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 3050 0001 2125 6164

September 9, 2014

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

Provider #: 135038

Dear Mr. Crowley:

On **August 22, 2014**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **July 16, 2014**. However, based on our on-site follow-up revisit conducted **August 22, 2014**, we found that your facility is not in substantial compliance with the following participation requirements:

F281 -- 42 CFR §483.20(k)(3)(i) -- Services Provided Meet Professional Standards
F332 -- 42 CFR §483.25(m)(1) -- Free of Medication Error Rates of 5% or More
F333 -- 42 CFR §483.25(m)(2) -- Residents Free of Significant Medication Errors

In addition, a Complaint Investigation survey was conducted in conjunction with the on-site follow-up.

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: 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 copy of the Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 22, 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.

- 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.*

As noted in the letter of **June 26, 2014**, following the **Recertification, Complaint Investigation and State Licensure** survey of **June 13, 2014**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **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.

STATE ACTIONS effective with the date of this letter (**September 9, 2014**): None

If you believe the 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, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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:

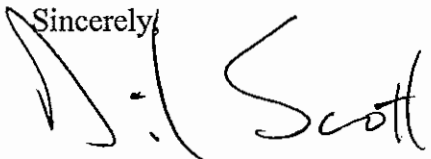
- BFS Letters (06/30/11)

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

This request must be received by **September 22, 2014**. If your request for informal dispute resolution is received after **September 22, 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 on-site follow-up revisit 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

DJS/dmj
Enclosures

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

PRINTED: 09/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135038		R-C 08/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BOISE	808 NORTH CURTIS ROAD BOISE, ID 83706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The following deficiencies were cited during the onsite follow up and complaint survey of your facility. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Lorraine Hutton, RN The survey team entered the facility on August 21, 2014 and exited on August 22, 2014. Survey Definitions: CC = Cubic centimeter DON/DNS = Director of Nursing Gm = Gram HS = Bedtime LN = Licensed Nurse MAR = Medication Administration Record MD = Physician MCG = Microgram RN = Registered Nurse ML = Millimeter PRN = As needed	{F 000}	RECEIVED SEP 11 2014 FACILITY STANDARDS 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	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation. medical record review, and staff interview, it was determined the facility failed to ensure LNs practiced within the Idaho Nurse Practice Act. This affected 1 of 4 residents (#29) who went on a 5 hour outing without	F 281	F281 **SPECIFIC RESIDENTS** Resident #27 has discharged from the facility. Resident # 28's Insulin order has been clarified to ensure that it is given per MD orders while meeting the Resident's personal preference. The Resident's Medication Administration Record, Blood Glucose sheet and care plan has been updated to reflect these changes.	9/12/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M. S TITLE: Administrator (X6) DATE: 9/11/14

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 281	Continued From page 1 scheduled medications, and 2 of 7 residents observed during medication pass (#27 & 28). The failure to follow the nurse practice act in administering medications as ordered by the physician put Resident #28 at risk for hypoglycemia, and Resident #s 27 & 29 at risk for not receiving full benefits of their medications. Findings include: The Idaho Nurse Practice Act (Idaho Statute, Title 54, Chapter 14, defines a licensed practical nurse (LPN) as a nurse who functions in a dependent role at the direction of RNs, MDs, and dentists; a licensed registered nurse is defined as one who implements the strategy of care authorized by advanced practice nurses, physicians, and dentists. The RN also authorizes nursing interventions not conflict with the nurse practice act. The Nurse Practice Act and RN scope of practice indicates the RN cannot generally make independent decisions to disregard medication and treatment orders. During medication pass observations on 8/21/14 between 11:10 a.m. and 11:45 a.m., and 8/22/14 at 8:17 a.m., the following was observed: 1. Resident #28 received her insulin, ordered to be given with lunch, 45 minutes before the meal. During interviews on 8/21/22 and 8/22/14, the DNS indicated this was a common practice for the resident. However, there were no physician's orders authorizing this common practice. (See F 332 for details) 2. Resident # 29 was sent on a 5 hour outing (11:00 am to 4:00 pm) without her 1:00 pm medication (Lasix 40 mg). The resident's MAR documented the 1:00 pm dose of Furosemide 40	F 281	Resident #29 will have Lasix administered per MD order. Resident #29 was assessed and no negative were outcomes noted. **OTHER RESIDENTS** All other residents have the potential to be affected by this practice. Residents will have their medications administered following the Nurse Practice Act to ensure that the services provided meet professional standards. Residents who receive Regnloid and/or Insulin have the potential to be affected by this issue. Chart Audits will be conducted to ensure that all Residents that have orders for Reguloid have measurable doses. Chart audits will be done for all Residents that have orders for insulin to ensure that the Medication Administration Record, BG Sheet, and individual care plans match the time on the MD order. Residents who have insulin ordered at mealtimes (breakfast, lunch, or dinner) will be audited to ensure that no personal preferences interfere with following MD orders. If any are found, MD will be notified for further orders.	

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F 281	Continued From page 2 mg was not given because the resident was "OOF" (Out of the Facility). On 8/21/14 at 1:30 p.m., the Unit Manager indicated the resident's physician had not authorized, nor been been notified of the missed medication. The Unit Manager stated no medications except pain pills are generally sent with residents on outings and residents' physicians were generally not notified if a medication would be held or given after the outing unless it was insulin. On 8/21/14, at 4:10 pm, the LN who accompanied the resident and five other residents on the outing stated she brought only pain medications for the residents on outings. She stated she did not take routine medications or insulin with her to administer while on outings. When asked if the residents' physicians were aware of this, she stated she was not certain. 3. Neither LN #2 (LPN) who administered a powdered medication to Resident #27, nor the DNS (RN), were certain of the volume of the powder needed to ensure the resident received the proper dose of medication. LN #2 guessed at what she thought was a proper dose, resulting in the resident receiving a larger dose than the physician had ordered. Neither the MD nor facility RNs, such as the Unit Managers or the DNS, provided the LPN with clear direction for the volume of medication that should be administered. Please refer to F 332 for details.	F 281	**SYSTEMIC CHANGES** LN's will be in-serviced to the Nurse Practice Act in regards to administering medications as ordered by physician and on when to notify MD for further guidance in regards to administering medications, specifically when the Resident's preferred time of administration does not match what is ordered, the holding of medications for outings and when the proper dose of medication cannot be verified in the facility. RN's and DNS will be in serviced to ensure that clear directions for the volume of medication that should be administered is provided to LPN's. Licensed Nursing Staff will be in-serviced on basic medication administration which includes the need to ensure that Bowel Care Powders doses are being given as ordered and that orders are measurable and that Insulin is given per MD ordered times and that residents receive food within the appropriate time frames when given Insulin. Licensed Nurses will complete a Med Pass Skills Check upon hire, annually, and PRN. Nursing Managers will review all new Doctors Orders 5 times per week in the daily department head meeting to ensure that all orders have measurable doses.	
{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.	{F 332}		

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{F 332}	Continued From page 3 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 of less than 5% when insulin was not administered per physician orders and staff did not correctly measure Reguloid powder before administering it. This was true for 2 of 25 medications (8%) which affected 2 of 6 residents (#s 27 and 28) during medication pass observations. Failure to administer the resident's insulin at the times ordered by the physician had the potential to cause hypoglycemia. The failure to provide a correctly measured amount of the Reguloid, a medication given to prevent constipation and bowel irregularity, had the potential for the resident to receive less than optimum benefit from the prescribed medication. Findings include: 1. During a medication pass observation on 8/21/14 at 11:10 am, Resident #28 received a fast-acting insulin and another injectable anti-diabetic medication, that increased the risk for hypoglycemia, 45 minutes before a substantial meal. On 8/21/14 at 11:10, the surveyor and LN #1 entered the resident's room to find Resident #28 sitting in a chair watching television. LN #1 greeted the resident and stated she was going to check her blood sugar. LN #1 did a finger stick blood glucose reading, which was 119, and then administered 50 units of Novolog insulin subcutaneously in the resident's right lower abdominal quadrant. LN #1 also administered Symlinpen 120 mcg subcutaneous injection	{F 332}	**MONITORING** Beginning on 8/28/14 Med Pass Audits to include insulin administration and Bowel Care powders will be done by either the Unit Manager, SDC, and or Designee twice a week times 4 weeks, then weekly times 8 weeks, then monthly times 3 months. Beginning on 9/12/14 Unit Managers or Designees will review the outing schedules to resident's MARS to verify that medication was given or that MD was notified and alternative order was received for the resident during the outing. This practice will continue on an on going basis. Results of audits will be reviewed during the monthly PI meeting and adjustments and training provided as indicated. F332 **SPECIFIC RESIDENTS** Resident #27 has discharged from the facility. Resident # 28's Insulin order has been revised by MD so that the Resident's personal preferences are met. Resident's Medication Administration Record, BG Sheet, and individual care plan have all been updated to match the new Doctor's order.	9/12/14

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{F 332}	Continued From page 4 approximately 2 inches from the Novolog injection site. Physician Orders, dated 5/15/14, instructed staff to administer 50 units of Novolog 100 unit/1ml with breakfast, lunch and dinner. Administration times listed on the physician ' s orders and the MAR were 8:00 a.m., 12:00 noon, and 5:00 p.m. The resident's Care Plan, dated 6/24/10, and updated 4/28/14, listed a problem with Alteration in Hormone levels: Diabetic. Approaches included: * BG's per MD. Administer insulin as ordered (see current physician's orders/MAR) * Offer HS snacks and snacks prn Per physician's orders Resident #28 was also scheduled to receive the following anti-diabetic medications to treat her Type II diabetes: * Lantus 100 unit/ml, 175 units subcutaneously at bedtime * Symlin Pen sub-q [subcutaneous] 120 mcg before meals * Metformin ER 500 mg tablet - 4 tabs (1200 mg) by mouth every evening Resident #28 was observed in the dining room between the 200 and 300 hall at 11:58 a.m. Resident #28 received the first tray off the food cart and began eating at 12:02 pm. There was no documentation in the resident's medical record, including her MAR, physician's orders, or Care Plan that allowed for her Novolog insulin to be given 45 minutes prior to the meal. Chapter 27 of the facility's policy guidelines, described Onset Actions for Commonly	{F 332}	**OTHER RESIDENTS** Residents who receive Reguloid and/or Insulin have the potential to be affected by this issue. Chart Audits will be conducted to ensure that all Residents that have orders for Reguloid have measurable doses. Med Pass audit will be conducted by Unit Managers or SDC on nurses who are administering Reguloid to residents to ensure that the administration of medication follows manufactures guidelines specifically that it is mixed with 8 ounces of water and stirred briskly and drunk promptly. Residents who have insulin ordered at mealtimes (breakfast, lunch, or dinner) will be audited to ensure that no personal preferences interfere with following MD orders and if any are found, clarification orders will be obtained. Chart audits will be done for all Residents that have orders for insulin to ensure that the Medication Administration Record, BG Sheet, and individual care plans match the time on the MD order.	

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{F 332}	Continued From page 5 Prescribed Insulin, and documented that Novolog Insulin was a fast-acting insulin whose onset action started in "under [less than]15 minutes," and with peak action is reached between 1 hour and 3 hours. The Manufacture's prescribing information on Symlin Pen 120 documented: * Should be administered immediately prior to each major meal of greater than/equal to 250 Kcal and greater than/equal to 30 grams of carbohydrate. * The injection site should be distinct from the site chosen for a concomitant insulin injection site and more than 2 inches from the insulin injection site * A Black Box warning for increased risk of severe hypoglycemia when Symlin is administered at the same time as insulin, especially in Type I diabetics. On 8/22/14 at 8:00 a.m., the DON was interviewed regarding the time of Resident #28's insulin administration at 11:15 on 8/21 versus the physician's orders which instructed staff to administer the insulin with the meals. The DON commented that this particular resident did not have a problem with hypoglycemia and would always eat yogurt right after the insulin was administered. When asked if this practice was known and approved by the resident's physician, the DON stated she believed it was. The DON was asked to provide documentation indicating the physician's approval of the practice and any care plan or MAR documentation that supported this practice. The DON later returned with a copy of the resident's care plan, which listed a handwritten entry, dated 8/22/14, that documented, "Resident demands her insulin be administered immediately after her BG is done	{F 332}	**SYSTEMIC CHANGES** Licensed Nurses will be in serviced to proper dosing times of insulin and on the policy and procedure for administering medication including how to accurately measure the dose of medication and to ensure that the Resident takes all of the medication. LN's will be in serviced on how to give Reguloid powder per manufactures' instructions. Licensed Nursing Staff will be in-serviced on basic medication administration which includes the need to ensure that Bowel Care Powders doses are being given as ordered and that orders are measurable and that Insulin is given per MD ordered times and that residents receive food within the appropriate time frames when given Insulin. Licensed Nurses will complete a Med Pass Skills Check upon hire, annually, and PRN. **MONITORING** Beginnig on 8/28/14 Med Pass Audits to include timely insulin administration and Reguloid Bowel Care powders will be done by either the Unit Manager, SDC, and or Designee twice a week times 4 weeks, then weekly times 8 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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{F 332}	Continued From page 6 and eats a snack [yogurt] after administration... has her own refrigerator..." The DNS did not provide a documented physician's order that changed the resident's insulin administration time or indicated a yogurt snack in lieu of administering the insulin with a substantial meal. The DON acknowledged the care plan was updated the day after the surveyor's observation and medical record review. 2. During a medication pass observation on 8/22/14 at 8:17 a.m., LN #2 administered a powdered medication to Resident #27 without accurately measuring it and not ensuring the medication was completely taken. In addition, other facility staff, including the DNS, did not know the quantity of the powder to give per physician orders. On 8/22/14 at 8:17 am, LN #2 prepared 14 oral medications for administration to Resident #27. During the preparation of the medications, LN #2 used a white plastic disposable spoon and measured 2 heaping teaspoons of Reguloid Powder into a 6 ounce [180cc] plastic cup. LN #2 then filled the cup with water and stirred the water until the powder was partially dissolved. LN #2 then entered the resident's room, administered 13 oral medications to the resident, and handed him the cup of Reguloid. LN #2 did not re-stir the cup before handing it to the resident. The resident drank all but approximately 20cc's of fluid from the cup. LN #2 took the cup from the resident and threw it into the garbage. The surveyor retrieved the cup and noted about 20cc's of undissolved Reguloid at the bottom of the cup. When the remaining medication was pointed out to LN #2 she stated,	{F 332}		

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{F 332}	Continued From page 7 "Well, that's Metamucil for ya." The LN then left the resident's room and proceeded to pass medications to other residents. The resident's Physician Orders, dated 7/18/14, and August MAR instructed staff to administer Regulbid Powder 2 gm by mouth three times a day. On 8/22/14 at 9:30 a.m., LN #2 was asked how she determined she was giving 2 gm of the powder. She said, "Oh, we just give a couple of teaspoons of it." Manufacturer's instruction for administering the Regloid Powder documented that the medication should be mixed with at least 8 ounces [240cc's] of water, stirred briskly, and drunk promptly. The instructions were given in teaspoons and tablespoons and indicated that 1 teaspoon was equal to 4 grams and 1 rounded tablespoon was equal to 12 gms. If the instructions on the container were followed, the resident would require 1/2 teaspoon of the powder to equal 2 gms. On 8/22/14 at 11:00 am, the DNS was asked how much Regloid Powder should be given to ensure that the resident received the 2 gm ordered by the physician. The DNS said it should be measured into a plastic measuring cup. When asked how many cc or ml the resident should receive, she said she was not sure but would check. The facility did not have medication cups that measured in grams. The DNS later returned with another nurse and stated 2 gm would equal 3 cc and should be measured accurately using medication measurement tools. Note: 1/2 teaspoon equals 2.5 ccs.	{F 332}		

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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 332}	Continued From page 8 The DON also acknowledge that a resident would need to take the full glass of fluid, not leaving a substantial amount of the medication in the bottom of the cup, in order to receive their full dose of medication.	{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 any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview it was determined the facility failed to ensure that a fast-acting insulin was administered with lunch as ordered by the resident's physician. This resulted in a significant medication error for 1 of 2 residents (#28) who received insulin during a medication pass. The failure to administer insulin with meals as ordered by the physician can result in residents experiencing severe low blood sugar. Findings include: During a medication pass observation on 8/21/14 at 11:10 a.m., Resident #28 received a fast-acting insulin and another injectable anti-diabetic medication that increased the risk for hypoglycemia 45 minutes before a substantial meal. Please refer to F 332 for details. Physician Orders, dated 5/15/14, instructed staff to administer 50 units of NovoLog 100 unit/1ml with breakfast, lunch and dinner. Administration times listed on the physician ' s orders and the	{F 333}	F333 **SPECIFIC RESIDENT** Resident # 28's Insulin order has been clarified to ensure that it given per MD orders while meeting the Resident's personal preference. The Resident's Medication Administration Record, Blood Glucose sheet and care plan has been updated to reflect these changes. Resident # 28 was assessed and no adverse effects were noted. **OTHER RESIDENTS** Residents who receive Insulin have the potential to be affected by this issue. Residents who have insulin ordered at mealtimes (breakfast, lunch, or dinner) will be audited to ensure that no personal preferences interfere with following MD orders if any are found clarification orders will be sought. Chart audits will be done for all Residents that have orders for insulin to ensure that the Medication Administration Record, BG Sheet, and individual care plans match the time on the MD order.	9/12/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135038		R-C 08/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BOISE	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 333}	Continued From page 9 MAR were 8:00 a.m., 12:00 noon, and 5:00 p.m. During the medication pass observation the resident received NovoLog insulin at 11:15 a.m. and began eating lunch at 12:02 p.m. Chapter 27 of the facility's policy guidelines described Onset Actions for Commonly Prescribe Insulin and documented that Novolog Insulin was a fast-acting insulin whose onset action starts in "under [less than]15 minutes," and with peak action reached between 1 hour and 3 hours. The Manufacturer's prescribing instructions for NovoLog documented, "NovoLog has a more rapid onset of action and a shorter duration of activity than regular human insulin. An injection of NovoLog should immediately be followed by a meal within 5-10 minutes" to prevent episodes of hypoglycemia (low blood sugar). The instructions further documented, "Severe hypoglycemia may lead to unconsciousness and/or convulsions and may result in temporary or permanent impairment of brain function or death... concomitant medications may also alter the risk of hypoglycemia..." Resident #28's Physician Orders documented the resident was also scheduled to receive additional anti-diabetic medications to treat her Type II diabetes: * Lantus 100 unit/ml, 175 units subcutaneously at bedtime * Symlin Pen sub-Q 120 mcg before meals * Metformin ER 500 mg tablet - 4 tabs (1200 mg) by mouth every evening The Manufacture's prescribing information on Symlin Pen 120 documented that it had the potential to increase risk of severe hypoglycemia	{F 333}	**SYSTEMIC CHANGES** Licensed Nurse's will be in serviced to following MD orders for administration of insulin. LN's will receive in servicing regarding the potential side effects for administering insulin before MD specified times. LN's will be in serviced on ensuring that any resident preferences that interfere with the timely delivery of insulin will be made known to the MD for further direction. Licensed Nursing Staff will be in-serviced on basic medication administration which includes ensuring insulin is given per MD ordered times and that residents eats food within the appropriate time frame. Licensed Nurses will complete Med Pass Skills Check upon hire, annually, and PRN. **MONITORING** Beginning on 8/28/14 Med Pass Audits which include insulin administration and the timeliness of delivery of the insulin per MD order will be done by either the Unit Manager, SDC, and or Designee twice a week times 4 weeks, then weekly times 8 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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	135038		R-C 08/22/2014

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LIFE CARE CENTER OF BOISE	808 NORTH CURTIS ROAD BOISE, ID 83706

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{F 333}	Continued From page 10 when administered at the same time as insulin. On 8/22/14 at 8:00 a.m., the DON was interviewed regarding the time of Resident #28's insulin administration at 11:15 on 8/21 versus the physician's orders which instructed staff to administer the insulin with meals. The DON commented that this particular resident did not have a problem with hypoglycemia and she "always" ate yogurt right after the insulin was administered. When asked if this practice was known and approved by the resident's physician, the DON stated she believed it was. The DON was asked to provide documentation indicating the physician's approval of the practice. The DNS did not provide a documented physician's order or progress note that authorized the insulin to be given early rather than at the time of a meal. The DON did provide a note written on 8/22/14, by a certified nurse practitioner, in response to a question about holding residents' short acting insulin when they went on outing. The note documented, "I received a call from [DON].... regarding short acting insulin and holding prior to the fair because the residents would not be able to eat for 45 minutes to an hour after leaving the building. I agreed with that as a Standard of Practice is to hold short acting insulin if residents are not able to eat within 15 - 30 minutes..."	{F 333}		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	MDS001380		R-C 08/22/2014

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) COMPLETE DATE
{C 000}	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the onsite follow up and complaint survey of your facility. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Lorraine Hutton, RN	{C 000}	RECEIVED SEP 11 2014 FACILITY STANDARDS Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies	
{C 788}	02.200,03,b,iv Medications, Diet, Treatments as Ordered 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 see F281 as it relates to professional standards of practice.	{C 788}	C788 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F281 C798 Refer to plan of correction for Federal "F" tags on the CMS 2567 for F332 and F333	9/12/14
{C 798}	02.200,04,a MEDICATION ADMINISTRATION Written Orders 04. Medication Administration. 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:	{C 798}		

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M. S.
TITLE: Administrator
(X6) DATE: 9/11/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	MDS001380		R-C 08/22/2014

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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{C 798}	Continued From page 1 Please refer to F 332 as it relates to following physician's orders and F 333 as it relates to a significant medication error	{C 798}		

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

September 9, 2014

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

Provider #: 135038

Dear Mr. Crowley:

On **August 22, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Boise. Bradley Perry, L.S.W. and Lorraine Hutton, R.N. conducted the complaint investigation. This complaint was investigated in conjunction with the facility's on-site follow-up revisit to the Recertification, Complaint Investigation and State Licensure survey conducted on June 13, 2014.

The following observations were completed:

- Residents with wet briefs and/or beds;
- Residents sitting in wheelchairs for long periods of time near the nurses' station and/or hallways; and,
- Residents needing repositioning.

The following documents were reviewed:

- The entire medical record of the identified resident;
- Three other residents were reviewed for care plan and positioning issues;
- One other resident was reviewed for incontinence issues;
- The facility's grievance file from June - August 2014;
- Resident Council minutes from June - August 2014;
- The facility's Incident and Accident reports from June - August 2014; and,
- The facility's Allegation of Abuse reports from June - August 2014.

The following interviews were completed:

- A housekeeper was interviewed regarding residents with incontinence;
- A laundry aide was interviewed regarding urine soaked linens;
- Six CNAs were interviewed regarding incontinent issues, wet bed linens, residents needing repositioning and following care plans.
- A physical therapist was interviewed regarding therapy referrals; and,
- The Director of Nursing was interviewed regarding incontinent issues, wet bed linens, residents needing repositioning and residents left in hallways.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006537

ALLEGATION #1:

The complainant stated that on June 6, 2014, an identified and an unidentified resident were found in their beds with urine soaked incontinence briefs.

FINDINGS #1:

The identified resident was no longer residing in the facility at the time the complaint was investigated.

During the entire survey, residents were observed for wet briefs and/or beds; no concerns were identified.

The facility's grievance file and Resident Council minutes were reviewed from June - August 2014; no issues regarding soaked incontinence briefs or bed linens were identified.

The entire record of the identified resident was reviewed, and the care plan documented the resident had a history of heavy urine incontinence. One other resident was reviewed for incontinence needs; no concerns were identified.

A housekeeper was interviewed and she said when a resident is noticed to need a change she immediately informs nursing staff. When asked if she finds urine soaked bedding, she said it rarely happens.

A laundry aide was interviewed and stated urine soaked bed linens come into the laundry, but it only happens occasionally.

Two CNAs were interviewed regarding incontinence care, and they stated residents were changed as

soon as staff discovered residents were incontinent. They were also asked about linen changes, and they said linens were changed when residents were bathed and on an as needed basis.

The DON was interviewed regarding incontinence care and bed linen changes. She stated residents are checked and changed every two hours and as needed for incontinence care. She also said staff investigate if they smell urine odors. She stated aides strip bed linens when residents bathe and as needed.

Although the incident may have occurred as described, based on the records reviewed and staff interviews it was determined the allegation could not be substantiated.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated that on June 6, 2014, an identified resident was left in a wheelchair at the nurses' station for about five hours without being toileted or repositioned. The complainant also stated that on the same day an unidentified resident was left in bed for two hours without being repositioned.

FINDINGS #2:

During the entire survey, residents were observed in wheelchairs near the nurses' station and/or in the hallways for long periods of time and residents with repositioning needs. No concerns were identified from the observations.

The facility's grievance file and Resident Council minutes were reviewed from June - August 2014; no issues regarding positioning or placement were identified.

The entire medical record of the resident was reviewed for repositioning concerns, as well as three other residents; no issues were identified.

Two CNAs were interviewed regarding repositioning needs, and they said most residents are care planned to be repositioned every two hours. They also stated when they observe a resident who needs to be repositioned, they take them to their room or other private area and reposition them.

A Physical Therapist was interviewed regarding positioning issues, and she stated any staff member can make a referral to the therapy department if they suspect a resident needs help with positioning.

The DON was interviewed regarding residents left in hallways, and she stated when she or other staff members notices this, they offer the resident an activity or see what the resident might need. She also

stated she and staff members watch for positioning issues and immediately take residents in their rooms to reposition them.

Although the incident may have occurred as described, based on the records reviewed and staff interviews it was determined the allegation could not be substantiated

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated that on June 6, 2014, an unidentified resident was assisted by staff without the use and/or knowledge of the resident's care plan.

FINDINGS #3:

Three residents were observed and reviewed for staff knowledge of their care plans; no issues were found.

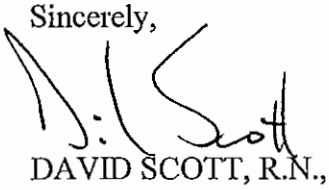
Three CNAs were interviewed regarding resident cares and they each said, if they had not worked with a resident before or were working with a new resident, they would look in the resident's chart and review the care plan prior to giving care.

Although the incident may have occurred as described, based on observations, records reviewed and staff interviews it was determined the allegation could not be substantiated.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,



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

DS/dmj