refuse to wear braces. Application of braces will be added to the TAR to be checked every shift. Any refusals will be noted on the 24 hour report to be discussed by the IDT during the daily stand up meeting. MONITORING TAR Audits will be done by either SDC, Unit Manager, and or designee twice a week times 4 weeks, then weekly times 4 weeks, then monthly times 3 months. Results of audits will be reviewed during the monthly PI meeting and adjustments and training provided as indicated.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 15 "Self Care Deficit..." on 5/9/14. Approaches to this problem included, "RUE brace on in AM off [at] HS." The resident was observed without the RUE brace in place on 6/11/14 at 2:50 and 3:50 p.m. and 6/12/14 at 11:00 a.m. and 3:40 p.m. Each time the resident was in her w/c by her bed. And, on 6/12/14 at 3:40 p.m., UM #9 was in the resident's room with the surveyors. On 6/12/14 at about 4:00 p.m., UM #9 was informed of the above observations and asked about the RUE brace. The UM acknowledged the brace was not in place and said she would have a staff member put it on the resident. On 6/13/14 at 3:15 p.m., the Administrator and DNS were informed of the issue. No other information was received which resolved the issue.	F 309			
F 310 SS=D	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff	F 310	F310 SPECIFIC RESIDENT Resident #13 was educated via the Interpreter Services and her son on the use of call lights. Resident #13 demonstrated good understanding of the use and function of her call light, however at times Resident will wave staff down instead of using her call light. Residents veritable compliance with using the call light has been care planned.	7/16/14	

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F 310	<p>Continued From page 16</p> <p>interview, the facility failed to ensure 1 of 1 non-English speaking sample residents (#13) understood the purpose of the call light and how to use it. This failure created the potential for the resident to experience a decline in activities of daily living and emotional distress from unmet needs when she was unable to summon help when she needed or wanted help. Findings included:</p> <p>Resident #13 was admitted to the facility on 5/9/14 with diagnoses that included cerebrovascular accident (CVA, or stroke) and right sided weakness.</p> <p>The resident's admission MDS assessment, dated 5/16/14, coding included:</p> <ul style="list-style-type: none"> * Spoke a different language and needed or wanted an interpreter; * Impaired vision; * Sometimes able to make self understood; * Understood others; * Short and long-term memory problems; * Moderately impaired cognition; * Inattention fluctuated; * Extensive assistance of 1 or 2 people for bed mobility, dressing, toileting, and personal hygiene; * Total assistance of 2 or more people for transfers; * Range of motion limitations in one upper and one lower extremity; and * Wheelchair (w/c) use. <p>The resident's Care Plan included the following problem areas, all with an onset date of 5/9/14 and all with a goal date of 8/9/14, and their associated goals and approaches:</p> <ul style="list-style-type: none"> * Alteration in cognition - Goals: "...needs will be anticipated and...resident will be encouraged to 	F 310	<p>OTHER RESIDENTS</p> <p>Non-English Speaking Residents have the potential to be affected by this practice. Other non-English Speaking Residents have been educated via their primary language to ensure that they understand the appropriate use and function of call lights.</p> <p>SYSTEMIC CHANGES</p> <p>Upon admit all non-English Speaking Residents will be educated via their primary language on the appropriate use and function of call lights.</p> <p>Staff will be in-serviced to ensure that non-English Speaking Residents understand the appropriate use of the call light on admit and PRN.</p> <p>MONITORING</p> <p>Call Light Audits for non-English Speaking Residents will be completed by either SDC, Unit Manager, or Designee twice a week times 4 weeks, then weekly times 4 weeks, then monthly times 3 months.</p> <p>Results of audits will be reviewed during the monthly PI meeting and adjustments and training provided as indicated.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 310	Continued From page 17 make...needs known thru [sic]" 8/9/14. Approaches included, "Utilize translation services with the speaker phone in...room. Utilize...son for assistance if needed. Provide verbal, visual and tactile cues...Utilize communication boards in...room." * "Alteration in wellbeing [sic]...unable to communicate with others on a regular basis due to the language barrier" - Approaches included, "Utilize translation services. Keep...son involved in...care..." * "...impaired vision...son...informed us of resident having difficulty seeing out of left eye-blurry..." - Approaches included, "Explain care and services before providing with either phone translator, son or laminated word board in room." * "...impaired communication Relating to... (difficulty understanding others)...Primary language other than English..." - Goals: "...will be able to communicate...needs through next review date" and "...needs will be anticipated and met by staff..." - Approaches: "Anticipate and meet needs...Use alternative communication tools...Use the following techniques to enhance communication *Phone translator or family translator." * Self care deficit - Goals, "...will continue to participate as able with daily ADLs..." and approaches included, "Encourage resident to participate..." in ADLs and "Explain all procedures and purpose with a translator..." * "Alteration in Continence...Resident able at times to notify the staff of need of bowel movement by indicating with word board..." * At risk for falls - Approaches included, "Provide environmental adaptations *Call light within reach..." A Resident/Family Education Assessment &	F 310		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/13/2014
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 310	<p>Continued From page 18</p> <p>Interdisciplinary Flow Record, dated "5/9," identified a family member as the "Learner." It documented the learner, "Has some understanding of basic information," was "Accepting," had no "Limitations & Barriers to Learning," and that the topics, information, instruction were, "Room, meal times, staff, laundry."</p> <p>On 6/11/14 at 2:50 p.m., 2 surveyors observed the resident seated in a w/c by her bed. Two sets of laminated communication tools were noted on the resident's over bed table and a telephone number for an interpreter was taped near a telephone on top of the bedside table. The resident spoke for several minutes in her native language (non-English). During that time, the resident raised and lowered her left arm and pointed in different directions in the room several times. The resident had a frustrated look on her face. The surveyors made multiple, unsuccessful, attempts to communicate with the resident using the laminated communication tools in the room.</p> <p>At 3:00 p.m., the surveyor informed the DNS of the above observation. The DNS and LN #5 went directly to the resident's room. The DNS and LN #5 attempted, without success, to communicate with the resident using the communication tools in the room. LN #5 then telephoned the interpreter. Initially, the interpreter said the resident's speech was "slurred" and it was difficult to understand the resident. The interpreter continued efforts to communicate with the resident and after a few minutes, the interpreter said, "She's hungry." The DNS found 2 containers of soup, one beef and one pork, in the refrigerator in the resident's room (which the DNS said the resident's son had provided). When asked by the interpreter which</p>	F 310			

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

PRINTED: 06/26/2014
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 06/13/2014
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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 83706
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F 310	<p>Continued From page 19</p> <p>soup she wanted, the resident chose beef. The DNS said they would warm the soup for the resident.</p> <p>On 6/11/14 at 3:50 p.m., 2 surveyors observed the resident in her w/c by her bed. With a questioning look on her face one surveyors rubbed and patted her own belly to which the resident nodded her head yes to indicate she was full.</p> <p>On 6/12/14 at 11:00 a.m., the resident waved 2 surveyors into her room. The resident was in her w/c by her bed. The call light cord was draped over the resident's right shoulder and the call light itself was attached to the resident's blouse. The resident spoke for several minutes in her native language (non-English) and motioned toward the bed several times. Attempts to communicate with the resident using the laminated communication tools were not successful. One of the surveyors pointed to the call light and the resident picked up and held the call light in her left hand. However, the resident did not make any effort to activate the call light.</p> <p>At about 11:05 a.m., the surveyors informed LN #2 of the observation and the LN said she would get staff to assist the resident.</p> <p>On 6/12/14 at 3:30 p.m., the Unit Manager (UM) #9 was informed of the observation that morning and asked if the resident understood how to use her call light.</p> <p>At 3:40 p.m., UM #9 accompanied 2 surveyors to the resident's room. The resident was in her w/c by her bed. The call light was on top of the over bed table. The over bed table was to the left of</p>	F 310		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/26/2014
FORM APPROVED
OMB NO. 0938-0391

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F 310	<p>Continued From page 20</p> <p>and slightly behind the resident. The resident was very talkative in her native language (non-English) and very expressive with facial expressions and left hand/arm movements. Right away, the UM telephoned the interpreter. Per the UM's and surveyors requests, the interpreter asked the resident if she could use the call light to which the resident said, "What do you mean by that?" When asked if she could reach the call light, the resident was expressionless. At that point, the UM handed the call light to the resident. The resident looked at the call light and the call light cord but made no efforts to activate the call light. When asked if the resident knew the purpose of the call light, the interpreter stated, "I've asked several different ways and she says something about electricity." The UM then educated and instructed the resident about the purpose and use of the call light. At one point, the interpreter stated, "I don't think she gets it." After almost 10 minutes of the education/instruction, the resident did express understanding and was able to activate the call light when asked to do so. The interpreter stated, "She gets it." The UM acknowledged that, initially, the resident did not understand the purpose of the call light or how to use it.</p> <p>On 6/13/14 at 3:15 p.m., the Administrator and DNS were informed of the issue.</p> <p>On 6/16/14, the facility hand delivered additional information regarding Resident #13. The additional information included a cover letter, Progress Notes, dated 5/16/14 at 10:50 p.m. and 5/23/14 at 4:28 p.m., and 3 witness statements by staff, all dated 6/16/14. However, none of the additional information resolved the issue.</p>	F 310			

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

PRINTED: 06/26/2014
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 06/13/2014
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F 312 F 312 SS=D	Continued From page 21 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, it was determined the facility did not adequately ensure residents received baths/showers, haircuts, and shaving as needed and scheduled. This was true for 2 of 15 (#s 9 & 14) sampled residents. This deficient practice had the potential to cause more than minimal psychological and/or physical harm if residents experienced rashes, skin issues, ingrown hairs due to beard stubble, infections, loss of self esteem and depression due to appearing disheveled. Findings included: 1. Resident #9 was admitted to the facility with multiple diagnoses which included difficulty walking, scoleosis, and paranoid type schizophrenia. The most current quarterly MDS assessment, dated 4/24/14, documented the resident was moderately cognitively impaired with a BIMS Score of 11 and needed extensive assistance of 1 person for personal hygiene and bathing. The care plan for self-care deficit documented the following problems: **declines to have facial hair trimmed, dated	F 312 F 312	F312 SPECIFC RESIDENTS Resident #14 no longer resides at the facility. Resident #9 has received a haircut and his beard was trimmed in the Beauty Salon. Resident #9 will be offered a shave/beard trimming on shower days and provided as Resident allows. Haircuts will be offered monthly and provided as allowed by Resident. OTHER RESIDENTS Residents who require assistance with daily grooming have the potential to be affected by this practice. SYSTEMIC CHANGES Nursing Staff will be in-serviced on providing appropriate bathing and grooming cares to Residents. MONITORING Bathing Audits will be completed by either SDC, Unit Manager, or Designee twice a week times 4 weeks, then weekly times 4 weeks, then monthly times 3 months. Results of audits will be reviewed during the monthly PI meeting and adjustments and training provided as indicated.	7/16/14

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

PRINTED: 06/26/2014
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 06/13/2014
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F 312	<p>Continued From page 22 7/7/12;" and, **"will only allow 1 particular show[er] aid to give him a shower, dated 4/16/14."</p> <p>The care plan approaches for self-care deficit, which were undated, documented the following: **"Assist [resident] with grooming, hygiene and dressing as needed or he will accept;" **"Inform LN if [resident] is in need of personal cares and has refused staff to provide care;" **"Shower at least 1-2X[time]/Week, Shampoo at least 1X/Week. Requires physical assist with bathing tasks;" and, **"Encourage resident to participate in dressing & grooming tasks, praise accomplishments. Resident is able to wash own face & hands."</p> <p>A progress note by social services, dated 5/7/14, documented, "[Resident] is alert and oriented x2 he can let his needs be known but does not always do so. Most of his needs are anticipated by the staff."</p> <p>On 6/9/14 at 1:20 PM and throughout the survey process, Resident #9 was observed to have a thick beard which was approximately 2-3" in length, had a flaky scalp and long disheveled hair.</p> <p>On 6/11/14 at 9:45, the surveyor asked the resident if he would like to have a shave or if he wanted a beard and moustache? The resident stated, "Maybe." The surveyor then asked the resident if he "would like a haircut," and he stated, "Yes."</p> <p>On 6/12/14 at 10:05 AM, CNA #8, the shower aid for Station 1, was interviewed by the surveyor and stated she was the aid the resident preferred to give him his shower. She stated the resident</p>	F 312			

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

PRINTED: 06/26/2014
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 06/13/2014
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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 83706
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F 312	<p>Continued From page 23</p> <p>showered on Mondays and Thursdays every week. She stated she "offered the resident a haircut and to shave his beard today," and the resident told her he "would wait for the barber." She stated the resident has let the beautician cut his hair and shave him in the past. When asked how often she asked the resident if he would like a shave, CNA #8 stated, "2-3 times per month." When asked why she only offered to shave him 2-3 times per month, CNA #8 stated, "I don't have an answer for that, I know I should ask him daily because of the sign by the door."</p> <p>NOTE: A sign by the shower door on Unit 1, where Resident #9 was showered, lists the "Responsibilities of Shower Aids." The "Resident Care" section documented: **"Wash resident's hair at least one time per week;" **"Residents needing shaved are to be shaved with each shower;" and, **"Notify Unit manager of any resident refusing shower, shampoo, shaving, clipping or cleaning of nails."</p> <p>NOTE: The monthly Flow Report for behaviors, documented the resident received one shave and did not document any resistance to care for May 2014.</p> <p>On 6/12/14 at 10:15 AM, the surveyor again asked the resident if he would like a shave today and the resident stated, "Yea." The surveyor then asked the resident if he would like to have his hair cut and the resident stated, "Yea."</p> <p>On 6/12/14 at 3:40 PM, UM #7 was interviewed by the surveyor regarding the resident's appearance and UM #7 stated the resident "looks</p>	F 312		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/26/2014
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 06/13/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
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F 312	<p>Continued From page 24</p> <p>like he needs a shave and haircut." The surveyor explained to UM #7 the two conversations with Resident #9 in which he stated he would like a haircut and shave. UM #7 stated, "Oh, really?" The surveyor and UM #7 then went to the resident's room where UM #7 asked the resident if he would like a hair cut and shave with the beautician and the resident stated, "Yes." UM #7 told the resident he would schedule an appointment.</p> <p>2. Resident #14 was admitted to the facility on 5/15/13 and discharged on 5/28/13 with multiple diagnoses which included rehabilitation, pneumonitis, surgery aftercare and malignant neoplasm of the tongue.</p> <p>The interim care plan, dated 5/16/13, documented the resident needed "assistance of one for bathing," and "assistance of 1 with ADL's."</p> <p>The Monthly Flow Report for daily care for May 2013 documented the resident only received only one bed bath on 5/20/14 (5 days after admission), one shower on 5/23/14 and two shaves during his 14 day stay at the facility. There was no documentation in the "Bathing Refused" section.</p> <p>On 6/13/14 at 11:55 AM, CNA #8, the shower aid for Station 1, was interviewed by the surveyor and asked how she set up the bath/shower schedule for residents. She stated she talked with residents, or their families if the resident was confused, to set up a schedule. She stated she generally gives 2 baths per week, but would schedule three per week if so desired by the resident. When shown the Monthly Flow Report for daily care for May 2013, CNA #8 stated, "He should have had at least 3 more baths." When</p>	F 312			

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

PRINTED: 06/26/2014
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 06/13/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
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F 312	Continued From page 25 asked why the resident did not receive more baths/showers, considering there was no documentation that the resident had refused them, CNA #8 stated, "I don't have an answer for that." When asked about shaving the resident on a daily basis, CNA #8 stated, "All CNA's are responsible for shaving, not just the shower aids, but the resident should have had more shaves than just two." On 6/13/14 at 12:05 PM, the DON was shown Resident #14's Monthly Flow Report for daily care for May 2013, regarding baths/showers and shaving with no documentation of refusals. She stated, "The resident should have received more bath/showers and should have been shaved every day; there should be more documentation than just the two times." On 6/12/14 at 5:40 PM, the Administrator and DON were made aware of the concerns with grooming. On 6/16/14, the facility hand delivered a binder that contained a cover letter and multiple duplicate documents for Residents #9 & 14, which did not resolve the above mentioned concerns.	F 312			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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	F 314	F314 SPECIFIC RESIDENTS Residents #3, 5, and 16 no longer reside at the facility.	7/16/14	

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 06/13/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
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F 314	<p>Continued From page 26</p> <p>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, record review and staff interview, it was determined the facility failed to ensure a resident who entered the facility without pressure ulcers did not develop 2 unstageable pressure ulcers to the heels, and residents who entered the facility with pressure ulcers received initial assessments and weekly assessments of those existing pressure ulcers. This was true for 3 of 3 (#s 3, 5 & 16) sampled residents reviewed for pressure ulcers. Resident #3 was harmed when he developed bilateral unstageable pressure ulcers to the heels less than 3 months after admission to the facility, which prolonged the timeframe in which he could receive bilateral hip surgery to relieve pain caused by chronic osteoarthritis. In addition, the failed practice created the potential for harm when Resident #5 did not receive an initial pressure ulcer assessment, and Resident #16 did not receive weekly pressure ulcer assessments. Findings included:</p> <p>1. Resident #3 was admitted to the facility on 12/24/13 with multiple diagnoses which included morbid obesity, osteoarthritis and diabetes.</p> <p>Resident #3's admission MDS assessment, dated 1/3/14, documented: * Intact cognition with a BIMS of 13; * Extensive assistance needed with 2 or more people for bed mobility, transfers, dressing and toilet use; * Range of motion impairments to bilateral lower</p>	F 314	<p>OTHER RESIDENTS</p> <p>Residents who have wounds or the potential to develop wounds could be affected by this practice.</p> <p>Residents will receive a skin assessment upon admission and weekly to ensure that Residents who are admitted to the facility without pressure sores do not develop pressure sores unless they are unavoidable.</p> <p>Residents that do have pressure sores are receiving the appropriate treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</p> <p>SYSTEMIC CHANGES</p> <p>Nursing Staff will be in-serviced on:</p> <ul style="list-style-type: none"> • Pressure Sore prevention • Pressure Sore treatment • Repositioning • Documentation for skin issues • Reporting Resident non-compliance with pressure sore prevention measures • Wound Documentation • Admission Skin Assessments • Weekly Skin Assessments 		

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

PRINTED: 06/26/2014
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 06/13/2014
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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 83706
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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 314	<p>Continued From page 27</p> <p>extremities; and, * At risk for pressure ulcer development with no pressure ulcers on admit.</p> <p>Resident #3's most recent quarterly MDS assessment, dated 3/31/14, documented: * Intact cognition with a BIMS of 15; * Total assistance needed with 2 or more people for transfers; * Extensive assistance needed with 2 or more people for bed mobility, dressing and toilet use; * Range of motion impairments to bilateral lower extremities; and, * Two unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar.</p> <p>A Pressure Ulcer Prevention Checklist for Resident #3, dated 12/24/13, documented interventions of, "Preventative mattress/overlay (pressure reduction); Turn & reposition schedule (Q [every] 2 Hours); Initiate weekly skin integrity assessment check form; Physical/Occupational/Speech Therapies consult(s)." Note: "Elevate heels off bed surface" was not ordered or checked on the form.</p> <p>The Initial Care Plan for Resident #3, dated 12/27/13, documented: * Resident Need - "At Risk for Break in Skin Integrity;" * Interventions - "Pressure reduction mattress; Elevate heels off bed surface and 'float' heels- no pressure on heels; Weekly skin check; Therapy consult: PT/OT [Physical Therapy/Occupational Therapy]; Bariatric bed to enhance bed mobility; DM [Diabetes Mellitus] foot checks daily; DM nail care by LN."</p>	F 314	<p>MONITORING</p> <p>Chart audits will be completed by DON and or designee on Residents with pressure sores to ensure weekly monitoring/assessments of wounds are being completed with corresponding documentation weekly for 4 months, then monthly for 3 months.</p> <p>Weekly skin assessment audits will be completed by either SDC, Unit Manager, and or Designee weekly for 4 months, then monthly for 3 months.</p> <p>Results of audits will be reviewed during the monthly PI meeting and adjustments and training provided as indicated.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/26/2014
FORM APPROVED
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F 314	<p>Continued From page 28</p> <p>The Care Plan for Resident #3, dated 12/24/13, documented:</p> <ul style="list-style-type: none"> * Problems - Self care deficit r/t (related to) dx (diagnosis) of osteoarthritis, difficulty in walking, pain and limited physical mobility r/t osteoarthritis; * Approaches - 1/4 SR (side rails) x 2 to assist with bed mobility; Requires extensive 1-2 person assist with bed mobility, dressing, toileting, and personal hygiene depends on staff needs.; Overbed trapeze to assist with bed mobility; * Problems - At risk for impaired skin integrity r/t dx of DM, restricted mobility, dx of difficulty in walking; * Approaches - Special protective devices used: pressure reducing mattress, cushion to wheelchair; LN will evaluate weekly; DM foot checks daily. <p>A February 2014 Monthly Flow Report for Resident #3 documented repositioning every 2 hours. There is a row for the day shift, evening shift and night shift to chart repositioning occurred every 2 hours and was as follows:</p> <ul style="list-style-type: none"> * Day shift repositioning occurred 5 times for the month of February on 2/3/14, 2/8/14, 2/22/14, 2/24/14 and 2/27/14; * Evening shift repositioning occurred 10 times for the month of February on 2/14/14-2/16/14, 2/18/14, 2/21/14-2/25/14 and 2/28/14; * Night shift repositioning occurred 1 time for the month of February on 2/16/14. <p>Note: Boggy and red heels were noted on 2/19/14. The resident was not repositioned on 2/17/14, was repositioned during the evening shift on 2/18/14, and was not repositioned on 2/19/14.</p> <p>The following documentation was gathered from Resident #3's Progress Notes (PN), Nurse Practitioner Office Progress Notes (NPPN),</p>	F 314			

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

PRINTED: 06/26/2014
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 06/13/2014
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 314	Continued From page 29 Pressure Ulcer Status Records (PUSR), Physician Orders (MD orders) and Telephone Orders (TMD orders), Care Plan (CP), Physical Therapy Daily Treatment Notes (PTDTN), Nurses Notes (NN), Weekly Skin Integrity Date Collection forms (WSIDC) and Treatment Administration Records (TAR): 12/25/13 - WSIDC, Bilateral heels intact and free from redness; 12/26/12 - MD orders, Check skin every week in the evening; 12/30/14 - MD orders, Over bed trapeze to aid in bed mobility; 12/30/13 - TAR, Diabetic foot checks every day. [Note:Initials documented this was completed every day for the month of February 2014 and March 2014]; 12/31/13 - MD orders, Diabetic foot check every day - day shift; 1/13/14 - MD orders, Ensure liquid lactose free liquid. Drink 237 ML (milliliters) every day as a replacement for noon meal; 2/13/14 - WSIDC, Bilateral heels intact with no redness noted; 2/19/14 - PTDTN, "...Redness/purple coloration/depression lasting longer than 15 min[utes] noted on bilateral heels...PT consulted with nursing/OT [Occupational Therapy] staff about such coloration/depression on bilateral heels. End of bed bolster put in pt's [patient's] bed to prevent further coloration/depression. Importance of bed repositioning throughout day to prevent further coloration/depression briefly discussed with pt..." 2/19/14 - TMD orders, Heel foam lift, when in bed to promote skin integrity; 2/19/14 - TAR, Heel foam lift when in bed r/t skin integrity. This was discontinued on 2/24/14. [Note: This was written as an FYI (For Your Information)]	F 314		

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

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F 314	Continued From page 30 and did not require initials]; 2/20/14 - WSIDC, Bilateral heels dry and intact; 2/24/14 - TMD orders, Discontinue heel foam list device. Prevalon boots while in bed; - MD orders, Prevalon boots while in bed, monitor for placement document refusals by circling; 2/24/14 - CP revision, "Prevalon boots in bed;" 2/24/14 - TAR, Prevalon boots while in bed. [Note: This was written as an FYI and did not require initials]; 2/27/14 - WSIDC, Bilateral heels red and intact; 3/6/14 - WSIDC, Bilateral heels intact with no redness noted; 3/13/14 - WSIDC, Bilateral heels red and intact; 3/17/14 - CP revision, "Bariatric air mattress for skin integrity antisher surface;" 3/18/14 - NN, "Patient identified to have impaired skin integrity to bilateral heels. Right heel noted to have an 0.8cmx1.5cm deep purple intact area. No drainage or erythema noted. Left heel noted 1.8cmx1.5cm intact deep purple area. No drainage or erythema. Patient denied pain with wound assessment although has pain with turning and repositioning. patient has end stage arthritis pending hip replacement. Patient has had recent weight loss which is intentional secondary to pending surgery. No edema to bilateral lower extremities. Patient has oral controlled diabetes. Patient was identified to have mushy heels on 2/19/14 where heels foam lift was initiated and changed to prevalon boots on 2/24/14 due to inability to tolerate heels foam lift. Patient stated that he rubs heels back [and] forth on mattress when he gets charlie horses and feels wounds are secondary to the back and forth rubbing. Airbed was placed with antisher surface. Patient educated regarding importance of elevating heels and current plan of care with treatment. Will have dietary interventions evaluated. Will continue to	F 314			

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

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OMB NO. 0938-0391

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F 314	Continued From page 31 monitor;" 3/18/14 - PUSR, First date of observation, Unstageable due to the coverage of wound bed by slough and/or eschar, Location: Right heel, Surface Area (Length x width): 0.8 cm x 1.5 cm with no depth, Debridement required: Yes, % of Necrotic Tissue: 100%; - First date of observation, Unstageable due to the coverage of wound bed by slough and/or eschar, Location: left heel, Surface Area (Length x width): 1.8 cm x 1.5 cm with no depth, Debridement required: No, % of Necrotic Tissue: 100%; 3/18/14 - MD orders, Full air mattress, dx: Skin integrity; - TMD orders, Prevalon boots while in bed, monitor for placement document refusals by circling initials; Beneprotein PO (by mouth) mixed in fluid of choice three times daily; 3/18/14 - CP revision, "Problems - Alteration in skin integrity: suspected, deep tissue injuries to bilateral heels;" "Approaches - Wound care as ordered. Observe effectiveness of/response to treatment as ordered; Prevalon boots while in bed; Bariatric air bed with antisher surface; Encourage resident to wear prevalon boots; and Beneprotein per MD order;" 3/18/14 - TAR, Prevalon boots while in bed, monitor for placement, document refusals by circling initials. [Note: No refusals were documented on the TAR for the month of March]; 3/20/14 - WSIDC, Bilateral heels red and intact; 3/20/14 - PUSR, Right heel, unstageable, 0.8 cm x 1.5 cm, no depth, 100% necrotic (eschar), no change in response to treatment; - Left heel, unstageable, 1 cm x 1 cm, no depth, necrotic, debride by NP, improved; 3/20/14 - PN, "Wound Assessment... Right heel measured 0.8cmx1.5 cm with no measurable	F 314		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	Continued From page 32 depth. Wound noted to be 100% necrotic tissue with small amount of serousangeous drainage. Periwound intact with dry flaky skin. NO s/sx [signs and symptoms] of infection. Wound to left heel measured 1cmx1cm with 100% necrotic tissue. No periwound erythema or drainage. Patient wearing prevalon boots and was started on beneprotein to support wound healing. Airbed in place. Patient provided with education regarding importance of elevating heels. Patients pain medications were adjusted due to patient stated that when he has muscle spasms he rubs his heels back and forth which may attribute to cause. Will continue to monitor; 3/20/14 - NPPN, History of Present Illness: "...About a month ago was noted to be at boggy heels and efforts were made at that time to offload. He has Prevalon boots in place as well as an air mattress. They were trying to turn him but again, the patient has significant pain...He does not have a history of issues with wound healing per the patient," Assessment: "Unstageable pressure ulcers of the heels," Plan: "Due to significant devitalized tissue in heels, he did require a superficial debridement with a 5 mm [millimeter] curet to remove devitalized tissue. Post-debridement measurements essentially remained the same, except for the depth that is about 0.1 or less bilaterally. There was no bleeding, some devitalized tissue remains in both heels and I stopped due to patient discomfort. The facility has done a good job offloading him, unfortunately he developed these rather quickly and progressed rather quickly. We will continue to have the Prevalon boots and the air mattress in place. We will utilize simple cover dressings and continue to try and turn him frequently;" 3/27/14 - WSIDC, Bilateral heels red with old open areas.	F 314			

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

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F 314	<p>Continued From page 33</p> <p>3/27/14 - PUSR, Right heel, unstageable, 1 cm x 1.2 cm, no depth, 100 % necrotic with periwound maceration, no change; - Left heel, unstageable, 1.5 cm x 1.5 cm, no depth, 100% necrotic, no change;</p> <p>3/27/14 - PN, Wound Assessment: Patient laying in bed with prevalon boots and heels elevated. Dressings removed for assessed. Wound to right heel measured 1cmx1.2cm with no measurable depth. Wound bed covered with 100% moist necrotic tissue. Periwound noted to have maceration. Moderate amount of serous drainage. Wound to left heel measured 1.5cm x 1.5cm with no measurable depth. Wound bed covered with 100% moist necrotic tissue. Small serous drainage. periwound noted to have light purple bruising. no undermining or tunneling noted. Patient continues to receive beneprotein to support wound healing. Patient has adequate offloading measures in place include airbed with antisheer surface, prevalon boots, elevation of heels, and trapeze to aide in bed mobility. Per interview of nurse patient has been observed removing prevalon boots and rubbing heels on bed. Nurse states she provided on the spot education regarding importance of prevalon boots. Wound healing [sic] complicated by DM, pain with mobility secondary to bilateral hip arthritis. Will request alternate treatment orders due to masceration [sic]. Will continue to monitor;"</p> <p>4/3/14 - PUSR, Right heel, unstageable, 1.5 cm x 1.2 cm, no depth, necrotic with decreased periwound maceration, improved; - Left heel, unstageable, 1.5 cm x 1.5 cm, no depth, necrotic, improved;</p> <p>4/3/14 - PN, "Wound Assessment: Wounds to bilateral heels assessed. Wound to Rt [right] heel measured 1.5cmx1.2cm with no measurable</p>	F 314		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	Continued From page 34 depth. Wound bed noted to have 100% eschar with periwound bruising noted. Wound edges noted to have decreased maceration. Wound to Left heel measured 1.5cm x 1.5cm with no measurable depth. Wound bed noted to have 100% eschar. Wound noted to have decreased maceration to wound edges. No drainage or s/sx of infection. Patient has adequate offloading interventions in place including airbed, prevalon boots. Patient receiving adequate pain control although turning and repositioning continues to be difficult. patient receiving beneprotein to support wound healing. patient has difficulty turning and repositioning secondary to severe arthritis to bilateral hips. Wound healing impeded by morbid obesity, Non-insulin dependent DM. No concerns at this time. Will continue to monitor;" 4/10/14 - PUSR, Right heel, unstageable, 1 cm x 1.5 cm, no depth, necrotic, improved; - Left heel, unstageable, 1 cm x 1.5 cm, no depth, necrotic, improved; 4/10/14 - PN, "Wound Note: [Nurse Practitioner's name] present for wound assessment. Wound to right heel measured 1cmx1.5cm with 100% eschar secured to wound base. Periwound noted to have a 1.5cm area of maceration. Small amount of serous drainage. No odor or erythema noted to periwound. Patient denied pain with wound assessment. Wound to left heel measured 1.5cmx2cm with no measurable depth. Wound bed covered with 100% secure eschar. Periwound intact with no s/sx of erythema or infection noted. New treatment orders obtained. Adequate offloading measures in place including prevalon boots, bariatric airbed, and trapeze to aide in bed mobility. Patient provided with education regarding wound healing. Continues with beneprotein to support wound healing. New treatment orders obtained. Will continue to	F 314		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	Continued From page 35 monitor;" 4/17/14 - PUSR, Right heel, unstageable, 1 cm x 1.5 cm, no depth, necrotic, wound debride by NP, improved; - Left heel, unstageable, 1.5 cm x 1.2 cm, no depth, 100% necrotic, no change; 4/17/14 - MD orders, Resource Beneprotein packet - Give 2 packets by mouth three times daily mix with choice of fluids; - TMD orders, Discontinue beneprotein one packet three times daily. Increase Beneprotein two packets three times daily per dietician recommendation; 4/17/14 - PN, "Wound Assessment: Wound to bilateral heels assessed by [Nurse Practitioner's name]. Wound to left heel measured 1.5cmx1.2cm with no measurable depth. Wound bed covered with 100% secure eschar. No periwound erythema or induration noted. Wound was debride by NP [Nurse Practitioner]. Wound to right heel measured 1.5cmx1.2cm with no measurable depth. Wound bed covered with 100% eschar. Periwound intact with no s/sx of infection. Wound was debride by NP. No change in treatment. Patient has adequate offloading measures including airbed and prevalon boots when in bed. Patient receiving beneprotein to support wound healing. No concerns at this time. Will continue to monitor;" 4/24/14 - PUSR, Right heel, unstageable, 1.5 cm x 3 cm, no depth, necrotic,debride by NP, no change; - Left heel, unstageable, 1 cm x 2 cm, no depth, 100% necrotic, debride by NP, improved; 4/24/14 - PN, "Wound Assessment: [NP's name] present for wound assessment. Wound to right heel measured 1.5cmx3cm with no measurable depth. Wound bed covered with 100% eschar with no drainage. Wound was debride by [NP's	F 314			

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F 314	Continued From page 36 name] with no bleeding. Wound to left heel measured 1cmx2cm with no measurable depth. Wound bed noted to have 100% eschar with no drainage. No s/sx of infection noted to either wounds. patient has adequate offloading interventions to include prevalon boots, and airbed. Patient receives beneprotein to support wound healing. No concerns at this time. Wounds showing improvement. Will continue to monitor;" 4/24/14 - NPPN, Subjective: "...wounds continue to have significant eschar. I did debrided the eschar away last week; however, he continues to form and eschar. We have been using Dakin's wet-to-dry with no improvement. He has no signs and symptoms of infection;" Plan: "...We will change to Santyl and cover dressing from the Dakin's wet-to-dry. My hope is that it will soften this more and we can get into good granulation tissue. Continue to utilize an air mattress, as well as Prevalon boots. Continue to follow weekly and p.r.n. [as needed];" 5/1/14 - PUSR, Right heel, unstageable, 2 cm x 3.5 cm, no depth, 100% slough, deteriorated, treatment changed with new order for x-rays to bilateral heels; - Left heel, unstageable, 1.5 cm x 3.5 cm, no depth, 100% slough, deteriorated, treatment changed and new order to x-ray bilateral heels; 5/1/14 - PN, "[NP's name] present for wound assessment. Wound to Rt heel measured 2cmx3.5cm with no measurable depth. Wound bed covered with 100% white/light brown slough with moderate amount of serous drainage. Periwound intact with no bogginess or s/sx of infection. Patient denied pain to wound although has significant pain to hips with repositioning. Wound to Lt [left] heel measured 1.5cmx3.5cm with no measurable depth. Wound bed covered with 100% light brown/white slough. Periwound	F 314		

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F 314	<p>Continued From page 37</p> <p>intact with no s/sx of infection. Moderate amount of serous drainage. Wound measurements greater than last week which is anticipated due to moistening of eschar per treatment and debridement by NP last week. Patient is adequately being offloaded with bariatric airbed and prevalon boots at all times. New order for beneprotein three times daily to support wound healing. Patient provided with education regarding plan of care with verbalized understanding. New treatment orders obtained and order for x-ray to bilateral heels to rule out osteomyelitis and abscess. Will continue to monitor;"</p> <p>5/1/14 - NPPN, Subjective: "...continues to have significant wounds of his wound bed. We did soften that with Santyl; however, he still has fairly fixed slough in these wounds, definitely mobility problems and is difficult to move down. He has not had x-rays of his heels any time for these wounds that I can find. He has no signs and symptoms of infection;" Plan: "No debridement today. We have debrided a significant amount of eschar previously. The eschar and slough is softer today. I believe he would benefit from Dakin's wet-to-dry, change daily. I would like to x-rays of his heels to rule out any gross abnormalities to include abscess or obvious osteomyelitis. If there are any suspicious findings on the x-ray we will go to MRI. We will continue to follow him weekly and p.r.n. Continue to recommend offloading with air mattress and frequently turning;"</p> <p>5/1/14 - TMD orders, X-ray bilateral heels;</p> <p>5/8/14 - PUSR, Right heel, unstageable, 2 cm x 3.5 cm, no depth, 100% necrotic, no change;</p> <p>- Left heel, unstageable, 1.5 cm x 3.2 cm, no depth, 100% necrotic, no change, treatment changed;</p>	F 314		
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F 314	Continued From page 38 5/8/14 - PN, "Wound Assessment: [NP's name] present for wound assessment. Wound to Rt heel measured 2cmx3.5cm with no measurable depth. Wound bed noted to have 100% eschar with no drainage. Periwound intact with no s/sx of infection. Wound to left heel measured 1.5cmx3.2cm with no measurable depth. Wound bed covered with 100% eschar. No erythema or s/sx of infection. NP concerned that patient continues to develop eschar with mechanical debridement and chemical debridement. x-rays negative for concerns. Patient has adequate offloading in place with airbed, prevalon boots. Turning and repositioning painful for patient due to hip pain. Will continue current treatment at this time and continue to monitor;" 5/8/14 - NPPN, Subjective: "...heels continue to be a problem for him. He is bed bound due to significant hip disease. He has a significant eschar of his heels bilaterally, debrided multiples times but his heels generate significant eschar tissue. I did order an X-ray, which was completed on 05/02/2014 due to the fact that he has had longstanding heel ulcerations. These were negative for any signs of osteomyelitis...For now we are utilizing padded heel protectors for offloading and we [are] utilizing with Dakin's wet-to-dry. We have also utilized Santyl in the past, which he has not really seemed to clean this wound up;" Plan: "No change. Continue the same. We will try to keep these stable until he transfers. Unfortunately we have had no luck with multiple debridements and unfortunately I do not follow at[local facility]...;" 5/15/14 - PUSR, Right heel, unstageable, 1.8 cm x 3.6 cm, no depth, necrotic, improved; - Left heel, unstageable, 2.1 cm x 3.6 cm, no depth, necrotic, no change; 5/15/14 - PN, "Wound Assessment: [NP's name]	F 314			

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F 314	Continued From page 39 present for wound assessment. Wounds to Rt heel measured 1.8cmx3.6cm with no measurable depth. Wound bed covered with soft eschar. Periwound intact with no s/sx of infection. Wound to left heel measured 2.1cmx3.6cm with no measurable depth. Wound bed covered with soft eschar. Periwound intact with no s/sx of infection. Patient has adequate offloading measures in place to include airbed, prevaalon boots, and trapeze to assist with bed mobility. Patient requested to have his spouse bring in a concoction of medication to put onto ulcers. Patient educated that it was not approved and it could not happen. Patient verbalized understanding. Patient receives beneprotein three times daily to support wound healing. Current treatment of lipogel in place to soften up eschar. No changes at this time. Will continue to monitor;" 5/15/14 - NPPN, Subjective: "I have had a difficult time with [Resident's name] wounds. He continues to produce significant eschar. I debrided the eschar on more than 1 occasion;" Plan: "Will utilize Santyl to no avail. Currently, we are utilizing Lipogel which does appear to be softening some of this eschar. He tells me that his wife believes that she can put some sort of 'poultice' that will heal this much more quickly than I can. I explained to the patient that unfortunately it is not a medically approved treatment and so we will not be able to use a poultice here in the skill nursing facility;" Recommendations: "Continue with Lipogel daily. My hope is this will do the job for debridement. I have not had any success with sharp debridement. I am open to debriding sharply in the future, if needed. We will continue to follow him weekly and p.r.n. Again, I explained that a poultice is not appropriate in this setting. He	F 314			

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

PRINTED: 06/26/2014
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 06/13/2014
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F 314	Continued From page 40 voices his understanding;" 5/22/14 - PUSR, Right heel, unstageable, 2.2 cm x 3.8 cm, no depth, 100% slough, improved; - Left heel, unstageable, 2 cm x 3.4 cm, no depth, slough, necrotic, improved; 5/22/14 - PN, "Wound Assessment: [NP's name] present for wound assessment. Bilateral heels assessed with noted to show improvement. Wound to Right heel measured 2.2cmx3.8cm with no measurable depth. Wound bed covered with 100% secure brown/white slough. Wound edges attached with no undermining or tunneling. Periwound note to have decreased maceration [sic]. No erythema or s/sx of infection noted. Wound to left heel measured 2cmx3.4cm with no measurable depth. Wound bed covered with 100% secured white/brown slough. No periwound erythema or s/sx of infection. Current treatment successful at softening Eschar to support autolytic debridement. Patient has adequate offloading in place including airbed with antisheer surface, prevalon boots. Trapeze to enable bed mobility. No change in current treatment. Patient educated on current wound status and what to expect. No concerns or questions verbalized. No concerns at this time. Will continue to monitor;" 5/22/14 - NPPN, Subjective: "We stopped sharp debridement on [Resident's name] because he continued to form significant eschar. We have trialed wet-to-dry dressings as well as Santyl. We finally started LipoGel, which does appear to be improving. The wound bed he continues to have slough; however, the slough is decreasing;" Plan: "No change. Continue with LipoGel. Continue to cover. Continue to offload. We will continue to follow him weekly and p.r.n.;" 5/29/14 - PUSR, Right heel, unstageable, 3.2 cm x 4 cm, no depth, 100% slough, improved; - Left heel, unstageable, 2.2 cm x 3.5 cm, no	F 314			

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

PRINTED: 06/26/2014
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 06/13/2014
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F 314	Continued From page 41 depth, 100% soft slough, improved; 5/29/14 - PN, "Wound Assessment: [NP's name] present for wound assessment. Upon entry to patients room patient noted to be laying in bariatric air bed with prevalon boots in place. Wound to right heel measured 3.2cmx4cm with no measurable depth. Wound bed covered with 100% soft slough with moderate amount of serous drainage. Periwound intact with no s/sx of infection. Wound was debride by NP. No change in current treatment, patient will continue with lipogel to continue to autolytic debridement of wounds. Wound to left heel measured 2.2cmx3.5cm with no measurable depth. Wound bed covered with 100% soft slough with moderate amount of serous drainage. Periwound intact with no s/sx of infection. Wound was debride by NP with no change in treatment at this time. patient denied pain with wound assessment although pain was noted with repositioning of lower extremities. Patient is on routine pain medication and pain is well managed. Patient utilized trapeze to move around in bed although repositioning is limited due to pain in hips and patient prefers laying on his back. Surgery has been placed on hold to bilateral hips until wounds are healed. Upon assessment bilateral lower extremities noted to be hairless and shiny. Pedal pulses very faint and difficult to palpate. New orders to obtain ABI due to suspicion of vascular component to wound attributing to cause of wound and impeding wound healing. Patient continues to receive beneprotein to support wound healing. Patient educated to current plan of care and questions were answered. No concerns at this time. Will continue to monitor;" 5/29/14 - NPPN, Subjective: "We have been utilizing Lipogel on his heels. his wound appears to be stable. The LipoGel has been softening the	F 314			

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

PRINTED: 06/26/2014
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 06/13/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
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F 314	Continued From page 42 slough. He has no questions or concerns today;" Plan: "I did debride using a 3 mm curet to remove slough superficially. I did not get into deep subcutaneous tissue...Patient tolerated this well. I did get rid of approximately 60% to 70% of the loosened slough and eschar to visualize some areas of granular tissue. I would like to continue with LipoGel as I believe this is cleaning up the wound bed nicely. I do believe it is also promoting granular tissue growth. I am not palpating excellent pulses today and I would like an ABI to help assess his flow. We will get vascular studies as needed. I will follow up on him in 2 weeks;" 5/29/14 - CP revision, "Problems - ABI [Ankle, Brachial Index] revealed moderate obstruction attributing cause of poor wound healing due to poor vascularization;" 6/5/14 - PUSR, Right heel, unstageable, 2.8 cm x 3.5 cm, no depth, 100% soft necrotic, no change; - Left heel, unstageable, 2.8 cm x 3.5 cm, no depth, 100% soft necrotic, no change. 6/5/14 - PN, "Wound Assessment: Patient resting in bed with prevalon boots to bilateral lower extremities upon entering room. Wounds to bilateral heels assessed. Wound to right heel measured 2.8cmx3.5cm with no measurable depth. Wound bed covered with 100% secure soft eschar. Wound edges attached with no undermining or tunneling identified. Small amount of serosanguinous drainage. Wound to Left heel measured 2.8cmx3.5cm with no measurable depth. Wound bed covered with 100% soft brown eschar with small amount of serosanguinous drainage. Wound edges attached with no undermining or tunneling. Periwound intact with no s/sx of infection. ABI study completed last week indicated moderate obstruction which will impede wound healing. Patient denied pain with assessment of wounds although does have pain	F 314			

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

PRINTED: 06/26/2014
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 06/13/2014
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F 314	<p>Continued From page 43</p> <p>with repositioning. Patient utilizes trapeze to aide in bed mobility although repositioning is limited due to pain in hips which he is pending hip surgery for. Pedal pulses difficult to palpate and detect with Doppler. Patient receives beneprotein to support wound healing. Suspect patient has vascular insufficiency impeding wound healing. Will refer patient for vascular studies. No change in current treatment. Lipogel effective in autolytic debridement. No s/sx of infection present. Will continue to monitor."</p> <p>6/5/14 - Referral to vascular surgeon for vascular studies of BLE (bilateral lower extremities).</p> <p>On 6/11/14 at 12:05 p.m., UM (Unit Manager) #7 was interviewed regarding the pressure ulcers to Resident #3's bilateral heels. When asked what risk factors were identified for the resident prior to the development of the pressure ulcers, the UM said initially on admit the resident was more mobile, which meant he was up in his wheelchair (w/c) frequently and participated in activities. The resident would spend up to 2 hours in the w/c when his wife and son came to visit. After some time the resident did not tolerate being up in the w/c well due to bilateral hip pain. The UM added that the resident made little progress in therapy, and the facility put in an overhead trapeze for increased bed mobility. UM #7 was asked what initial interventions were put into place to prevent pressure ulcers. The UM said the resident would allow staff to turn and reposition him, had a heel foam lift device which was changed to prevalon boots and the resident received moisturizer to his feet and legs. The UM said the resident used a regular house mattress which was a general cushion mattress which was supposed to be helpful in the prevention of pressure ulcers, but not as helpful as other mattresses. When asked</p>	F 314			

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

PRINTED: 06/26/2014
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 06/13/2014
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F 314	Continued From page 44 why the resident received an air mattress, the UM said it was for skin integrity. UM #7 said the resident was on a turning schedule but had issues with turning and refused it often. He added the refusals should have been charted in the nurses notes. [Note: Review of the Nurses Notes showed no documented refusals of turning in February or March prior to the development of the unstageable pressure ulcers] The UM was informed a turning schedule and approach was not identified on the resident's care plan at which the UM said the resident could turn himself but also needed assistance due to pain. After reviewing the resident's medical record, the UM noted a handwritten addition on the resident's Risk for Impaired Skin Integrity care plan, dated 6/10/14, which instructed staff to cue and assist resident to turn every 2 hours while in bed and, "Resident has often refused to be turned." [Note: The handwritten addition was not in place when the care plan was copied by the surveyor.] UM #7 said refusals to be turned should be reported by the CNA staff to nurses who would then chart it, and the nurse would reapproach the resident. The UM was asked when the approach of Beneprotein was added to the care plan. He looked through the Physician's Orders and stated, "I'm looking for the order," looked through nurses notes, and did not provide an answer. [Note: The care plan did not include dates when approaches were added.] The UM was asked how the area on the heels were identified as SDTIs (Suspected Deep Tissue Injuries), as documented on the care plan, if the wound was covered with 100% eschar, and the UM referred the surveyor to the wound nurse. On 6/11/14 at 3:30 p.m., UM #7 provided a copy of Resident #3's Risk for Impaired Skin Integrity	F 314		

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

PRINTED: 06/26/2014
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 06/13/2014
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F 314	<p>Continued From page 45</p> <p>care plan which had a printed approach of, "Observe skin weekly and PRN, report any red or broken areas to nurse; Turn & reposition Q [every] 2 hours or more frequently as resident will allow. Resident has often refused to be turned." There was not a date included on the approach and when asked, the UM could not say when it was added to the care plan.</p> <p>On 6/12/14 at 10:00 a.m., the wound nurse, LN #2, was interviewed regarding Resident #3. She said she became involved with the resident's care after the unstageable pressure ulcers developed. The LN said Resident #3 was identified at risk for pressure ulcers and was reviewed for adequate interventions such as the trapeze for bed mobility, a standard pressure relieving mattress, and the heels up device, which were all put into place on admit. [Note: The heels up device was not put into place until 2/19/14, after the heels were noted by PT to be red and boggy.] The wound nurse was asked when and where the SDTI came from as documented as a problem area on the resident's care plan. She said the wounds originated as SDTI's with the boggy heels.</p> <p>On 6/12/14 at 1:45 p.m., Resident #3's heels were observed while LN #2 changed the dressings. The left heel pressure ulcer was observed by the surveyor to be black eschar which covered the back side of the heel. The pressure ulcer measured 2.8 cm x 3.8 cm. The bottom of the left foot and heel were dry and flaky. The right heel pressure ulcer was observed by the surveyor to be black eschar which covered the back side of the heel. The top portion of the wound had a deep purple color and the bottom portion had white tissue. The pressure ulcer measured 3 cm x 3.8 cm with a depth of 0.2 cm.</p>	F 314			

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

PRINTED: 06/26/2014
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 06/13/2014
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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 83706
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F 314	<p>Continued From page 46</p> <p>The LN said the eschar was detaching and it was the first time she was able to measure depth.</p> <p>On 6/13/14 at 8:04 a.m., LN #2 was again interviewed regarding Resident #3's pressure ulcers. The DON was also present for the interview. The LN said Resident #3's initial Braden scale had a score of 18, the resident was on a bariatric bed with a trapeze for bed mobility. The LN continued, in January 2014 through February 2014 there was documentation about the nurses making sure the resident's heels were elevated and about repositioning. The resident was receiving therapy which noted the resident was able to turn side-to-side with minimal assist. The Braden assessment was performed on the resident weekly for 4 weeks after admit, weekly skin checks were done, and diabetic foot checks were completed. The resident was intentionally losing weight and skipping meals. She said the resident accepted Ensure as a meal replacement and was educated on the risks related to his food choices. The LN said the resident's leg spasms were addressed when Flexeril was changed, then discontinued and Miraplex was added for restless leg syndrome. LN #2 said on 2/19/14, when the boggy heels were noted, the facility intervened right away with the heels foam device which the resident did not tolerate and switched to prevalon boots. She said interventions other than those aforementioned were not initiated after the development of boggy heels.</p> <p>On 6/13/14 at 9:00 a.m., the DON was asked if SDTIs would be documented as pressure ulcers on the Pressure Ulcer Status Records. She stated, "Yeah, it would be on the pressure record."</p> <p>Note: There was no documentation related to the</p>	F 314		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/26/2014
FORM APPROVED
OMB NO. 0938-0391

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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 83706	
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F 314	<p>Continued From page 47</p> <p>SDTIs other than the PT note on 2/19/14 and the identified problem area on the resident's skin integrity care plan.</p> <p>On 6/16/14, additional information was provided by the facility which included a narrative note and supporting documentation regarding Resident #3, which documented: "[Resident's name] admitted to [Facility's name] on 12/14/13. [Resident's name] is alert and oriented and able to make his needs known. Upon admit [Resident's name] was evaluated using the Braden Assessment with a score of 18...Upon admit, based on risk factors the following interventions were initiated: Bariatric bed to enhance bed mobility, Trapeze to aide in bed mobility, Diabetic feet checks daily, diabetic nail care, and heels elevated off bed surface... [Resident's name] had chronic bilateral hip pain due to severe osteoarthritis to bilateral hips and was pending surgery. [Resident's name] was evaluated for physical and occupational therapy on 12/27/14. Diathermy was used during therapy to aide in pain management. Therapy was limited due to pain with movement of hips. Therapy notes indicated [Resident's name] was able to roll side to side utilizing bed rails with supervision with the use of his side rails and trapeze...Risk for development of pressure ulcers were evaluated weekly x 4 post admission to evaluated for needed changes in interventions...On 1/13/14 changes were made to pain medication with discontinuation of Flexaril [sic] 5mg TID [Three times per day] per [Resident's name] request due to increased lethargy during the day and was started on Flexaril [sic] 5mg at 2000 [8:00 p.m.]. Although due to increased spasms patient was restarted on Flexaril [sic] mg BID [Two times per day]...On 2/19/14 [Resident's name] was found to</p>	F 314		

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

PRINTED: 06/26/2014
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 06/13/2014
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F 314	Continued From page 48 have boggy, red heels. Interventions were initiated promptly on 2/19/14 with the initiation of a heel foam lift...Unfortunately, [Resident's name] was unable to tolerate height of the heel foam due to hip pain and on 2/24/14 the heel foam was discontinued and prevalon boots were initiated...Pain management was monitored and per patient report of spasms that cause him to rub his heels back and forth in bed patient had flexaril [sic] discontinued on 3/14/14 and Mirapex 0.125mg two hours before bedtime started due to restless leg syndrome. Pain management was closely monitored and on 3/20/14 Norco was started every six hours routine. The impact of pressure relieving interventions were evaluated weekly through skin checks and daily with diabetic feet checks that showed current interventions were effective prior to the development of the wounds...Interventions were reassessed on 2/19/14 when bilateral heels were found to be boggy and interventions were assessed in attempts to prevent further progression...During this period of time [Resident's name] had a 31lb [pound] weight loss in preparation for surgery. [Resident's name] was frequently declining meals and replacing them with Ensure. Due to concern that he is not getting adequate protein he received extensive education from RD [Registered Dietician] and nursing on making healthy food choices to support weight loss and was provided with support. Due to decreased nutritional intake it placed patient at increased risk of skin breakdown. From January to February there are 22 documented entries in the [Resident's name] medical record indicated that he was closely monitored for heel elevation and encouraged to turn and reposition...In February there is 25 documented entries of patient being repositioned...Per ABI assessment	F 314		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/26/2014
FORM APPROVED
OMB NO. 0938-0391

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F 314	<p>Continued From page 49</p> <p>patient was found to have mild obstruction to Right LE [lower extremity] and moderate obstruction to left lower extremity indicated concern with vascularization...As a facility we feel that [Resident's name] wounds were unavoidable. Optimal treatment was provided with reevaluation of interventions as identified. [Resident's name] was alert and oriented and able to make needs known. He was educated on importance of turning and repositioning and heel elevation to prevent skin breakdown and was monitored through ample amount of nursing and therapy documentation. There was no point through-out [Resident's name] care that he did not receive evaluation of his clinical status and pressure ulcer risk factors, implementation of intervention to prevent pressure ulcers based off his identified risk factors, reassessment of interventions and revision of interventions were completed as appropriate. In spite of optimal treatment provided by the facility prior to the development of the ulcers [Resident's name] un-fortunately [sic] still developed the unavoidable ulcers due to patients comobidities including vascular insufficiency, diabetes, and pain secondary to osteoarthritis."</p> <p>Note: On 2/19/14 Resident #3 was noted to have red boggy heels. There was no documented assessment of the heels other than the PT note. The wound nurse said the boggy heels were SDTIs. However, there was no Pressure Ulcer Status Record related to the SDTIs. The only intervention added at that time was the heel foam lift, which was changed to prevalon boots. There was no documented evidence in February the resident's heels were floated prior to the intervention of prevalon boots, and there was no documented evidence the resident refused to be turned, to elevate heels, or to wear the prevalon</p>	F 314			

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

PRINTED: 06/26/2014
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 06/13/2014
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 314	<p>Continued From page 50</p> <p>boots prior to the development of the bilateral unstageable pressure ulcers to his heels. In addition, turning and repositioning was not on the resident's care plan as an approach to prevent pressure ulcers until 6/10/14. It is unclear how the resident developed bilateral unstageable pressure ulcers to the heels when the nurses documented foot checks were being performed daily as well as weekly skin checks.</p> <p>On 6/13/14 at 5:10 p.m., the Administrator and DON were informed of the pressure ulcer issue.</p> <p>2. Resident #5 was admitted to the facility on 6/2/14 with multiple diagnoses which included palliative care for end stage dysphagia and failure to thrive, and wounds.</p> <p>The resident's Initial Data Collection Tool/Nursing Service record, dated 6/2/14 at 10:00 p.m., included a General Skin Condition (GSC) with front and back body diagrams. In the GSC section was documented, "Multiple pressure sores, quantity: 4" and "Opened lesions on feet." The front and back body diagrams noted dressings in place to the right posterior shoulder, right posterior elbow; right hip; right medial and lateral ankle, right inner foot (near the arch of the foot); left heel, and coccyx.</p> <p>A Braden Scale for Predicting Pressure Sore Risk, dated 6/2/14, documented the resident was at "High Risk" with a history of pressure ulcers (PU), existing PUs, decreased or impaired bed/chair mobility, and urinary or bowel incontinence. Documented in the comments section was, "coccyx wound r [right] elbow r shoulder r inner foot wound."</p>	F 314		

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

PRINTED: 06/26/2014
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 06/13/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
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F 314	<p>Continued From page 51</p> <p>The resident's Interim Care Plan, dated 6/3/14, identified "Has Break in Skin Integrity" and "Community aquired [sic] Pressure ulcer to Lt. [left] heel & [and] Rt. [right] inner foot. Terminal ulcer to coccyx" as resident needs. Interventions included:</p> <ul style="list-style-type: none"> * Education to resident and family on pressure prevention; * Pressure reduction mattress-air mattress with bolsters; * Heel elevation, no pressure on heels, implemented 6/5/14; * Reposition every 2 hours in bed; * Head of bed less than 30 degrees; * Skin to skin padding to knees with pillows, implemented 6/5/14; * Skin treatment per the physician's orders; * Weekly skin checks; and, * Prevalon boots to both lower extremities when in bed, implemented 6/5/14. <p>The resident's Admission Physician's Orders, dated 6/2/14, included, "24 hour post admit skin check pm shift" and "weekly skin check pm shift." * Note: There were no other wound care orders.</p> <p>A Telephone Order (TO), dated 6/2/14 at 5:00 p.m., included, "Cleanse coccyx, (r) [right] elbow, (r) shoulder, (r) inner foot with wound cleanser - apply mepilex [sic] border every 3 days - 6-4-14."</p> <p>A TO, dated 6/5/14, documented, "1.) Cleanse wound to Lt heel, cover with protective foam, change every 3 days and PRN [as needed] 2.) Prevalon boots to bilat[eral] LE [lower extremities] when in bed 3.) DC [discontinue] treatment to Rt elbow, Rt shoulder, Rt inner foot 4.) Cleanse wound to right inner foot with wound cleanser cover with protective foam dressing. Change</p>	F 314			

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

PRINTED: 06/26/2014
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 06/13/2014
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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 83706
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F 314	<p>Continued From page 52 every 3 days [and] PRN."</p> <p>A TO, dated 6/10/14 at 2:00 p.m., documented, "1) DC Mepilex border dressing to coccyx. 2) Continue care to wound as ordered on 6-2-14 Use bordered foam dressing in place of Mepilex."</p> <p>A TO, dated 6/10/14 at 4:00 p.m., documented, "Continue to place protective dressing on R outer bony malleolus. D/C [discontinue] protective dressing to (L) hip[,] D/C protective dressing to R hip and R shoulder."</p> <p>Three Pressure Ulcer Status Records (PUSRs), all dated 6/5/14, were found in the resident's clinical record. The PUSRs included front and back body diagrams.</p> <p>The PUSRs documentation included: * Right inner foot - unstageable, 2.5 x (by) 1 cm (centimeter), depth 0, granulation 0, no drainage, and 100% necrotic tissue. The right medial ankle was circled on the front body diagram. * Left heel - unstageable, 4 x 9.5 cm, depth 0, no drainage deep purple non-blanching. The left heel was circled on the posterior body diagram. * Coccyx - unstageable, 4.5 x 2.5 cm, depth 0, granulation 0, moderate serosanguinous drainage, 100% necrotic tissue, and 100% slough. The coccyx was circled on the posterior body diagram.</p> <p>The resident's June 2014 Treatment Record (TR) documented a 24 hour skin check was done 6/3/14 and a weekly skin check was done 6/10/14.</p> <p>The resident's Progress Notes (PNs), dated 6/2/14 at 7:18 p.m. - 6/11/14 at 10:27 p.m.</p>	F 314		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/26/2014
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 06/13/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
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F 314	Continued From page 53 documentation included: * 6/2 at 7:18 p.m. - "...Resident has dressings on right elbow., right shoulder, right instep right foot and coccyx. All dressings are dry and intact..." (Note: There was no documented evidence the dressings were removed and the resident's skin was assessed on 6/2.) * 6/3 at 3:53 p.m. - "...[W]ounds to right shoulder and elbow and coccyx with drsgs [dressings] intact...remains on airbed to maintain skin integrity..." (Note: There were 2 PNs for 6/3. However, neither of them contained documentation that the dressings were removed and the resident's skin was assessed on 6/3.) * 6/4 at 12:27 a.m. - "...clean, dry & intact dressings covering wounds on the Lt shoulder, Rt elbow, coccyx, Rt hip, Lt heel, and bilateral [medial and lateral] Rt ankles..." * 6/4 at 3:08 a.m. - "...Drsgs [dressings] to Lt shoulder, Rt elbow, coccyx, Rt hip, Lt heel, bilateral ankles clean dray and intact..." (Note: There were 3 PNs for 6/4. However, none of them documented that the dressings were removed and the resident's skin was assessed. In addition, this was the first day a dressing to the left shoulder was noted.) * 6/5/14 at 12:26 a.m. - "...Wound care and dressing changes done on...Lt shoulder, coccyx, & Lt heel. No signs of excessive erythema, warmth, excessive drainage, edema, or excessive pain at any of the wounds. Bandages also replaced on right bilateral ankle, bilateral hips, & right elbow. These bandages are in place providing extra padding the order to prevent wounds to bony prominences since resident is so thin-there are no wounds under these dressings..." (Note: More than 48 hours after the resident's	F 314			

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

PRINTED: 06/26/2014
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 06/13/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
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F 314	<p>Continued From page 54</p> <p>admission, the dressings were removed and the wounds were finally observed. However, there was no documented evidence the wounds were thoroughly assessed.)</p> <p>* 6/5/14 at 4:12 p.m. - "Wound Assessment: ...assessment of coccyx...4.5cmx2.5cm with 100% slough secure to wound bed. Peri-wound...non-blanching purple tissue...terminal ulcer, pear shaped...left heel noted to have a purple non-blanching area measuring 4cmx9.5cm intact with no drainage...boggy with no erythema intact with slight redness...Right inner foot noted to have a 2.5cmx1cm area of light brown calloused tissue...Skin is anticipated to further decline due to terminal condition."</p> <p>On 6/10/14 at 3:30 p.m., LN #1 and CNA #3 were observed as they uncovered and repositioned the resident in bed. The LN changed the coccyx dressing while CNA #3 maintained the resident on her right side. The coccyx wound bed was approximately 4 cm by 2.5 cm and dull red with approximately 1 by 1 cm of yellow slough near the center. The LN cleansed the wound with wound cleanser, patted it dry, then applied a Mepilex border dressing. At the time, a small padded dressing was observed on the resident's left hip and when the resident was turned to the left side, a small padded dressing was observed on the right hip. At the surveyor's request, the LN and CNA removed the Prevalon boots which exposed a dressing to the left heel and bilateral dressings to the right ankle. There was no evidence of a skin problem at the instep, or arch, or the medial aspect of the right foot. All of the aforementioned dressings were dry and intact. When asked when the other dressings would be changed, the LN indicated they were not</p>	F 314			

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

PRINTED: 06/26/2014
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 06/13/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
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F 314	<p>Continued From page 55</p> <p>scheduled to be changed that day. The LN said she would check the resident's chart and let the surveyors know when the dressing changes would be.</p> <p>(Note: A corresponding PN was not found in the resident's clinical record after this dressing change. Also, the LN did not communicate to the surveyors when the other dressings were to be changed.)</p> <p>On 6/10/14 at about 4:30 p.m., the DNS was asked if there were any orders not to remove any of the resident's dressings, the DNS stated, "No."</p> <p>On 6/12/14 at 3:00 p.m., the facility's Wound Nurse (WN) was interviewed. The WN stated she visited the facility once a week on Thursdays. When asked about the resident's wounds, the WN said she had assessed the resident on 6/5/14 and identified 3 areas of concern, the coccyx, left heel, and right inner foot. She stated that all other dressings were for protection only and the skin underneath those dressings was intact. When asked about the location of the right "inner foot" wound, the WN said that actually it was the medial ankle. When asked if the resident's PUs were assessed before 6/5/14, the WN briefly reviewed the resident's clinical record then acknowledged that the PUs were not thoroughly assessed until 6/5/14, the fourth day of the resident's stay in the facility.</p> <p>On 6/12/14 at 5:40 p.m., the DNS was asked to provide policies and procedures (P&P) regarding pressure ulcers.</p> <p>On 6/13/14, the DNS provided the facility's PU Program Manual.</p>	F 314			

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

PRINTED: 06/26/2014
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 06/13/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706	
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F 314	<p>Continued From page 56</p> <p>The PU Program Manual documentation included:</p> <p>* Page 2-5 - "1. Do an assessment (evaluation and screening for risk of skin breakdown on admission, weekly, and quarterly..."</p> <p>* Page 2-7 - "Admission...2. The admitting nurse follows the placement of the resident into bed with a careful full-body skin check. Pertinent information obtained from the check is recorded in the admission note..."</p> <p>On 6/13/14 at 1:50 p.m., the DNS was again interviewed. The DNS acknowledged that a thorough assessment of the resident's skin/PUs was not done on admission. When asked for the surveyor to observe the resident's other PUs, the DNS said that was not possible because the resident had died in the night.</p> <p>On 6/13/14 at 2:05 p.m., the WN and MDS Nurse #5 informed the survey team a facility-employed Nurse Liaison had assessed the resident on 6/2/14, while the resident was still in the hospital. The WN provided an untitled document which she said was the Nurse Liaison's pre-admission assessment. The WN also provided Cumulative Flowsheet Reports (CMRs) from the resident's hospital stay. The WN stated, "I agree the PUs should have been assessed on admission and they weren't." The WN stated that the hospital CMRs showed the PUs had not deteriorated since the resident's stay in the facility. When asked when the facility received the CMRs, the WN confirmed the CMRs were received that day (after the resident died). The WN acknowledged that the facility did not have the hospital information about the resident's skin/PU condition until 6/13/14.</p>	F 314		

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

PRINTED: 06/26/2014
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 06/13/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706	
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F 314	<p>Continued From page 57</p> <p>Review of the Nurse Liaison's pre-admission assessment revealed the following documentation, "Skin Issues...Wound Coccyx, Elbow, Back, Foot." The documentation was general and did not contain the exact locations (which elbow, which foot, where on the back), the stages, or the characteristics of any of the wounds. The WN agreed that it was a general assessment.</p> <p>Review of the hospital CMRs revealed the following documentation for 5/29/14 (4 days prior to resident's admission to the facility), "Multiple pressure related wounds...Right trochanter: blanchable[;] Left trochanter: blanchable[;] Right shoulder: blanchable[;] Left shoulder: 2.8cm X 1.2 cm 100% eschar[;] Coccyx: 7cm X 7cm X immeasurable. Progressing DTI [deep tissue injury]. Some open areas of pink clean non granulating tissue. Most of the wound is covered with dark purple sloughing skin. Cannot determine depth of wound[;] Right lateral heel: 3cm X 2 cm X no depth. Area of non blanchable erythema, stage I[;] Right medial malleolus: 2.3 cm X 1.2 Cm X 0.2 cm stage II open pink wound base[;] Left heel: 2 wounds: 1) 7.8 cm X 4.5 cm dark purple fluid filled blister DTI[;] 2) 3 cm X 2.8 cm serous filled blister Stage II." And, printed at the top of each CMR page was a facsimile (fax) stamp of "6/13/14" and "From MYFAX." The time the CMR pages were faxed was 12:10 to 12:13 p.m.</p> <p>Guidance at F 314, Pressure Ulcers, stated in ASSESSMENT, "An admission evaluation helps identify the resident at risk of developing a pressure ulcer, and the resident with existing pressure ulcer(s) or areas of skin that are at risk for breakdown. Because a resident at risk can</p>	F 314		

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

PRINTED: 06/26/2014
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 06/13/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706	
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F 314	<p>Continued From page 58</p> <p>develop a pressure ulcer within 2 to 6 hours of the onset of pressure, the at-risk resident needs to be identified...The admission evaluation helps define those initial care approaches. In addition, the admission evaluation may identify pre-existing signs...suggesting that deep tissue damage has already occurred and additional deep tissue loss may occur. This deep tissue damage could lead to the appearance of an unavoidable Stage III or IV pressure ulcer or progression of a Stage I pressure ulcer to an ulcer with eschar or exudate within days after admission..."</p> <p>Guidance at F 314 also stated in ASSESSMENT AND TREATMENT OF PRESSURE ULCER(S), "It is important that each existing pressure ulcer be identified, whether present on admission or developed after admission...When assessing the ulcer itself, it is important to: ...* Determine the ulcer's stage; * Describe and monitor the ulcer's characteristics;..."</p> <p>The facility was aware that Resident #5 had multiple "wounds" prior to her admission. And, the facility determined the resident was at high risk for pressure ulcers when she was admitted on 6/2/14. However, the facility did not perform a thorough skin/PU assessment on admission and it was the resident's 4th day in the facility before the coccyx, left heel, and right medial ankle PUs were thoroughly assessed. In addition, there was no documented evidence the facility ever conducted an assessment of the resident's left shoulder PU which was noted with 100% eschar 4 days before the resident's admission to the facility.</p> <p>On 6/13/14 at 3:15 p.m., the Administrator and</p>	F 314		

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

PRINTED: 06/26/2014
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 06/13/2014
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 314	<p>Continued From page 59</p> <p>the DNS were informed of the concerns regarding PUs.</p> <p>On 6/16/14, the facility hand delivered a binder that contained a cover letter, PNs dated 6/12 and 6/13/14, and several duplicate documents already mentioned regarding Resident #5's skin/PUs. However, none of the information resolved the issue.</p> <p>3. Resident #16 was admitted to the facility on 6/17/13 with multiple diagnoses which included hydrocephalus, spinabifida, scoliosis with a history of Harrington rod placement, sacral decubitus (ulcer), and a history of asthma and chronic abdominal pain. The resident was transferred to another facility on 1/10/14.</p> <p>Review of the resident's closed medical record revealed the following documentation:</p> <ul style="list-style-type: none"> * Braden Scale for Predicting Pressure Sore Risk - Moderate Risk on 6/17/13, 6/24/13, 7/8/13, 9/6/13, 9/13/13, 9/20/13, and 9/27/13; and, High Risk on 7/1/13 and 12/12/13. * Initial Data Collection Tool/Nursing Service (IDCT/NS), dated 6/17/13 - Included a General Skin Condition (GSC) section with "Pressure Sores" and "History of Pressure sores..," and "Admitted with" in handwriting. The GSC included front and back body diagrams. The back body diagram contained a circle drawn at the coccyx and the left medial calf. The front body diagram contained a circle drawn at the left hip, left knee, right thigh, and just below the right knee toward the lateral aspect. A line was drawn from the word "dressing" to the circled areas at the coccyx, left medial calf, right thigh, and right knee on the body diagrams. * Pressure Ulcer Status Records (PUSRs) - 	F 314		

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

PRINTED: 06/26/2014
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 06/13/2014
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 314	<p>Continued From page 60</p> <p>Identified a Stage III pressure ulcer (PU) at the left knee, 2 Stage II PUs at the left hip (numbered #1 and #2), and 2 Stage II PU at the left thigh (numbered #1 and #2), all of which were first observed on 6/17/13.</p> <p>* Non-Pressure Skin Condition Record (N-PSCR) - contained a circle just below the right knee on a front body diagram. The area was labeled "A" and noted as a "Fluid Blister." It was first observed on 6/17/13.</p> <p>The PUSRs contained documentation that the resident's 2 (L) hip PUs and 2 (L) thigh PUs were not consistently assessed at least weekly as follows:</p> <p>* 6/27/13 (10 days after the initial assessment); * 7/3/13 then 7/11/13 (8 days later) and 7/20/13 (9 days later); * 7/24/13 then 8/2/13 (9 days later) and 8/16/13 (14 days, or 2 weeks later). (Note: On 8/16/13 all of these PUs were noted as healed.)</p> <p>The PUSRs also contained documentation that the resident's (L) knee PU was not consistently assessed at least weekly on the same dates as the aforementioned 2 (L) hip and 2 (L) thigh PUs through 8/2/13, and as follows:</p> <p>* 8/8/13 then 8/16/13 (8 days later); * 8/23/13 then 9/4/13 (11 days later) and 9/12/13 (8 days later) and 9/20/13 (8 days later); * 10/2/13 then 10/10/13 (8 days later); * 10/24/13 then 11/8/13 (15 days later); * 11/26/13 then 12/5/13 (9 days later); * 12/19/13 then 12/27/13 (8 days later); * 1/2/14 then no other documentation. (Note: The resident was transferred to another facility on 1/10/14, 8 days after the last documented (L) knee PU assessment.)</p>	F 314		

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

PRINTED: 06/26/2014
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 06/13/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
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F 314	<p>Continued From page 61</p> <p>On 6/12/14 at 3:00 p.m., the facility's Wound Nurse (WN) informed the surveyor that she visited the facility once a week on Thursdays. The WN stated that a Nurse Practitioner (NP) also visited the facility weekly, usually on Thursdays, to provide wound care.</p> <p>On 6/12/14 at 5:40 p.m., the DNS was asked to provide policies and procedures (P&P) regarding pressure ulcers.</p> <p>On 6/13/14, the DNS provided the facility's PU Program Manual.</p> <p>The PU Program Manual documentation included: * Page 2-5 - "1. Do an assessment (evaluation and screening for risk of skin breakdown on admission, weekly, and quarterly..."</p> <p>On 6/13/14 at 1:30 p.m., the DNS was interviewed about the resident's PU wound assessments. The DNS acknowledged there were "gaps" in the assessments. The DNS said the resident was frequently non-compliant and often refused repositioning and/or baths/showers. The DNS said she would provide nurses notes that documented the residents refusal of cares.</p> <p>Further review of the resident's closed record revealed the following documentation: * Behavior/Intervention Monthly Flow Records (B/IMFR) for: - July 2013 - Only zeros, or blanks, for each day of the month regarding "non adherence to POC (plan of care); and, - August 2013 - Only zeros, or blanks, for each day of the month regarding "non adherence to</p>	F 314			

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

PRINTED: 06/26/2014
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 06/13/2014
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F 314	<p>Continued From page 62</p> <p>POC" and "refusal of care;" and, * Monthly Flow Reports (MFRs) for: - June 2013 - No evidence bathing was refused; - July 2013 - Bathing refused twice (7/26 and 7/31); and, - August 2013 - Bathing refused once (8/9). (Note: Refer to F 514, for details regarding incomplete medical records.)</p> <p>On 6/13/14 at 2:05 p.m., the WN and MDS Nurse #5 met with the surveyor. The WN said the NP had followed the resident closely during the resident's stay in the facility. The WN stated that the NP assessed the resident's PUs on 6/21/13. The WN indicated that the NP assessments took the place of the facility's assessments.</p> <p>On 6/13/14 at about 3:00 p.m., the DNS provided copies of the residents All Progress Notes (APNs), dated 6/17/13 at 5:49 p.m. through 7/31/13 at 2:00 p.m. and 11/1/13 at 9:06 p.m. through 1/14/14 at 10:39 a.m.</p> <p>The aforementioned APNs contained documentation that the resident was noted as "non-complaint" with positioning once in June and 3 times in July.</p> <p>Guidance at F314 stated in ASSESSMENT AND TREATMENT OF PRESSURE ULCER(S), "With each dressing change or at least weekly (and more often when indicated by wound complications or changes in wound characteristics), an evaluation of the pressure ulcer wound should be documented..."</p> <p>Resident #16 was admitted to the facility with multiple PUs. However, the facility failed to consistently assess the resident's PUs at least</p>	F 314		

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

PRINTED: 06/26/2014
FORM APPROVED
OMB NO. 0938-0391

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F 314	Continued From page 63 weekly. On 6/13/14 at 3:15 p.m., the Administrator and the DNS were informed of concerns regarding PUs. On 6/16/14 at about 11:00 a.m., the DNS was telephoned and asked to provide the resident's APNs for 7/31/13 after 2:00 p.m. through 8/31/13. On 6/16/14 at 12:51 p.m., the resident's APNs, dated 7/31/13 at 7:04 a.m. through 8/30/13 at 10:12 p.m., were received via facsimile (fax) at the Bureau of Facility Standards (BFS). Review of the APNs for the last day in July through 8/30/13 revealed no other documented "non-compliance" with cares in July and 2 instances in August. The August APNs also contained 7 entries that the resident was "pleasant and cooperative with cares."	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 SPECIFIC RESIDENT Resident #10 has been assessed to ensure he can safely use his assistive devices of lap tray, Broda Chair, and siderails. Siderail orders have been clarified. Consents have been obtained. Resident #13 has been assessed to ensure she can safely use her assistive devices of ½ lap tray, ½ siderails and pommel cushion. A consent has been completed for assistive devices.	7/16/14

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

PRINTED: 06/26/2014
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OMB NO. 0938-0391

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F 323	Continued From page 64 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure 2 of 13 sample residents (# 10 and #13) were assessed to determine if they were safe with the use of assistive devices, such as side rails, lap trays, and a pommel cushion. Additionally, the facility did not obtain consent or provide information regarding the risks and benefits of side rails, lap trays, or a pommel cushion. These failures created the potential for harm should a resident become entrapped in a side rail or lap tray or not be able to rise from a chair with a pommel cushion in it. Findings included: 1. Resident #10 was admitted to the facility on 2/13/13, and readmitted on 7/16/13 with multiple diagnoses which included dementia with agitated behaviors, delirium, muscle spasms, and pain. The resident's most recent quarterly MDS assessment, dated 5/21/14, coding included: * Severe cognitive impairment; * Extensive assistance of 2 or more people with bed mobility, dressing, toileting, and personal hygiene; * Total assistance of 2 or more people with transfers; * Limited range of motion in both lower extremities; and, * Wheelchair (w/c) use. A recapitulation (recap) of the resident's June 2013 Physician's Orders included the order, "11/18/13: 1/2 side rails X [times] 2...to aid in bed mobility."	F 323	OTHER RESIDENTS Residents that have siderails, lap trays, and pommel cushions will be assessed to ensure that they can safely use them and have a consent completed. SYSTEMIC CHANGES Nursing and Therapy Staff will be in-serviced regarding the need to assess any Residents that have or receive new orders for assistive devices to ensure that they can be safely used and the need for a consent completed prior to implementation. MONITORING Either the Unit Manager, SDC, and or Designee will complete assistive device audits twice a week times 4 weeks, then weekly times 4 weeks, then monthly times 3 months. Results of audits will be reviewed during the monthly PI meeting and adjustments and training provided as indicated.		

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

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F 323	<p>Continued From page 65</p> <p>A Telephone Order (TO), dated 6/6/14, documented, "Full lap tray to Broda chair to be used by resident during activities and meals/snacks to provide ease of positioning of personal items."</p> <p>The resident's Care Plan (CP) included the problem area, "At risk for falls..." Approaches included, "1/2 siderails X 2 to aid in bed mobility..." (Note: The date the approach was implemented was not documented. Refer to F280, regarding care plan revisions/updates for details.)</p> <p>The CP also included the problem area, "Self care deficit..." Approaches included, "Full lap tray to Broda chair (type of wheelchair)...during activities and meals/snacks. Remove when not in use." The approach was implemented 6/6/14.</p> <p>The resident was observed in bed with 1/2 side rails in the raised position on both sides of the bed on: * 6/11/14 at 5:50 p.m.; and, * 6/12/14 at 9:15 a.m.</p> <p>The resident was observed in the Broda chair with a full lap tray in place on: * 6/11/14 at 9:00 a.m., 11:40 a.m., 12:35 p.m., and 2:45 p.m.; * 6/12/14 at 1:15 p.m.; and, * 6/13/14 at 7:30 a.m. and 7:50 a.m.</p> <p>The resident's medical record included the following documentation: * Evaluation for Use of Side Rails, dated 5/6/13, with, "1/4 SR [siderails] X 2 for bed mobility" per the resident's request.</p>	F 323			

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

PRINTED: 06/26/2014
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 66</p> <p>(Note: There was no documented evidence the resident was assessed to determine if he was safe with the use of the SR. In addition, the physician ordered 1/2, not 1/4 SR.)</p> <p>* Initial and Quarterly Restraint Assessments, dated 11/12/13, 2/24/14, and 5/22/14, which referred to side rails, were blank in the area to document, "This device has been assessed to be appropriate and safe for use by this resident."</p> <p>* A consent, risk and benefits, and assessment for the full lap tray was NOT found.</p> <p>On 6/12/14 at 2:20 p.m., Unit Manager (UM) #9 was interviewed about the resident's SR and lap tray. Regarding the SR, the UM stated, "I can see we do need to clarify that we assessed for safety." Regarding the lap tray, the UM stated, "I did not do an assessment."</p> <p>On 6/13/14 at 3:15 p.m., the Administrator and DNS were informed of the issue. No other information was provided which resolved the issue.</p> <p>2. Resident #13 was admitted to the facility on 5/9/14 with diagnoses that included cerebrovascular accident (CVA, or stroke) and right sided weakness.</p> <p>The resident's admission MDS assessment, dated 5/16/14, coding included:</p> <ul style="list-style-type: none"> * Spoke a different language and needed or wanted an interpreter; * Impaired vision; * Sometimes able to make self understood; * Understood others; * Short and long-term memory problems; * Moderately impaired cognition; * Inattention fluctuated; 	F 323			

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

PRINTED: 06/26/2014
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 67</p> <ul style="list-style-type: none"> * Extensive assistance of 1 or 2 people for bed mobility; * Total assistance of 2 or more people for transfers; * Range of motion limitations in one upper and one lower extremity; and * Wheelchair (w/c) use. <p>A recapitulation (recap) of the resident's June 2013 Physician's Orders included: * "05/14/14: 1/2 lap tray added to wheelchair;" and, * "05/14/14: 1/4 side rails X [times] 2. To bed to assist with bed mobility."</p> <p>A Telephone Order (TO), dated 6/6/14, documented, "Pt [patient] requires pommel cushion in w/c at all times to prevent forward thrust and to maintain adequate w/c positioning."</p> <p>The resident's Care Plan (CP), dated 5/9/14, included the problem area, "Self care deficit..." Approaches included, "1/2 lap tray to right side of w/c to provide for positioning of RUE [right upper extremity]."</p> <p>The CP also included the problem area, "At risk for falls..." Approaches included, "1/4 Side rail(s) as an enabler."</p> <p>(Note: The use of a pommel cushion was not included anywhere in the resident's care plan. In addition, the date the side rails and the 1/2 lap tray were implemented was not documented. Refer to F280, regarding care plan revisions/updates for details.)</p> <p>The resident's bed was observed with 1/2 side rails in the raised position on both sides of the</p>	F 323			

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

PRINTED: 06/26/2014
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 68</p> <p>bed on: * 6/11/14 at 11:45 a.m.; and, * 6/12/14 at 9:15 a.m. (Note: The resident was not in the room at the time of these observations.)</p> <p>On 6/11/14 at 6:15 p.m., the side rail on the resident's right side was observed in the raised position and the left side rail was down while a male visited, seated next to the bed, assisted the resident to eat.</p> <p>The resident was observed in her w/c with a 1/2 lap tray and/or a pommel cushion in place on: * 6/11/14 at 2:50 p.m. and 3:50 p.m. - pommel cushion only in place ; and, * 6/12/14 at 9:45 a.m. and 11:00 a.m. - 1/2 lap tray and pommel cushion in place.</p> <p>The resident's medical record included the following: * Evaluation for Use of Side Rails, dated 5/9/14, documented, "Side rails are not indicated at this time." * Initial and Quarterly Restraint Assessments, dated 5/9/14, documented, "No interventions needed at this time." * (Note: No other side rail evaluations or assessments were found in the resident's medical record. And, regarding the 1/2 lap tray and the pommel cushion, there was not documented evidence an evaluation or assessment was completed for either of them. In addition, there was no documented evidence a consent/risk and benefits was completed for the use of the side rails, the 1/2 lap tray, or the pommel cushion.)</p> <p>On 6/12/14 at 3:45 p.m., Unit Manager #9 was</p>	F 323			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 323	Continued From page 69 interviewed about the resident's assistive devices. When asked if consents were obtained, risks and benefits provided and safety assessments were completed to determine if the resident was safe with the side rails, the 1/2 lap tray, and the pommel cushion, the UM stated, "No." Regarding side rails, the UM stated, "The side rails were added later and no assessment was done when they were added. Regarding the lap tray, the UM stated, "I don't see an assessment." Regarding the pommel cushion, the UM stated, "I don't see one [assessment] in the chart." On 6/13/14 at 3:15 p.m., the Administrator and DNS were informed of the issue. No other information was provided which resolved the issue.	F 323			
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329	F329 SPECIFIC RESIDENT Resident #1's Sulfazine order has been discontinued. Resident #8's medical record has been updated to include a diagnosis and written justification for the multiple medications from the same pharmacological class for bipolar. Resident #4's medical record has been updated to include the correct diagnosis for Midrodine. Resident #6's recaps and MARs have been updated to include diagnosis or indication for use for prescribed medications, including Lipitor, Zestril, Reglan, Oxybutynin, Dilantin, and Vitamin D3.	7/16/14	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	<p>Continued From page 70</p> <p>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure each resident's drug regimen had adequate indications for use and did not provide rationale for the use of duplicate therapy. This was true for 4 of 13 residents (#s 1, 4, 6, and 8) sampled for unnecessary drugs. This deficient practice had the potential for more than minimal harm if residents received multiple medications without clinical indication as unnecessary drugs can lead to adverse reactions and health decline. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 3/20/07 with multiple diagnoses including cerebral degeneration, dysphagia, abnormal involuntary movements and muscle weakness.</p> <p>Review of Resident #1's Physician's Orders (Recapitulation Orders), for 6/1/14 through 6/30/14, included a medication for Sulfazine, an anti-inflammatory, with a start date of 9/6/13, which did not document a diagnosis or indication for use.</p> <p>On 6/12/14 at 4:15 PM, UM #7 was interviewed and stated he was unable to find a diagnosis for Sulfazine in the resident's clinical record.</p>	F 329	<p>OTHER RESIDENTS</p> <p>LSW has reviewed medical records for Residents that have orders for duplicate therapies for psychotropic medications to ensure diagnosis and indications for use are present as well as written justification for duplicate therapy. Housewide audit of recaps and mars was conducted to ensure correct diagnosis or indication for use was present for prescribed medications.</p> <p>SYSTEMIC CHANGES</p> <p>The Medical Director, Psychiatric Nurse Practitioner, Licensed Staff, Nurse Managers and Social Service Staff will be in-serviced on the need to include diagnosis and indications for use for all prescribed medications, including psychotropic medications. In-service included the requirement for written justification for duplicate psychotropic therapies.</p> <p>MONITORING</p> <p>Residents requiring Psychotropic medications will be reviewed for duplicate therapies during our weekly psychotropic meetings by the IDT, this monitoring will continue on an ongoing basis.</p> <p>Unit Managers and or Designee will monitor for diagnosis for medications weekly by review of the telephone orders and monthly by review of the recaps this monitoring will continue on an ongoing basis.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	<p>Continued From page 71</p> <p>2. Resident #8 was admitted to the facility on 2/9/04 and readmitted on 3/22/14 with multiple diagnoses including muscle weakness, hypertension, depression, and bipolar disorder.</p> <p>Review of Resident's #8's Physician Orders (Recapitulation Orders), for 6/1/14 through 6/30/14, documented the resident was taking Lamictal and Depakote ER, which are classified as anticonvulsants, and Risperdal, which is classified as an antipsychotic medication.</p> <p>NOTE: The Physician Orders did not include diagnoses for the above medications.</p> <p>The resident's clinical record contained three Consultation Reports from the facility's pharmacy, signed by the Nurse Practitioner (NP), which documented: *Risperdal for the diagnosis of bipolar disorder, dated 10/2/13; *Depakote ER for the diagnosis of bipolar disorder, dated 10/24/13; and, *Lamictal for the diagnosis of bipolar disorder, 1/11/14.</p> <p>On 6/12/14 at 2:10 PM, UM #7 was interviewed by the surveyor and was asked to provide justification or the rationale for the use of Risperdal, Depakote ER and Lamictal for the diagnosis of bipolar disorder. He stated he would contact the NP and get back with the surveyor.</p> <p>On 6/12/14 at 5:40, the Administrator and DON were informed of the concerns regarding incorrect diagnosis, missing diagnosis or indications for use and duplicate therapy.</p> <p>On 6/13/14 at 1:40 PM, UM #7 stated the NP</p>	F 329	Results of the reviews will be discussed during the monthly PI meeting and adjustments and training provided as indicated.	

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

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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 06/13/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706	
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F 329	<p>Continued From page 72</p> <p>provided diagnosis information. When asked for documentation or the justification of use for three medications (2 anticonvulsants and an antipsychotic) for the diagnosis of bipolar disorder, UM #7 stated he did not have documentation for the use of duplicate therapy.</p> <p>On 6/16/14, the facility delivered a binder that contained a cover letter and multiple documents for Resident #8, which addressed the justification for duplicate therapy. However, documentation of the clinical rationale for the benefit of, or necessity for, the use of multiple medications from the same pharmacological class was not in the chart prior to the survey. This information was supplied after the surveyor investigated and requested the justification for duplicate therapy.</p> <p>3. Resident #4 was admitted to the facility with multiple diagnoses which included end-stage renal disease and on peritoneal dialysis.</p> <p>Recapitulations (recaps) of the resident's May and June 2014 Physician's Orders included an order for Midodrine (brand name Proamatine) 2.5 milligrams (mg), 1 tablet by mouth three times daily for "hypertension [high blood pressure]." The following was included in the Midodrine order, "(Hold for systolic blood pressure > [greater than] 140)."</p> <p>The resident's June 2013 MAR included the same Midodrine order and "hold" information. This MAR contained documentation that Midodrine was administered 3 times daily 6/1 through 6/10/14 at 8:00 a.m. and that the resident's systolic BP was less than 140 each time.</p>	F 329		

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

PRINTED: 06/26/2014
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 06/13/2014
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F 329	<p>Continued From page 73</p> <p>On 6/10/14 at 3:15 p.m., Unit Manager (UM) #9 was interviewed about the resident's Midodrine order. The UM was asked why a high blood pressure (BP) medication would be held for a systolic BP (top number of a BP reading) greater than 140. The UM reviewed the order and said it was "unusual." The UM said she would contact the physician for clarification.</p> <p>At about 3:20 p.m., the UM returned and said the Midodrine was for hypotension, "So, the diagnosis was wrong." She stated, "It's interesting because the blood pressure has to be high enough to keep the fistula open." The UM indicated that the diagnosis would be corrected immediately.</p> <p>An Internet search of the Mayo Clinic website revealed the following regarding the oral route of Midodrine, "...used to treat low blood pressure (hypotension). It works by stimulating nerve endings in blood vessels, causing the blood vessels to tighten. As a result, blood pressure is increased...midodrine is used in certain patients with the following medical conditions: * Low blood pressure...caused by kidney dialysis..."</p> <p>On 6/13/14 at 3:15 p.m., the Administrator and DNS were informed of the issue. No other information was received from the facility which resolved the issue.</p> <p>4. Resident #6 was admitted to the facility with multiple diagnoses which included history of cerebrovascular accident (CVA) with left side hemiplegia, neurogenic bladder, and depression.</p> <p>The resident's recapitulation (recap) of Physician Orders and MAR for June 2014 both included</p>	F 329			

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

PRINTED: 06/26/2014
FORM APPROVED
OMB NO. 0938-0391

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F 329	Continued From page 74 orders for Lipitor, Zestril, Reglan, Oxybutynin, Dilantin, and Vitamin D3. (Note: The diagnosis, or indication for use, was not documented in the recap orders or the MAR for any of these medications). On 6/12/14 at about 12:05 p.m., when asked for the diagnosis, or indication for use, regarding the aforementioned medications, Unit Manager (UM) #9 acknowledged that the diagnosis, or indication for use, was not documented for these medications. The UM indicated she would contact the resident's physician to request the missing information. On 6/13/14 at 3:15 p.m., the Administrator and DNS were informed of the issue. No other information was received from the facility which resolved the issue.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to maintain a medication error rate less than 5% when PD (peritoneal dialysis) fluid was started late, and 2 doses of levothyroxine were administered at the wrong time. This was true for 3 of 33 medications (9%) which affected 3 of 8 residents (#s 4, 18, and 19) during medication pass observations. Failure to administer PD fluid	F 332	F332 SPECIFIC RESIDENTS Resident #4's recapitulation order has been update to reflect the correct start time. Resident #4 is receiving peritoneal dialysis (PD) within acceptable delivery times. Resident #18's order for Levothyroxine has been clarified to ensure the medication is administered at the appropriate time. Resident #19's order for Levothyroxine has been clarified to ensure the medication is administered at the appropriate time.	7/16/14

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

PRINTED: 06/26/2014
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 06/13/2014
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F 332	<p>Continued From page 75</p> <p>and levothyroxine at the times they were ordered created the potential for the residents to receive less than optimum benefit from their prescribed medications. Findings include:</p> <p>1. Resident #4 was admitted to the facility with multiple diagnoses which included end-stage renal disease and on peritoneal dialysis.</p> <p>The resident's Admission Physician's Orders, dated 4/15/14, included, "Hiflow dialysis per personal fluid balance chart to direct fluid use to begin at 3 pm, pause and place flexidirect at 1700 [5:00 p.m.], resume at 2100 [9:00 p.m.] and disconnect at 0800 [8:00 a.m.]." (Note: The recapitulation (recap) of the resident's Physician's Orders for May and June 2014 incorrectly noted the disconnect time as 8:00 p.m. Refer to F514, Medical Records, for details regarding the inaccuracy.)</p> <p>On 6/11/14 at about 3:55 p.m., LN #12 was asked when the resident's PD fluid was to start. The LN, stated, "I think it starts at 8 pm and so you probably won't be around then. But, I'll have to check." A moment later, Unit Manager (UM) #9 joined the conversation and said the PD fluid was suppose to start at 3:00 pm. The UM told the LN that she would help.</p> <p>At about 4:15 pm, UM #9 informed the resident that LN #10 would take over for LN #12 and the PD would be started right away.</p> <p>On 6/11/14 from 4:20 to 4:40 p.m., LN #10 was observed as she prepared the PD equipment and fluid.</p> <p>At 4:40 p.m., the resident's PD fluid was stated 1</p>	F 332	<p>OTHER RESIDENTS</p> <p>Residents who receive Levothyroxine and/or PD treatments have the potential to be affected by this issue.</p> <p>SYSTEMIC CHANGES</p> <p>Licensed Nursing Staff will be in-serviced on basic medication administration which includes appropriate timing of medications and PD administration.</p> <p>Licensed Nurses will complete a Med Pass Skills Check upon hire, annually, and PRN.</p> <p>MONITORING</p> <p>Med Pass Audits will be done by either the Unit Manager, SDC, and or Designee twice a week times 4 weeks, then weekly times 4 weeks, then monthly times 3 months.</p> <p>Results of audits will be reviewed during the monthly PI meeting and adjustments and training provided as indicated.</p> <p>→ The med Pass audits will include documenting the start time for PD. me 7/20/14</p>	

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

PRINTED: 06/26/2014
FORM APPROVED
OMB NO. 0938-0391

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F 332	<p>Continued From page 76</p> <p>hour and 40 minutes later than ordered. The resident said she was uncomfortable and she was anxious when the PD solution was not started on time. (Refer to F333, Significant Medication Error, for the details.)</p> <p>On 6/13/14 at 3:15 p.m., the Administrator and the DNS were informed of medication error. No other information was received from the facility which resolved the issue.</p> <p>2. On 6/12/14 at 4:35 pm, LN #12 was observed as she administered levothyroxine to Resident #18.</p> <p>Review of the resident's June 2014 MAR and the pharmacy label on the levothyroxine package revealed the administration time was 3:00 p.m.</p> <p>On 6/12/14 at about 4:40 pm, LN #12 was asked about the time the resident's levothyroxine was given. The LN reviewed the resident's MAR then stated, "It was given late. I usually don't work this shift." The LN indicated she had been doing paperwork.</p> <p>On 6/13/14 at 3:15 p.m., the Administrator and the DNS were informed of medication error. No other information was received from the facility which resolved the issue.</p> <p>3. On 6/13/14 at 9:00 am, LN #10 was observed as she administered 12 medications to Resident #19. The 12 medications included Miralax, Allopurinol, aspirin, bupropion, Digoxin, potassium, a multivitamin, Spironolactone, Senna lax, Omeprazole, Salonpas (patch), and Spiriva (oral inhalant).</p>	F 332			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 332	Continued From page 77 Upon reconciliation of the aforementioned medications with the resident's recapitulation of Physician's Orders for June 2014, the resident was also ordered to have levothyroxine 75 mcg (micrograms) 1 tab by mouth every morning for hypothyroidism at 8:00 a.m. However, levothyroxine was not administered during the medication pass at 9:00 a.m. on 6/13/14. On 6/13/14 at about 9:15 am, LN #10 was asked about the resident's levothyroxine. The LN reviewed the resident's MAR then said the levothyroxine was changed to be given at 6:00 am and that the night time nurse gave it that morning. When asked who had changed the time on the MAR, the LN stated, "I don't know." The resident's June 2014 MAR included the levothyroxine order. However, 0800 (8:00 a.m.) had 2 lines drawn through it and 0600 (6:00 a.m.) handwritten right below it. On 6/13/14 at 9:20 am, the DNS was asked about the resident's levothyroxine administration time. The DNS stated, "I'm surprised it's scheduled for that time [8:00 a.m.]. We've been changing times to the evening. We were giving it at 6 am, but we were waking people up. The time of giving the thyroid medication depends on each resident." On 6/13/14 at 3:15 p.m., the Administrator was also informed of medication error. No other information was received from the facility which resolved the issue.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of	F 333	F333 SPECIFIC RESIDENT Resident #4 is receiving PD treatment within ordered time frames. She is no longer displaying any anxiety related to the PD process.	7/16/14

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

PRINTED: 06/26/2014
FORM APPROVED
OMB NO. 0938-0391

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F 333	<p>Continued From page 78 any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure there were no significant medication errors when Resident #4's peritoneal dialysis (PD) fluid was stated one hour and forty minutes later than ordered. Failure to start the dialysis fluid on time caused the resident to experience anxiety and increased discomfort. Findings included:</p> <p>Resident #4 was admitted to the facility with multiple diagnoses which included end-stage renal disease and on peritoneal dialysis.</p> <p>The resident's Admission Physician's Orders, dated 4/15/14, included, "Hiflow dialysis per personal fluid balance chart to direct fluid use to begin at 3 pm, pause and place flexidirect at 1700 [5:00 p.m.], resume at 2100 [9:00 p.m.] and disconnect at 0800 [8:00 a.m.]." (Note: The resident's recapitulation (recap) of Physician's Orders for May and June 2014 incorrectly noted the disconnect time as 8:00 p.m. Refer to F514, Medical Records, for details regarding the inaccuracy.)</p> <p>On 6/11/14 at 3:52 p.m., Resident #4 was observed lying on her left side in bed. The resident's PD equipment was not set up and the PD fluid had not been started. When asked when the PD fluid was supposed to start, the resident stated, "I thought they already had me hooked up and going. It's supposed to start at 3. I am not feeling well." The resident said she had been</p>	F 333	<p>OTHER RESIDENTS</p> <p>Residents who require PD administration have the potential to be affected by this practice.</p> <p>SYSTEMIC CHANGES</p> <p>Licensed Nursing Staff will be in-serviced on basic medication administration which includes appropriate timing of medications and PD administration.</p> <p>Licensed Nurses will complete Med Pass Skills Check upon hire, annually, and PRN.</p> <p>MONITORING</p> <p>Med Pass Audits which include PD will be done by either the Unit Manager, SDC, and or Designee twice a week times 4 weeks, then weekly times 4 weeks, then monthly times 3 months.</p> <p>Results of audits will be reviewed during the monthly PI meeting and adjustments and training provided as indicated.</p>	

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

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OMB NO. 0938-0391

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F 333	<p>Continued From page 79</p> <p>nauseated several times throughout the day.</p> <p>On 6/11/14 at about 3:55 p.m., LN #12 was asked if she was Resident #4's nurse and the LN said she was. When asked when the resident's PD fluid was to start, the LN, stated, "I think it starts at 8 pm and so you probably won't be around then. But, I'll have to check." A moment later, Unit Manager (UM) #9 joined the conversation and said the PD fluid was supposed to start at 3:00 pm. The UM told the LN that she would help.</p> <p>At about 4:00 p.m., UM #9 accompanied 2 surveyors to the resident's room. The UM informed the resident her weight was 145.2 pounds and they would use "2 yellows and a green or 3 yellows" of dialysis fluid for the PD. The resident said, "Use 3 greens, otherwise I'll gain weight." UM #9 said she would have to contact the physician in order to change which dialysis fluid was used. The resident asked the UM, "Why is it so late getting started?" The UM stated, "[LN #12's name] needed help and she was running a little behind." The resident again said that she did not feel well.</p> <p>At about 4:15 pm, UM #9 informed the resident that LN #10 would take over for LN #12 and the PD would be started right away. The UM also said the dialysis provider had given an order which allowed the resident to direct which dialysis fluid to use. She stated, "So, we'll use 3 greens."</p> <p>At about 4:20 p.m., LN #10 arrived in the resident's room. The LN pulled 2 green bags of 6000 mL (milliliters) each and 1 green bag of 3000 mL of Dianeal Low Calcium (2.5 mEq/L [millequivalents per liter] PD fluid with 2.5% Dextrose each from the supply in the resident's</p>	F 333			

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

PRINTED: 06/26/2014
FORM APPROVED
OMB NO. 0938-0391

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F 333	Continued From page 80 room. Then, LN #10 cleansed the resident's dialysis port, hooked up the tubing, and primed the lines, which took about 20 minutes. During that time, the resident said, "I'm not comfortable." The resident was becoming anxious. LN #10 asked the resident, "What can I do to make you comfortable?" The resident responded in a firm voice, "Get that thing going." The resident's PD dialysis was started at 4:40 p.m. (1 hour and 40 minutes late) on 6/11/14. On 6/12/14 at 8:50 a.m., the resident was observed in her wheelchair (w/c) next to her bed with her breakfast tray on the over bed table in front of her. The PD line was still connected to the resident's dialysis port and the screen on the PD machine read, "Last fill." The resident stated, "I feel better now, I had a nausea med this morning." On 6/12/14 at 10:15 a.m., when asked about the dialysis fluid start time on 6/11/14, UM #9 stated, "It was late." When asked about the resident's discomfort and anxiety on 6/11/14, the UM stated, "No she wasn't [feeling well]." The UM added, "I followed up with her this morning to be sure there was no further anxiety." On 6/13/14 at 3:15 p.m., the Administrator and DNS were informed of the significant medication error. No other information was received from the facility which resolved the issue.	F 333			
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly.	F 372	F372 SPECIFIC/OTHER The lid to the dumpster is kept closed at all times, the cracked lid has been replaced, and the area on the ground around the dumpster is kept clean.	7/16/14	

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

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FORM APPROVED
OMB NO. 0938-0391

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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 83708		
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F 372	<p>Continued From page 81</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the outside trash dumpster was covered, lids were maintained in a safe and sanitary condition and the area surrounding the trash dumpster was free from debris. This created the potential for harm should rodents and bugs be attracted to the exposed contents. Findings included:</p> <p>On 6/11/14 at 11:30 AM, during the Environmental Tour with the Maintenance Director (MD) present, the outside trash dumpster was observed to have two large, black plastic lids. One black plastic lid covered the left side of the dumpster bin but a second black plastic lid was hanging on the back of the dumpster leaving the right side of the dumpster bin open to the environment. Additionally, both lids were observed to be cracked in the middle horizontally from side-to-side. On the ground, surrounding the dumpster, lay three vinyl gloves and various food items. When asked about the dumpster being uncovered and the cracked plastic lids, the MD stated, "I made a stick to help close the trash bin lids but looks like whoever was out here last didn't close the lid on the trash bin. Also, I will have those lids replaced." The MD also stated, "The trash on the ground should be in the dumpster and the area should be free of trash."</p> <p>On 6/12/13 at 5:40 PM, the Administrator and DON were made aware of the garbage and refuse concerns. No further information was provided which resolved the above concerns.</p>	F 372	<p>SYSTEMIC CHANGES</p> <p>Staff will be in-serviced on ensuring that garbage and refuse is disposed of properly and lid is closed.</p> <p>MONITORING</p> <p>Executive Director and or Maintenance Supervisor will monitor for compliance during daily environmental rounds this monitoring will continue on an ongoing basis.</p> <p>Results of the monitoring will be reviewed during the monthly PI meeting and adjustments and training provided as indicated.</p> <p><i>the environmental rounds will be done 5 times per week and they will continue on an ongoing basis MC 7/20/14</i></p>	

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

PRINTED: 06/26/2014
FORM APPROVED
OMB NO. 0938-0391

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F 431 F 431 SS=D	Continued From page 82 483.60(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. 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. 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. 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. This REQUIREMENT is not met as evidenced by:	F 431 F 431	F431 SPECIFIC RESIDENTS Resident #5 no longer resides in the facility. Resident #17 no longer resides in the facility. OTHER RESIDENTS Residents with fentanyl patches and or insulin will be audited to ensure that insulin vials have current prescription labels on them and that fentanyl patches are being destroyed appropriately. SYSTEMIC CHANGES Licensed Nurses will be in-serviced on the appropriate procedure for destroying fentanyl patches. Licensed Nurses will be in-serviced on ensuring that insulin vials have current prescription labels on them. MONITORING Fentanyl patch destruction logs and appropriate insulin labeling will be audited by either SDC, Unit Manager, and or Designee twice a week times 4 weeks, then weekly times 4 weeks, then monthly times 3 months. Results of audits will be reviewed during the monthly PI meeting and adjustments and training provided as indicated.	7/16/14

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

PRINTED: 06/26/2014
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 06/13/2014
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F 431	<p>Continued From page 83</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure used fentanyl (a controlled medication) patch disposal was witnessed by 2 licensed nurses (LNs) and documented; and, a medication prescription label matched the physician's order. This was true for 1 sample resident (#5) during inspection of 1 of 4 medication (med) carts and for 1 random resident (#17) during 1 of 8 medication pass observations. These failed practices created the potential for harm should the remaining medication in Resident #5's used fentanyl patches be misused or diverted and if Resident #17 was administered the wrong dose of insulin. Findings included:</p> <p>1. Note: Informational Letter, Reference: S&C: 13-02 NH, stated, "Fentanyl transdermal patches are a controlled substance commonly used in nursing homes for pain medication. These patches present a unique situation given the multiple boxed warnings, the potential for abuse, misuse and diversion, and the substantial amount of fentanyl remaining in the patch after use. The facility's policies must address safe and secure storage, limited access and reconciliation of controlled substances in order to minimize loss or diversion, and provide for safe handling, distribution and disposition of the medications.</p> <p>"One benefit of the patch is the continuous delivery of fentanyl over 72 hours. This slow-release of fentanyl from the transdermal reservoir allows for more consistent pain control in patients with chronic pain. This unique delivery system, however, is not impervious to diversion, even after the fentanyl patch has been used, removed and/or disposed. One study determined that even after three days of use, 28 to 84.4% of the original fentanyl dose was still present in the</p>	F 431			

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

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F 431	<p>Continued From page 84</p> <p>patch. The study noted that the dose remaining in the patch was within the limits of a lethal fentanyl dose.</p> <p>"The remaining fentanyl in a used patch is a potential vehicle of abuse and accidental overdose and warrants implementation of adequate disposal policies. Fentanyl products contain several boxed warnings related to potential abuse, misuse, and diversion, and specifically, the contraindication of fentanyl transdermal patch use in individuals who are not opioid tolerant.</p> <p>Staff should dispose of fentanyl patches in the same manner as wasting of any other controlled substances, particularly because the active ingredient is still accessible. Wasting must involve a secure and safe method, so diversion and/or accidental exposure are minimized. ..."</p> <p>Resident #5 was admitted to the facility on 6/2/14 with multiple diagnoses which included palliative care for end stage dysphagia and failure to thrive, and wounds.</p> <p>The resident's Admission Physician's Orders, dated 6/2/14, included an order for fentanyl patch 25 micrograms (mcg) topically every 72 hours.</p> <p>The June 2014 MAR contained documentation that the 25 mcg fentanyl patch was administered to the resident on 6/3, 6/6, and 6/9/14 on the "PM [evening]" shift.</p> <p>On 6/11/14 at 11:30 a.m., the resident was observed in bed and turned slightly toward the left. A fentanyl patch, with "6/9," written on it, was noted just under the resident's left clavicle (collar bone).</p>	F 431			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 431	<p>Continued From page 85</p> <p>On 6/12/14 at about 9:30 a.m., during inspection of Med Cart D with LN #11 in attendance, documentation of the disposal of the resident's used fentanyl patches was requested. LN #11 looked through the controlled medications log binder and the MAR binder on the cart then stated, "I did not find a destruction audit log for [resident's name] fentanyl." The LN said he would "get one started right away."</p> <p>On 6/13/14 at 3:15 p.m., the Administrator and DNS were informed of the issue. No other information was received which resolved the issue.</p> <p>2. On 6/12/14 at 12 noon, during a medication pass observation, LN #11 was observed as he drew up Novolog insulin 25 units for subcutaneous (SQ) injection for Resident #17. However, the prescription label on the Novolog box documented, "NovoLog...Inject 22 units subcutaneously before meals..." The prescription was filled 3/5/14.</p> <p>Before the insulin was administered, the LN was asked about the discrepancy between the dose drawn up and the dose noted on the resident's NovoLog prescription label. The LN said the insulin orders had changed several times. The LN showed the surveyor a physician's Telephone Order (TO), dated 5/8/14, which increased the NovoLog to 25 units. The LN said the 5/8/14 TO was the most recent NovoLog order change.</p> <p>The Review of the resident's physician's orders revealed the NovoLog insulin was changed 3 times between 3/5/14 and 5/8/14 as follows: * 3/5/14 - "[Decrease] Novolog to 22 units before</p>	F 431		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 431	Continued From page 86 meals" and "D/C [discontinue] Novolog 30 units AC [before meals];" * 3/6/14 - "Decrease AC Novolog to 15 units SQ AC" and "D/C Novolog 30 units AC;" * 4/17/14 - "Increase AC Novolog to 20 units SQ AC;" and, * 5/8/14 - "Increase Novolog to 25 units SQ AC." The same medication label was on the resident's NovoLog insulin medication since 3/5/14, even though the insulin dosage changed on 4/17/14 (42 days later), then changed again on 5/8/14 (21 days later), and was still in place on 6/12/14 (35 days after the last dosage change. On 6/13/14 at 3:15 p.m., the Administrator and DNS were informed of the issue. No other information was received which resolved the issue.	F 431		
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, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	F441 SPECIFIC RESIDENTS Resident #4's bedpan has been replaced. Resident #12's dirty linen has been removed and the floor has been cleaned. OTHER RESIDENTS All Residents have the potential to be affected by this practice.	7/16/14

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

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F 441	<p>Continued From page 87</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</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, policy review, and staff interview, it was determined the facility failed to ensure a bedpan that was in contact with the floor was not placed under a resident and that soiled linens were not placed on the floor. This was true for 2 of 13 sample residents (#4 and #12). Failure to follow standard infection control measures placed residents at increased risk for infections. Findings included:</p> <p>1. On 6/10/14 at 9:40 a.m., CNA #14 was observed while in the process of providing incontinence care for Resident #4. A fracture bedpan (smaller than regular bedpans and tapered at the front to improve the ease of placement and removal after use) with 2 pieces</p>	F 441	<p>SYSTEMIC CHANGES</p> <p>C.N.A. #14 has received education regarding the cleaning and sanitization of bedpans.</p> <p>C.N.A #11 has received education regarding the correct procedure for handling dirty linen.</p> <p>Nursing Staff will be in-serviced on basic infection control measures which include the handling of bed pans and dirty linens.</p> <p>MONITORING</p> <p>Infection Control rounds which include the handling of linens and bedpans will be completed by either SDC, Unit Manager, and or Designee twice a week times 4 weeks, then weekly times 4 weeks, then monthly times 3 months.</p> <p>Results of the rounds will be reviewed during the monthly PI meeting and adjustments and training provided as indicated.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 88</p> <p>of hard formed brown stool in it was on the floor. A barrier was not utilized under the bedpan. Near the end of the incontinence care, the resident requested the bedpan again. CNA #14 took the bedpan to the resident's bathroom, emptied the contents into the toilet, then returned to the bedside and placed the bedpan under the resident. The CNA did not cleanse or sanitize the bedpan in anyway before she placed it back under the resident.</p> <p>The "Cleaning/Sanitizing, Disinfection, & Sterilization" policy found in Chapter 6: General Resident Care, found in the facility's Infection Control Manual, included the following, "Clean supplies and equipment immediately after use. Remove gross blood, secretions, and debris as soon as possible. Cleaning may be done in the resident's room or in soiled utility room."</p> <p>On 6/13/14 at 8:00 a.m., CNA #14 was asked how she assisted Resident #4 with toileting. The CNA stated, "After she uses the fracture pan, I put it on the floor while I clean her up then I empty it [bedpan] and sanitize it with sanitizing wipes." When asked if the bedpan was sanitized before she placed it under the resident the second time on 6/10/14, the CNA stated, "No."</p> <p>On 6/13/14 at 3:15 p.m., the Administrator and DNS were informed of the issue. No other information was provided which resolved the issue.</p> <p>2. Resident #12 was admitted to the facility on 3/27/02 with multiple diagnoses which included hemiplegia affecting dominant side (late effects of cerebrovascular disease) and atrial fibrillation.</p> <p>On 6/11/14 at 10:05 AM, the surveyor observed</p>	F 441			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 441	Continued From page 89 CNA #11 changing the resident's bed linen. When the surveyor walked into the room, the dirty bed linen had been removed from the mattress and was observed on the floor. CNA #11 was interviewed by the surveyor and stated, "Dirty laundry should never be on the floor." CNA #11 then put on gloves, picked up the dirty laundry and placed it in a plastic bag. The facility's policy and procedure for laundry services found in "A Guide to Infection Control, Chapter 7" documented, "All soiled linen should be bagged or put into carts at the location where used; it should not be sorted or pre-rinsed in patient-care areas. Linen that is saturated with blood or body fluids should be deposited and transported in impervious bags."	F 441			
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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;	F 514	F514 SPECIFIC RESIDENTS Resident #4's Physicians Orders for Scope of Treatment (POST) and PD has been clarified. Resident #1's orders have been clarified to include diagnosis for prescribed medications and her incontinent program/check and change is consistently documented. Resident #9's orders have been clarified to include diagnosis for prescribed medications. Resident #8's orders have been clarified to include correct diagnosis for prescribed medications.	7/16/14	

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F 514	<p>Continued From page 90 and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain clinical records for each resident in accordance with accepted professional standards and practices to ensure the records were complete and accurate. This was true for 4 of 16 sample residents (#s 1, 4, 8, and 9). This deficient practice created the potential for medical decisions to be based on incomplete or inaccurate information which increased the risk for complications due to inappropriate care or interventions. Findings included:</p> <p>1. Resident #4 was admitted on 11/1/13, and readmitted on 4/15/14, with multiple diagnoses which included End Stage Renal Dialysis on PD (peritoneal dialysis).</p> <p>a) The resident's POST (Physician Orders for Scope of Treatment), dated 4/22/14, included checked boxes in Section A for Cardiopulmonary Resuscitation: Resuscitate (Full Code); Section B for Medical interventions: Limited additional interventions; and Section C for Artificial Fluids and Nutrition: No to feeding tube, Yes to IV (intravenous) fluids, and Yes to antibiotics and blood products.</p> <p>The resident's recapitulation (recap) Physician's Orders for May and June 2014 both documented, "Code Status: DNR [Do Not Resuscitate]."</p> <p>b) The resident's Admission Physician's Orders, dated 4/15/14, included, "Hiflow dialysis per</p>	F 514	<p>OTHER RESIDENTS</p> <p>All Residents have the potential to be affected by this practice.</p> <p>SYSTEMIC CHANGES</p> <p>Housewide audit to ensure POSTs and Physician orders are accurate.</p> <p>Housewide audit to ensure that all prescribed medications have diagnosis.</p> <p>CNAs will be in-serviced on ensuring that cares that are provided are documented, including toileting programs.</p> <p>Licensed Nurses and LSW in-serviced on ensuring accuracy and completion of the medical record which includes Physicians' orders with Diagnosis, POST with matching orders, and accurate recaps.</p> <p>MONITORING</p> <p>Unit Managers and or Designee will monitor for diagnosis for medications weekly by review of the telephone orders and monthly by review of the recaps.</p> <p>During the Admission chart review Nurse Manager will ensure that the POST form is accurate and that all prescribed medications have diagnosis for new Admission.</p>		

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

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F 514	<p>Continued From page 91</p> <p>personal fluid balance chart to direct fluid use to begin at 3pm, pause and place flexidirect at 1700 [5:00 p.m.], resume at 2100 [9:00 p.m.] and disconnect at 0800 [8:00 a.m.]."</p> <p>The resident's recap of Physician's Orders for May and June 2014 documented the disconnect time of the dialysis fluid as, "8PM."</p> <p>On 6/12/14 at 10:15 a.m., Unit Manager (UM) #9 was asked about the aforementioned discrepancies in the resident's medical records. The UM reviewed the resident's POST and compared it to the May and June recap orders. The UM said that the resident's code status for full code should have been changed on the recap orders. The UM also reviewed the resident's 4/15/14 Admission Orders, which documented 8:00 a.m. as the disconnect time of the dialysis fluid, and compared it to the recap orders for May and June. The UM stated, "That's not right. It [disconnect time] got skewed on the recap." The UM indicated the errors would be corrected immediately.</p> <p>On 6/13/14 at 3:15 p.m., the Administrator and DNS were informed of the documentation issues. No other information was received from the facility which resolved the issues.</p> <p>2. Resident #1 was admitted to the facility on 3/20/07 with multiple diagnoses including cerebral degeneration, dysphagia, abnormal involuntary movements and muscle weakness.</p> <p>The care plan for elimination, with an onset date of 6/5/12, documented an approach, which was not dated, to "check and change attends [adult brief]</p>	F 514	<p>Unit Manager and or Designee will monitor for documentation of the incontinent programs twice a week times 4 weeks, then weekly times 4 weeks, then monthly times 3 months.</p> <p>Results of the reviews and audits will be discussed during the monthly PI meeting and adjustments and training provided as indicated.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	<p>Continued From page 92 every 2 hours and prn."</p> <p>Review of the Monthly Flow Report for the month of May to June, 2014, documented there was inconsistent documentation of the check and change program as follows: *Day shift: 5/5, 5/8, 5/20 and 5/25. *Evening shift: 5/1, 5/3, 5/4, 5/7, 5/8, 5/9, and 5/13-31. *Night shift: 5/6, 5/8, and 5/12.</p> <p>Review of the resident's Physician's Orders (Recapitulation Orders), for 6/1/14 through 6/30/14, documented the following medications which did not list a diagnosis or indication for use for the following medications: *Acetaminophen; *Atorvastatin Calcium; *Clonazepam; *Diazepam; *Glimepiride; *Invega Sustenna; *Ipratropium-Albuterol Nebulizer; *Januvia; *Klor-Con; *Omeprazole; *Saline Nasal Spray; and, *Sulfazine.</p> <p>On 6/12/14 at 11:20 AM, UM #7 was interviewed by the surveyor and shown the Monthly Flow Report documentation of the care plan approach to check and change every 2 hours and prn. UM #7 stated, "I don't think the CNA's are documenting like they should." When asked about the above mentioned medications without diagnosis or indication for use on the Physician's Orders (Recapitulation Orders), for 6/1/14 through 6/30/14, he stated he would check into it.</p>	F 514			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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	
F 514	<p>Continued From page 93</p> <p>On 6/12/14 at 1:15 PM, UM #7 stated the diagnosis for medications were listed on the admission orders or on a telephone order, which he supplied to the surveyor. He stated he was still looking for the diagnosis of the medication, Sulfazine. UM #7 stated the diagnoses were not carried over to the recapitulation orders or the MARs.</p> <p>On 6/12/14 at 4:15 PM, UM #7 stated, he was unable to "find a diagnosis for Sulfazine."</p> <p>3. Resident #9 was admitted to the facility on 5/6/11, and readmitted on 1/22/14, with multiple diagnoses including difficulty walking and paranoid type schizophrenia.</p> <p>Review of the resident's Physician's Orders (Recapitulation Orders), for 6/1/14 through 6/30/14, documented the following medications which did not list a diagnosis or indication for use: *Zyprexa; and, *Phenergan.</p> <p>On 6/12/14 at 3:40 PM, UM #7 was interviewed by the surveyor regarding the above medications without diagnosis or indication for use on the Physician's Orders (Recapitulation Orders), for 6/1/14 through 6/30/14, and stated he would check into it.</p> <p>On 6/13/14 at 1:35 PM, UM #7 stated the diagnosis for medications were listed on the admission orders, which he supplied to the surveyor. UM #7 stated the diagnoses were not carried over to the recapitulation orders or the MARs.</p>	F 514			

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

PRINTED: 06/26/2014
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 06/13/2014
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F 514	<p>Continued From page 94</p> <p>4. Resident #8 was admitted to the facility on 2/9/04, and readmitted on 3/22/14, with multiple diagnoses including muscle weakness, hypertension, depression, and bipolar disorder.</p> <p>Review of the resident's Physician's Orders (Recapitulation Orders), for 6/1/14 through 6/30/14, documented the following medications which did not list a diagnosis or indication for use: *Atorvastatin Calcium; *Wellbutrin XL; *Peridex Mouthwash; *Norco; *Risperidal; and, *Tramadol.</p> <p>On 6/12/14 at 2:10 PM, UM #7 was interviewed by the surveyor regarding the above medications without diagnosis or indication for use on the Physician's Orders (Recapitulation Orders), for 6/1/14 through 6/30/14, and stated he would check into it.</p> <p>On 6/13/14 at 1:40 PM, UM #7 stated the diagnosis for medications were listed on the admission orders or on a telephone order, which he supplied to the surveyor. He stated the diagnosis on the Physician's Orders for Wellbutrin XL was incorrect and should be bipolar/mood stabilizer as indicated on the 6/13/14 clarification telephone order he received from the Nurse Practitioner. UM #7 stated the diagnoses were not carried over to the recapitulation orders or the MARs.</p> <p>On 6/12/14 at 5:40 PM, the Administrator and DON were informed of the documentation concerns, missing diagnosis and incorrect diagnosis issues on the Physician's Orders</p>	F 514			

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

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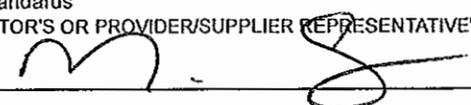
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F 514	Continued From page 95 (Recapitulation Orders). No further information was provided by the facility which resolved the concern.	F 514			

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 State licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Lauren Hoard, RN, BSN Linda Kelly, RN Linda Hukill-Neil, RN</p>	C 000	<p style="text-align: center;">RECEIVED JUL - 8 2014 FACILITY STANDARDS</p> <p><i>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</i></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; This Rule is not met as evidenced by: Refer to F164 as it related to privacy during personal cares.</p>	C 125	<p>C125 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F164</p> <p>C147 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F329</p>	7/16/14
C 147	<p>02.100,05,g Prohibited Uses of Chemical Restraints</p> <p>g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician.</p>	C 147	<p>C335 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F372</p>	

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 7/8/14
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C 147	Continued From page 1 This Rule is not met as evidenced by: Please refer to F-329 as it relates to duplicate therapy and diagnosis or indication for use.	C 147	C336 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F372	
C 335	02.108,03 GARBAGE AND REFUSE 03. Garbage and Refuse. The premises and all buildings used as facilities shall be kept free from accumulation of weeds, trash and rubbish. Material not directly related to the maintenance and operation of the facility shall not be stored on the premises. This Rule is not met as evidenced by: Please refer to F-372 as it relates to garbage bins and trash.	C 335	C338 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F372 C361 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F253	
C 336	02.108,03,a Construction of Garbage/Refuse Containers a. All containers used for storage of garbage and refuse shall be constructed of durable, nonabsorbent material and shall not leak or absorb liquids. Containers shall be provided with tight-fitting lids unless stored in vermin-proof rooms or enclosures, or in a waste refrigerator. This Rule is not met as evidenced by: Please refer to F-372 as it relates to garbage bins and trash.	C 336	C362 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F253 C367 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F372	
C 338	02.108,03,c Sanitary Maintenance of Garbage Containers c. Garbage containers shall be maintained in a sanitary manner. Sufficient containers shall be	C 338	C669 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F441	

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C 338	Continued From page 2 afforded to hold all garbage and refuse which accumulates between periods of removal from the premises. Storage areas shall be clean and sanitary. This Rule is not met as evidenced by: Please refer to F-372 as it relates to garbage and trash.	C 338	C671 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F441 C781 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F279	
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Please refer to F-253 as it relates to odors and cleanliness.	C 361	C782 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F279 and F280 C784 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F309 and F310	
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: Please refer to F-253 as it relates to bathing rooms and cleanliness.	C 362	C785 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F312	
C 367	02.108,07,b,iv Maintenance of Facility and Grounds iv. Storage areas, attics,	C 367	C788 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F333	

Bureau of Facility Standards

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C 367	Continued From page 3 basements, and grounds shall be kept free from refuse, litter, weeds, or other items detrimental to the health, safety or welfare of the patients/residents. This Rule is not met as evidenced by: Please refer to F-372 as it relates to dumpsters not covered.	C 367	C789 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F323	
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: Refer to F441 as it related to a fracture bedpan on the floor.	C 669	C792 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F323 C798 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F332	
C 671	02.150,03,b Handling Dressings, Linens, Food b. Proper handling of dressings, linens and food, etc., by staff. This Rule is not met as evidenced by: Please refer to F-441 as it relates to linen and infection control.	C 671	C832 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F431	
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: Please refer to F-279 as it relates to Care Plans.	C 781	C881 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F514	

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C 782	Continued From page 4	C 782		
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F-279 and F-280 and it relates to Care Plans.	C 782		
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: Refer to F309 regarding the failure to impliment an arm brace as ordered. Also, refer to F310 as it related to a resident's understanding of the purpose of a call light.	C 784		
C 785	02.200,03,b,i Grooming Needs i. Good grooming and cleanliness of body, skin, nails, hair, eyes, ears, and face, including the removal or shaving of hair in accordance with patient/resident wishes or as necessitated to prevent infection; This Rule is not met as evidenced by: Please refer to F-312 as it relates to grooming.	C 785		
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered	C 788		

Bureau of Facility Standards

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C 788	Continued From page 5 iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Please refer to F333 as it relates to late delivery of mediations.	C 788		
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: Please refer to F323 as it relates to pressure ulcers.	C 789		
C 792	02.200,03,b,viii Comfortable Environment viii. Maintenance of a comfortable environment free from soiled linens, beds or clothing, inappropriate application of restraints and any other factors which interfere with the proper care of the patients/residents; This Rule is not met as evidenced by: Refer to F323 as it related to the use of assistive devices.	C 792		
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders 04. Medication Administration.	C 798		

Bureau of Facility Standards

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C 798	Continued From page 6 Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Refer to F332 as it related to a 5% or greater medication error rate and significant medication errors.	C 798		
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 related to medication labels.	C 832		
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by:	C 881		

Bureau of Facility Standards

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C 881	Continued From page 7 Refer to F514 as it related to complete and accurate medical records. Please refer to F541 as it relates to medical records and documentation. <i>SHOULD BE "F514" NOT F541 per conversation with Lauren Hoop on 7/18/14 mgs</i>	C 881		



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

July 22, 2014

Michael Crowley, Administrator
Life Care Center of Boise
808 North Curtis Road
Boise, ID 83706-1306

Provider #: 135038

Dear Mr. Crowley:

On **June 13, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Boise. Linda Hukill-Neil, R.N., Becky Thomas, R.N., Lauren Hoard, R.N., and Linda Kelly, R.N., conducted the complaint investigation.

This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey of June 2014.

Observations of care were conducted throughout the survey week and the following documents were reviewed:

- The identified resident's closed record and the records of 13 other sampled residents;
- Grievances from May 2013 to June 2014; and,
- Resident Council Meeting minutes January 2014 to June 2014.

The following interviews were conducted:

- Quality of Life Resident Group Interview on June 11, 2014 with 15 residents in attendance;
- Quality of Life Assessment Resident Interviews during the Recertification Survey;
- Quality of Life Assessment Family Interviews during the Recertification Survey;
- Two Certified Nurse Aides (CNAs), one of whom provided care to the identified resident;
- One Licensed Nurse-- all of the nurses for the identified resident's unit were new hires;
- One Licensed Social Worker (LSW); and,
- Director of Nursing Services (DNS).

The complaint allegations, findings and conclusions are as follows:

FILE COPY

Michael Crowley, Administrator
July 22, 2014
Page 2 of 3

Complaint #6146

ALLEGATION #1:

Letters from two different complainants stated an identified resident was found unshaven, smelled of body odor and was dressed inappropriately.

FINDINGS:

During the resident's 13 day stay at the facility, there was documentation the resident received only two baths and was shaved twice. No documentation was found that the resident refused cares. The allegation was substantiated and the facility was cited at F-312.

CONCLUSION:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainants stated the identified resident did not receive proper pain management during his stay at the facility and on May 20, 2014, was found sobbing, telling the complainants he was in pain.

FINDINGS:

Review of the identified resident's closed record revealed the resident received Acetaminophen, Ibuprofen, and Norco for pain control on a scheduled and PRN (as needed) basis. The medical record documented the resident received pain medication 28 times between May 5 and May 28, 2014. Additionally, the resident received pain medication on May 20, 2014, on three occasions. Nursing notes did not document concerns related to the resident verbalizing inadequate pain control.

Grievances were reviewed from May 2013 through June 2014 and did not include any pain control concerns.

Interviews with four residents and two family members during the recertification survey indicated residents were happy with their pain control/medications and did not have problems with pain.

The DNS and the LSW both stated they did not receive any complaints with regard to pain for the identified resident. The DNS stated, "The resident did have pain issues but they were taken care of and I felt like he was adequately controlled."

Although the incident may have occurred, based on the evidence, it could not be substantiated.

Michael Crowley, Administrator
July 22, 2014
Page 3 of 3

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3: The complainants stated the identified resident's trash was full and was not emptied for two or more days.

FINDINGS:

During the survey process, resident rooms were observed to be consistently clean. Housekeeping staff were observed to empty the trash on a daily and as needed basis.

At the Resident Group Interview, residents reported the housekeeping staff did a good job and they did not verbalize any concerns related to their trash being emptied.

Grievances were reviewed from May 2013 through June 2014 and there were not any documented concerns related to housekeeping.

Interviews with four residents and two family members during the recertification process indicated they were happy with the cleanliness of their rooms and the facility.

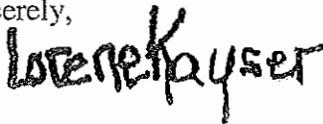
CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

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, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care 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 signature is written in a cursive, somewhat stylized font.

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

LK/lj



IDAHO DEPARTMENT OF
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July 22, 2014

Michael Crowley, Administrator
Life Care Center of Boise
808 North Curtis Road
Boise, ID 83706-1306

Provider #: 135038

Dear Mr. Crowley:

On **June 13, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Boise. Linda Hukill-Neil, R.N., Becky Thomas, R.N., Lauren Hoard, R.N., and Linda Kelly, R.N., conducted the complaint investigation.

The records of 14 residents including that of the identified resident were reviewed during the recertification survey and complaint investigation that was conducted June 9-13, 2014.

The complaint allegations, findings and conclusions are as follows:

Complaint #6389

ALLEGATION #1:

The complainant stated the identified resident received an antibiotic medication without clarification orders from the doctor.

FINDINGS:

The identified resident's medical record provided evidence that the facility contacted the resident's physician regarding an antibiotic the resident was receiving upon admission and requested the antibiotic be discontinued per the resident's request. The physician responded with an order to continue the antibiotic through to the stop date prescribed. The facility provided education to the resident and family members on the reasoning in which the antibiotic was prescribed, and the resident agreed to take the medication.

The Director of Nursing and a licensed nurse were interviewed regarding the identified resident. They

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Michael Crowley, Administrator
July 22, 2014
Page 2 of 2

were unable to recall issues concerning the administration of the prescribed antibiotic. They did recall, however, issues related to pain management and the use of narcotics.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the identified resident was having loose stools and the nurses tried to administer stool softeners.

FINDINGS:

The identified resident's medical record was reviewed during the survey process. The medical record provided evidence that the facility contacted the resident's physician regarding the resident's request to make two stool softener medications prescribed on an as needed basis, rather than scheduled. The physician responded with an order to change the two stool softeners to administer as needed. There was no documented evidence that the resident had, or complained of, loose stools after admission to the facility.

The Director of Nursing and a licensed nurse were interviewed regarding the identified resident. They were unable to recall issues related to the resident having loose stools. They did recall, however, issues related to pain management and the use of narcotics.

CONCLUSION:

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,



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

LK/lj



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

August 15, 2014

Michael S. Crowley, Administrator
Life Care Center of Boise
808 North Curtis Road
Boise, ID 83706-1306

Provider #: 135038

Dear Mr. Crowley:

On **June 13, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Boise. Becky Thomas, R.N., Lauren Hoard, R.N., Linda Kelly, R.N. and Linda Hukill-Neil, R.N. conducted the complaint investigation.

This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted June 9, 2014 through June 13, 2014.

Observations of care, including wound care were conducted during the survey week and the following documentation was reviewed:

- The identified resident's closed record;
- The identified resident's hospital records, dated August 27, 2013;
- Clinical records for thirteen sample residents, which included two residents reviewed for pressure ulcers;
- Grievance records from May 2013 to June 2014;
- Incident and accident reports for January to June 2014; and,
- The facility's policies and procedures regarding pressure ulcers.

Interviews were conducted with:

- Fifteen residents who attended a Quality of Life Assessment Group Interview on June 11, 2014;
- Four residents during Quality of Life Resident Interviews;
- Two family members during Quality of Life Assessment Family Interviews;

Michael S. Crowley, Administrator
August 15, 2014
Page 2 of 2

- Two Licensed Nurses who provided care for the two sample residents with pressure ulcers; and,
- The Director of Nursing Services (DNS).

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006404

ALLEGATION:

The complainant stated that an identified resident with spina bifida came to the hospital for suprapubic catheter placement. Once the resident's contractures were relaxed under anesthesia, multiple wounds with foul smell and discharge were found on the resident's lower extremities. The resident was sent back to the facility with physician's orders for daily dressing changes.

FINDINGS:

Review of the identified resident's closed record and hospital records and interview with the DNS revealed that the facility failed to assess consistently the pressure ulcers on the resident's lower body and lower extremities, at least weekly. The facility was cited at F314 for the failed practice.

CONCLUSIONS:

Substantiated. Federal and State 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, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care 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,



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

LKK/dmj