



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 6034**

October 27, 2014

Mark Barglof, Administrator  
Avamere Transitional Care & Rehabilitation - Boise  
1001 South Hilton Street  
Boise, ID 83705-1925

Provider #: 135077

Dear Mr. Barglof:

On **October 10, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Avamere Transitional Care & Rehabilitation - 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form

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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 **November 10, 2014**. Failure to submit an acceptable PoC by **November 10, 2014**, may result in the imposition of civil monetary penalties by **December 1, 2014**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- 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*.

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 **November 14, 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 **November 14, 2014**.

A change in the seriousness of the deficiencies on **November 14, 2014**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **November 14, 2014** includes the following:

Denial of payment for new admissions effective **January 10, 2015**. [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 **April 10, 2015**, 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, they 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 **October 10, 2014** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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

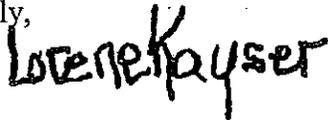
- BFS Letters (06/30/11)

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

This request must be received by **November 10, 2014**. If your request for informal dispute resolution is received after **November 10, 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,



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

LKK/dmj  
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  135077	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	DATE SURVEY COMPLETE: 10/10/2014
NAME OF PROVIDER OR SUPPLIER  AVAMERE TRANSITIONAL CARE & REHAB - BOISI		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 204	<p>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG</p> <p>A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to account for the belongings of a deceased resident. This was true for 1 of 3 closed records (#14) reviewed. Findings included:</p> <p>Resident #14 was admitted to the facility in May 2012 with multiple diagnoses which included other chronic pain and acute osteomyelitis, site unspecified. In April 2014, lung cancer was also diagnosed and the resident died in the facility on 7/8/14.</p> <p>Review of the resident's closed medical record revealed the resident's belongings, which included clothing items, "2 gold rings" and "2 silver rings," were not accounted for on the Inventory of Personal Effects form, nursing progress notes dated 6/28/14 through 7/8/14 or social services progress notes dated 11/10/13 through 5/14/14.</p> <p>On 10/9/14 at 2:00 p.m., the Medical Records Nurse (MRN) was asked about the disposition of the resident's belongings. The MRN reviewed the resident's Inventory of Personal Effects form and stated, "There's no signature [on discharge]." The MRN also reviewed the aforementioned nursing and social services progress notes and confirmed there was no documentation regarding the disposition of the personal belongings. The MRN said the resident's family did pick up the belongings about 2 weeks after the resident's death, "But they didn't document it."</p> <p>On 10/9/14 at 6:25 p.m., the Administrator and DNS were informed of the issue. The facility did not provide any additional information.</p>		
F 278	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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NAME OF PROVIDER OR SUPPLIER  AVAMERE TRANSITIONAL CARE & REHAB - BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 278	<p>Continued From Page 1</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</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 1 of 13 (#7) sampled residents who were reviewed for an accurate MDS, had an accurate MDS as it related to ROM (range of motion) and ethnicity. Findings include:</p> <p>Resident #7 was admitted to the facility on 3/20/13 with diagnoses that included paralysis agitans, depressive disorder, schizoaffective disorder, anxiety, and diabetes mellitus Type II.</p> <p>The resident's admission Nursing Evaluation form, completed on 3/20/13, documented the resident had bilateral upper extremity and lower extremity impairment on both sides.</p> <p>The resident's Admission MDS dated 3/26/13, subsequent Quarterly MDS' and Annual MDS dated 3/10/14, documented in section G 400 the resident had functional limitation of range of motion to one upper extremity and to both lower extremities. The Quarterly MDS', dated 6/3/14 and 8/26/14, documented in section G 400 the resident had functional limitation of range of motion in both upper extremities and both lower extremities.</p> <p>The resident's Admission MDS, dated 3/26/13, documented the resident ethnicity as Hispanic or Latino. The resident's Annual MDS dated 3/10/14, Quarterly MDS', dated 6/3/14 and 8/26/14, documented the resident's ethnicity as white.</p> <p>On the morning of 10/10/14 LN #6, who coordinated medical records, provided the resident's Quarterly MDS dated 3/11/13, which was documented at the resident's prior facility for review. The MDS documented section G 400 the resident had functional limitation of range of motion in both upper extremities and both lower extremities. The resident's ethnicity was documented as both Hispanic or Latino and white.</p> <p>On 10/10/14 at 10:00 AM, LN #15, whom was identified as the MDS Coordinator, was asked how she had assessed the resident for ROM. LN #15 stated she used the test provided for the MDS 3.0; she had her own worksheet she documented the results on and she talked to LNs and CNAs. LN #15 was asked how she had come to the conclusion that the resident had ROM limitations to one upper extremity for over a year then had</p>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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AH  
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  135077	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	DATE SURVEY COMPLETE: 10/10/2014
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NAME OF PROVIDER OR SUPPLIER  AVAMERE TRANSITIONAL CARE & REHAB - BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 278	<p>Continued From Page 2</p> <p>a change and had ROM limitations to both upper extremities. LN#15 stated she would have documented on the worksheet how the resident completed the test, but she does not keep them and consequently was unable to provide the worksheet at the time of the survey. LN #15 was asked why the resident was documented as Hispanic and then white. She stated it was on the face sheet as white and it automatically pulled forward to the MDS, and stated, "I didn't check it."</p> <p>On 10/10/14 at 10:30 AM, the DON was asked if she was aware of the resident's inconsistencies on the MDS, she stated she had known the resident for a long time and the resident's ROM had not changed over the years.</p>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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PRINTED: 10/27/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/10/2014
NAME OF PROVIDER OR SUPPLIER  AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET 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 annual federal recertification and complaint survey of your facility.  The surveyors conducting the survey were: Sherri Case, BSW, LSW, QIDP, Team Coordinator Linda Kelly, RN Susan Gollobit, RN Kirsti Stephenson, RN The survey team entered the facility on October 6 and exited on October 10, 2014.  Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CAA = Care Assessment Area CP = Care Plan CNA = Certified Nurse Aide DNS/DON = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligram ML = Milliliter PRN = As Needed SDAC = Safety Device Assessment and Consent	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Avamere Transitional Care and Rehab – Boise, does not admit that the deficiencies listed on Form CMS 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS  The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.  The resident has the right to be fully informed in advance about care and treatment and of any	F 154	RECEIVED  NOV - 7 2014  FACILITY STANDARDS	

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

TITLE

(X6) DATE

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.

*Mark B. [Signature], Admin.* 11-6-14

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NAME OF PROVIDER OR SUPPLIER  AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705	
(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 154	<p>Continued From page 1</p> <p>changes in that care or treatment that may affect the resident's well-being.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interview it was determined the facility failed to ensure 3 of 5 (#2, #9, &amp; #11) sampled residents for the use of side rails, were informed of the risks with the use of side rails. All three of the residents used side rails for mobility and the facility's Safety Device Assessment and Consent (SDAC) form did not document the residents and/or their representatives had been informed of the risks with the use of side rails. Findings include:</p> <p>1. Resident #11 was admitted to the facility 7/10/13 with diagnoses that included diabetes mellitus Type II, bipolar disorder, chronic pain, morbid obesity, muscular wasting and disuse atrophy.</p> <p>The resident's annual MDS dated 8/11/14, documented the resident's cognition was intact.</p> <p>The resident's care plan, dated 9/27/14, documented the resident had a self care deficit in ADLs for limited mobility. Interventions included a need for limited to extensive assistance of one person to reposition and turn in bed with the use of "nonrestrictive bilateral bed mobility bars to assist."</p> <p>The resident's SDAC form dated 5/3/14, documented the resident used "1/2 mobility bars x 2," and were used for bed mobility, to assist with transfers and to assist with positioning for</p>	F 154	<ol style="list-style-type: none"> <li><b>Identified Resident</b>  Residents # 2,9, and 11 or responsible parties were notified of the risk of ongoing mobility rail use.</li> <li><b>Other Residents</b>  All residents with mobility bars were reviewed.</li> <li><b>Systemic Change</b>  At time of device implementation assessment and consent will be completed. Risks associated with mobility bar use will be identified on the assessment and consent. Education of risk of mobility bar use will be documented in the resident record.</li> <li><b>Monitoring</b>  DNS or designee will audit documentation for compliance of risk education completed weekly and report findings to the QA committee for 3 months.</li> </ol>	11/21/2014

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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)	(X6) COMPLETION DATE
F 154	<p>Continued From page 2</p> <p>activity of daily living or other activities. The form had eight documented risk options with a box to check, all boxes were left blank. The resident signed the form on 5/4/14.</p> <p>On 10/10/14 at 9:00 AM, the resident was observed in bed with two 1/4 side rails up. The resident was asked if she used the side rails. She stated she did use them to help get herself up in bed.</p> <p>On 10/10/14 at 10:25 AM, the surveyor reviewed the resident's SDAC with the DON. The DON was asked if the resident had been informed of the risks of the use side rails. She stated the boxes needed to be marked to be an informed consent.</p> <p>On 10/9/14 at 6:30 PM, the Administrator and DON were notified of the findings. No additional information was provided.</p> <p>2. Resident #2 was admitted to the facility 3/19/14 with diagnoses that included diabetes, paralysis, dementia with Lewy Bodies and chronic kidney disease.</p> <p>The resident's quarterly MDS dated 9/8/14, documented the resident's cognition was severely impaired.</p> <p>The resident's ADL care plan dated 3/19/14, documented the resident used positioning mobility bars for transfers, ADLs and bed mobility.</p> <p>The resident's SDAC form dated 3/27/14, documented the resident used mobility bars to assist with transfers and to assist with positioning for activity of daily living or other activities. The form had eight documented risk options with a</p>	F 154		

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NAME OF PROVIDER OR SUPPLIER  AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
(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 154	Continued From page 3 box to check, all boxes were left blank. The form was signed by a family member on 3/27/14.  On 10/7/14 at 3:10 p.m., the resident was observed in bed with two 1/4 side rails up.  On 10/9/14 at 6:30 PM, the Administrator and DON were notified of the findings. No additional information was provided.  3. Resident #9 was admitted to the facility 12/19/11 and was readmitted on 9/3/13 and 11/30/13 with diagnoses which included upper limb amputation above elbow, history of traumatic brain injury, post traumatic stress disorder and other convulsions.  The resident's quarterly MDS dated 8/18/14, documented the resident's cognition was intact.  The resident's SDAC form dated 11/30/13, documented the resident used "bed rails" for bed mobility, to assist with transfers and to assist with positioning for activity of daily living or other activities. The form had eight documented risk options with a box to check, all boxes were left blank.  On 10/7/14 at 7:55 and 8:29 a.m., the resident was observed in bed with two 1/4 side-rails up.  On 10/9/14 at 6:30 p.m., the Administrator and DON were notified of the findings. No additional information was provided.	F 154			
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive	F 246			

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F 246	<p>Continued From page 4</p> <p>services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</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 2 of 13 (#'s 6 &amp; 10) sampled residents and 2 (#'s 17 &amp; 18) random residents were provided access to their call lights. The deficient practice had the potential to cause more than minimal harm when residents did not have access to their call lights to request staff assistance as needed. Findings included:</p> <p>1. On 10/6/14 at 10:05 AM, during the initial tour of the facility, Resident #18 was observed in bed asleep. The right side of the resident's bed was approximately a foot from the wall with a light fixture attached to the wall. The resident's call light was hooked to the top of the light cord and out of reach of the resident.</p> <p>2. On 10/6/14 at approximately 10:30 AM, during the initial tour of the facility, Resident #17 was observed in bed talking to herself. The resident's bed was positioned next to the wall. The resident's call light was observed lying on the floor next to the open side of the bed, out of reach of the resident.</p> <p>On 10/7/14 at 6:30 PM, the Administrator and the DON were informed of the findings. No additional information was provided.</p>	F 246	<p>1. Identified Residents</p> <p>Rounds completed to ensure call lights within reach.</p> <p>2. Other Residents</p> <p>All residents reviewed for proper call light placement.</p> <p>3. Systemic Changes</p> <p>Staff educated on keeping call lights within reach or in a place of easy access to the client.</p> <p>4. Monitoring</p> <p>SDC or designee will audit call light placement three times a week to ensure proper placement and report findings to the QA committee for 3 months.</p>	11/21/2014

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/10/2014
NAME OF PROVIDER OR SUPPLIER  AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705	
(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 246	Continued From page 5  3. Resident #6 was admitted to the facility 5/6/13, and readmitted 4/18/14, with multiple diagnoses which included unspecified infantile cerebral palsy, joint contractures at multiple sites, chronic duodenal ileus, dysphagia and gastroparesis.  The resident's most recent quarterly MDS assessment, dated 9/30/14, documented: * No speech, absence of spoken words; * Total dependence for bed mobility, eating, toileting, personal hygiene, and bathing; * Functional limitation in range of motion in both upper and both lower extremities; * Frequent bowel incontinence; * Non-verbal indicators of pain observed 1-2 days in last 5 days; * Feeding tube in place.  a) On 10/6/14 at 9:45 AM, during the initial tour of the facility, Resident #6 was observed in bed on his back with vomitus on his face. The resident was moaning. His call light was attached to the right upper corner of the bed out of reach of the resident. At 10:50 a.m., the DNS entered the room and cleaned the resident's face.  b) On 10/10/14 at 11:35 AM., Resident #6 was observed on his back with the head of the bed elevated at 35-40 degrees. The resident's touch pad call light was on the top right corner of the mattress. The call light was 8-10 inches above and away from the resident's right shoulder.  On 10/10/14 at 11:40 a.m., LN #12 was asked where the resident's call light needed to be for the resident to access it. The LN stated, "By his right side." When asked if the resident could reach the call light if it was on the top right corner of the	F 246		

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F 246	<p>Continued From page 6</p> <p>mattress, the LN stated, "No I don't think so." When informed where the call light was placed, the LN said he would move the call light.</p> <p>4. Resident #10 was admitted to the facility in 2011 with multiple diagnoses which included other persistent mental disorder, anxiety and, dementia without behavioral disturbance.</p> <p>The resident's annual and most recent quarterly MDS assessments, dated 3/10/14 and 8/25/14 respectively, documented:</p> <ul style="list-style-type: none"> <li>* Severe cognitive impairment;</li> <li>* Extensive assistance for bed mobility, transfers, dressing, and toilet use; and,</li> <li>* Frequent bowel and bladder incontinence.</li> </ul> <p>The resident's care plan included the risk for falls as a focus area. Interventions included, "personal care items within reach." This intervention was dated 9/27/13. The resident's care plan did not include the use or placement of the call light.</p> <p>On 10/8/14 at 3:25 p.m., the resident was observed lying on her right side in her bed against the wall. The resident was turned away from the wall. The surveyor was unable to see the resident's call light.</p> <p>On 10/8/14 at 3:28 p.m., CNA #7 entered the resident's room and provided fresh water. When asked about the call light, the CNA traced the call light cord from the wall, between the bed mattress and the wall, and to the pillow under the resident's head. The call light was clipped to the end of the pillow by the wall and behind the resident's head. When asked if the resident could reach the call light behind her head, the CNA stated, "I don't know but I'll move it in front of her." The CNA</p>	F 246			

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F 246	Continued From page 7 moved the call to the pillow in front of the resident.  On 10/8/14 at 3:30 p.m., when asked if the resident was able to use the call light, LN #8 stated, "Well she can but not usually for the right reason." When asked if the resident could reach the call light if it was behind her head, the LN stated, "Probably not. Is it behind her head?" The LN was informed CNA #7 moved the call light within the resident's reach.  On 10/9/14 at 6:25 p.m., the Administrator and DNS were informed of the call light accessibility issue. The facility did not provide any other information regarding the issue.	F 246			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280			

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F 280	<p>Continued From page 8</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 resident care plans were reviewed and revised to reflect a resident's current needs and status. This was true for 2 of 13 residents (#s 5 and 8) reviewed for care plan revisions. The deficient practice had the potential to cause harm if Resident #5 did not receive care needed for the prevention of falls and if Resident #8's did not receive adequate and appropriate care for pseudobulbar affect. Findings included:</p> <p>1. Resident #5 was admitted to the facility on 3/12/13 with multiple diagnoses including diabetes type II, bipolar, schizoaffective disorder, and dementia.</p> <p>The resident's 8/4/14 Significant Change MDS assessment documented the following: *Required extensive assistance of one staff member for toilet use; *Required limited assistance with one staff member to transfer in/out of bed; and, *Was severely cognitively impaired, BIMS=5.</p> <p>The resident's 9/2/13 care plan (revised 9/12/13) for fall prevention included interventions: to encourage in activities to increase strength, provide mobility bars, non-skid foot wear, and personal items within reach.</p> <p>The resident's fall prevention care plan was revised on 5/14/14 to include a bag on the back of her wheelchair for her belongings, to cue the</p>	F 280	<p>1. Identified Resident</p> <p>Resident # 5 Care plan was reviewed and updated to reflect current fall interventions. Resident #8 Care plan was updated to reflect Pseudobulbar affect and interventions identified.</p> <p>2. Other Residents</p> <p>Residents who have fallen in the facility have been reviewed to ensure care plans reflect current fall interventions. Residents having a diagnosis of mental health disorder reviewed to ensure care plans reflect diagnosis.</p>	11/21/2014

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F 280	<p>Continued From page 9</p> <p>resident to sit back in her wheelchair, and to keep her personal items to the front or side of the wheelchair. On 9/23/14 the care plan was revised to cue the resident to "scoot back" in her wheelchair if needed.</p> <p>The resident's medical record included incident reports and nursing notes that documented the following: 6/20/14 - The resident fell out of bed while trying to get to the bathroom and crawled to the bathroom. The resident had a 1 cm by 1 cm reddened area on the back of her head. 7/2/14 - On 7/2/14 the resident was yelling for help and found lying on her back near the doorway. The resident did not have any injuries. 8/22/14 - The resident refused to go to bed and attempted to stand without locking her wheelchair brakes and fell. The resident did not have any injuries. The Interdisciplinary team reviewed the fall and recommended "... encourage patient to lay down in bed at night..." 9/23/14 - Resident was observed sitting on the edge of her wheelchair but slid off seat before the staff were able to assist her to scoot back. The resident did not have any injuries.</p> <p>On 10/10/14 at 8:35 a.m. the DON stated she would check for revisions for the falls on 6/20/14, 7/2/14 and 8/22/14. The facility provided no further information.</p> <p>Resident #8 was admitted to the facility in 2011 with multiple diagnoses which included, Parkinson's disease, senile dementia, Lewy bodies dementia, major depressive disorder, unspecified anxiety state and insomnia.</p> <p>The annual MDS assessment, dated 9/8/14,</p>	F 280	<p><b>3. Systemic Changes</b></p> <p>Educated nurse supervisors to update care plan after each fall. After event occurs facility will determine the factors leading to the fall and determine appropriate fall interventions. The intervention identified will then be placed on the care plan. In-servicing completed with SW and supervisor LN staff regarding completing care plans to reflect mental health disorders.</p> <p><b>4. Monitoring</b></p> <p>DNS or designee will audit care plans on a weekly basis for fall interventions and for psychotropic medication, mental health diagnoses and behaviors. Findings of audits will be reported to the QA committee for three months.</p>	

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F 280	<p>Continued From page 10</p> <p>documented the resident's cognition was moderately impaired, with a BIMS score of 9, and she received antipsychotic, antianxiety, antidepressant, and hypnotic medications 7 of the past 7 days.</p> <p>The resident's Psychotropic Drug Use CAA, dated 9/9/14, care plan considerations documented, "...receives abilify [sic], xanax [sic], Cymbalta and ambien [sic] for...major depression and anxiety...followed by a community psychiatrist and receives in house counseling with a psychologist. Also with dx [diagnosis] of pseudobulbar affect [uncontrolled crying or laughing which may be disproportionate or inappropriate to the social context] for which she receives neudexta [sic]..."</p> <p>The resident's Order Summary Report of active orders included:</p> <ul style="list-style-type: none"> <li>* Abilify 10 milligrams (mg) by mouth (PO) 2 times/day for major depressive disorder, started 5/12/14;</li> <li>* Alprazolam (generic Xanax) 0.25 mg PO 4 times/day for anxiety, started 6/11/13;</li> <li>* Cymbalta delayed release capsule 60 mg PO every morning for major depressive disorder, started 4/17/13;</li> <li>* Neudexta capsule 20-10 1 PO every 12 hours for pseudobulbar affect, started 4/16/13; and,</li> <li>* Ambien discontinued 9/18/14.</li> </ul> <p>A Psychotropic Medication Review and Physician Communication Form, dated 8/9/14, documented the resident received the Abilify, Xanax, Cymbalta, and Ambien 5 mg at bedtime. The target behaviors were agitation and anxiety.</p> <p>A Psychotropic Medication Review and Physician</p>	F 280		

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F 280	Continued From page 11 Communication Form, dated 9/23/14, documented the resident received Abilify, Xanax, and Cymbalta 60. The target behaviors were agitation and anxiety.  The aforementioned Psychotropic Medication Review and Physician Communication Forms did not include Neudexta for pseudobulbar affect and the target behaviors listed did not include uncontrolled crying or laughing.	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.  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 wound on a resident's thumb received treatment and healing was monitored. This was true for 1 of 13 sampled residents (#6) and placed the resident at risk for wound infection. Findings include:  Resident #6 was admitted to the facility 5/6/13	F 309			

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F 309	<p>Continued From page 12 with multiple diagnoses which included unspecified infantile cerebral palsy and joint contractures at multiple sites. He was hospitalized 4/10/14 and readmitted to the facility 4/18/14 with a diagnosis of other functional disorders of intestine.</p> <p>The resident's annual MDS assessment, dated 4/23/14, and quarterly MDS assessments, dated 7/9/14 and 9/30/14 respectively, documented: * Total dependence for bed mobility, personal hygiene, and bathing; * Functional limitation in range of motion in both upper and both lower extremities; * No unhealed or healed pressure ulcers and no other skin problems.</p> <p>An incident report, dated 5/2/14 at 2:47 p.m., documented, "...skin impairment on...L [left] thumb at the bending crevice...0.5cm x [by] 0.9cm...appears dry and crusted over...L hand middle finger was rubbing against his thumb causing the skin impairment."</p> <p>A late entry Incident Note, dated 5/4/14, documented, "IDT [interdisciplinary team] follow-up for 5/2/14...open area to left thumb...Upon investigation, patient's middle finger of left hand...contracted and finger nail scratches...thumb causing an open area...nails...trimmed and filed, and a foam padded dressing applied to his thumb..."</p> <p>Review of the resident's clinical record revealed that nail care by a LN was done weekly in March 2014 and the first 2 weeks in April 2014. However, after the resident was hospitalized on 4/10 and readmitted to the facility on 4/18/14, nail care was not provided from 4/18/14 until 5/2/14</p>	F 309	<ol style="list-style-type: none"> <li><b>Identified Resident</b>  No correction was able to be implemented for resident #5 as the scratch had already healed.</li> <li><b>Other Residents</b>  Residents who have skin tears or minor lacerations were reviewed to determine proper treatment and monitoring were in place.</li> <li><b>Systemic Changes</b>  Education provided on the 24 hour follow up process to identify changes in resident status. LN educated on proper documentation and monitoring of skin tears, or lacerations completed.</li> <li><b>Monitoring</b>  DNS or designee will audit skin tears or lacerations for treatment and monitoring weekly and will report findings to the QA committee for three months.</li> </ol>	11/21/2014	

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F 309	<p>Continued From page 13 (14 days) when the left thumb open area was found.</p> <p>Refer to F312 for details about inconsistent nail care.</p> <p>The resident's hands and fingers were observed multiple times during the survey week. He was able to move his contracted fingers slightly. All of his fingers, including the thumbs, were intact without signs of impairment and the nails were trimmed and clean.</p> <p>On 10/9/14 at 11:05 a.m., Wound Nurse, LN #13, was asked about the resident's left thumb open area noted 5/2/14. About then, another Wound Nurse, LN #14, joined the interview and began to search for the documentation in the resident's electronic medical record. At 11:15 a.m., the DNS joined the interview and said she would look for the information and get back with the surveyor.</p> <p>On 10/10/14 at 8:00 a.m., the DNS said nail care "got dropped" on 4/18/14 when the resident readmitted to the facility and the thumb was scratched by a "jagged" fingernail. She provided a Nursing Care Note, dated 5/2/14, which documented, "...finger nail was trimmed and a foam padding was placed over the skin impairment..." The DNS was asked for evidence the open area was monitored and when it resolved. The DNS said nothing was documented on 5/3/14 and she would look for other documentation.</p> <p>On 10/10/14 at 10:15 a.m., the DNS stated, "I did not find follow-up monitoring or resolution documented." She added, "I know it wasn't long [when it healed]." The DNS said the open area</p>	F 309			

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F 309	Continued From page 14 should have been monitored and care documented, including when it was resolved.	F 309			
F 312 SS=D	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, incident report reviews, and staff interview, it was determined the facility failed to ensure nail care was consistently provided for 1 of 9 residents (#6) reviewed for ADL assistance. Resident #6 developed a "scratch" to his left thumb when nail care was not provided for fourteen days. Findings included:  Resident #6 was admitted to the facility 5/6/13 with multiple diagnoses which included unspecified infantile cerebral palsy and joint contractures at multiple sites. The resident was hospitalized 4/10/14 and readmitted to the facility 4/18/14 with a diagnosis of other functional disorders of intestine.  The resident's annual MDS assessment and most recent quarterly MDS assessment, dated 4/23/14 and 9/30/14 respectively, documented: * No speech, absence of spoken words; * Moderately severe impaired cognition and	F 312	1. Identified Resident  Correction for resident #6 in place prior to annual survey, no further correction needed.  2. Other Residents  Residents who have a diabetes diagnosis reviewed for nail care needs.  3. Systemic Changes  In-servicing completed regarding readmission process and reinstatement of previous nursing care needs. All residents identified with diabetes at the time of admission will have weekly nail care placed on the TAR for the LN to complete.  4. Monitoring  DNS or designee will audit on a weekly basis to ensure nail care is completed and report findings to the QA committee for three months.	11/21/2014	

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F 312	<p>Continued From page 15</p> <p>severely impaired cognition respectively;</p> <ul style="list-style-type: none"> <li>* Total dependence for bed mobility, personal hygiene, and bathing; and,</li> <li>* Functional limitation in range of motion in both upper and both lower extremities.</li> </ul> <p>The resident's care plan included a focus on ADL self care performance deficit and limited mobility, dated 9/27/13. Interventions for this focus area included "Total assistance with personal hygiene care."</p> <p>The resident's April 2014 MAR included an order, dated 1/8/14, for an LN to "check and trim/file nails" every Tuesday. Nail care was documented as done 4/1 and 4/8/14. However, the nail care was noted as discontinued on 4/18/14, the day the resident was readmitted to the facility.</p> <p>The resident's May 2014 MAR included an order, dated 5/2/14, for "nail care Q [every] week by LN...every Wed[nesday]." Nail care was documented as done 5/7, 5/14, 5/21, and 5/29/14.</p> <p>An incident report, dated 5/2/14 at 2:47 p.m., documented a CNA "found a skin impairment on the anterior of his L [left] thumb at the bending crevice...0.5cm x [by] 0.9cm...appears dry and crusted over, the residents L hand middle finger was rubbing against his thumb causing the skin impairment."</p> <p>A Nursing Care Note, dated 5/2/14 at 6:19 p.m., documented the resident's middle finger nail was trimmed and a foam padding was placed over the skin impairment for protection for [sic] furthur [sic] irritation..."</p>	F 312			

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PRINTED: 10/27/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/10/2014
NAME OF PROVIDER OR SUPPLIER  AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
(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 312	Continued From page 16 A late entry Incident Note, dated 5/4/14, documented, "IDT [interdisciplinary team] follow-up for 5/2/14...open area to left thumb...Upon investigation, patient's middle finger of left hand noted to be contracted and finger nail scratches on his thumb causing an open area...nails have been trimmed and filed, and a foam padded dressing applied to his thumb..."  On 10/9/14 at 10:55 a.m., the resident was observed in bed. His left arm was raised slightly and his left hand was open, the fingernails were trimmed and clean and none of the fingers touched one another.  Note: Refer to F309 for details regarding the non-pressure related skin impairment.  On 10/10/14 at 8:00 a.m., when asked about nail care, the DNS said the resident's thumb was scratched by a "jagged" fingernail and that nail care "got dropped" when the resident was readmitted to the facility on 4/18/14. The DNS confirmed that nail care was not provided from 4/18/14 until 5/2/14 (14 days) when the thumb scratch was noted.  The facility did not provide any other information regarding the resident's nail care.	F 312			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 315			

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F 315	<p>Continued From page 17</p> <p>catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review, it was determined the facility failed to offer residents the opportunity to use the toilet. This was true for 1 of 13 residents (#5) sampled for toileting assistance. The deficient practice had the potential to cause complications, such as skin breakdown or infections, from becoming incontinent of urine. Findings include:</p> <p>Resident #5 was admitted to the facility on 3/12/13 with multiple diagnoses including type II diabetes, bipolar, schizoaffective disorder, and dementia.</p> <p>The resident's 8/4/14 Significant Change MDS assessment documented the following: *Frequently incontinent, *Required extensive assistance of one staff member for toilet use, *Required limited assistance with one staff member to transfer in/out of bed, and, *Was severely cognitively impaired, BIMS=5.</p> <p>The resident's Bowel and Bladder Evaluation, signed 7/29/14, documented: *Voids appropriately without incontinence, not always, but at least daily; *Able to get to the bathroom independently, but slowly;</p>	F 315	<ol style="list-style-type: none"> <li><b>Identified Resident</b>  Resident #5 was reviewed for a incontinence retraining program and care plan updated to reflect potential toileting needs.</li> <li><b>Other Residents</b>  Residents identified as good candidates for retraining have been evaluated for toileting needs</li> <li><b>Systemic Changes</b>  Education provided on development of toileting programs to unit managers. Toileting needs will be screened at the time of admission and toileting plan will be identified. Toileting plan will then be documented on the care plan for the resident.</li> <li><b>Monitoring</b>  DNS or designee will audit weekly to ensure toileting plan is indicated on care plan and report findings to QA committee for 3 months.</li> </ol>	11/21/2014

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F 315	<p>Continued From page 18</p> <ul style="list-style-type: none"> <li>*Forgaful but follows commands; and</li> <li>*Usually aware of need to toilet.</li> </ul> <p>The Category section at the top of the assessment documented, "Good Candidate for retraining."</p> <p>The resident's 9/2/13 ADL Care Plan (revised on 8/8/14) included in the Intervention section, for toilet use, the resident required 1 staff to supervise the use of the toilet and ensure proper hygiene.</p> <p>The resident's Care Plan for urinary incontinence included the following interventions all with the start date of 5/15/14:</p> <ul style="list-style-type: none"> <li>*Use of incontinence brief</li> <li>*Used bathroom mostly independently with supervision/limited assist at times for proper per care.</li> <li>*Monitor for signs of incontinence and cue/provide assist as needed.</li> </ul> <p>On 10/7/14 at 10:00 a.m., Resident #5 was observed in the small dining room in an activity. The resident remained in the dining room by herself after the activity, asleep in her wheelchair. At 12:05 p.m., CNA #8 moved the resident to a dining table and gave the resident a cup of coffee. At 12:20 p.m. CNA #2 stated "you slept for a long time" and brought the resident her meal. At 1:03 p.m., the resident pushed herself back from the table and was assisted to her room. The resident stated to the surveyor she needed to use the bathroom but thought someone was "in there." The bathroom was checked and observed to be empty. The surveyor asked the resident if she needed help and she said yes; however, the resident did not know how to activate the call</p>	F 315			

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F 315	Continued From page 19 light. The resident stated she needed to urinate. LN #10 was informed by the surveyor the resident stated she needed to urinate. LN #10 stated "she takes herself but she probably should have help."  Note: The resident fell on 6/20/14 when attempting to take herself to the bathroom and crawled to the bathroom door.  On 10/10/14 at 8:00 a.m. the DON was informed of the resident not being toileted for approximately 3 1/2 hours. The DON stated Resident #5's Care Plan needed to be revised to offer the resident use of the toilet.	F 315			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to provide ROM (Range of Motion) to 1 of 6 (#7) sampled residents who had a limited ROM. The facility did not provide a ROM program to ensure the resident did not experience continued decline in her extremities. Findings included:  Resident #7 was admitted to the facility on 3/20/13 with diagnoses that included paralysis	F 318	1. Identified Resident  Resident #7 evaluated for and placed on a ROM program that resident can tolerate.  2. Other Residents  Residents with limited range of motion evaluated to ensure proper ROM programs were in place.		

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F 318	<p>Continued From page 20</p> <p>agitans, depressive disorder, schizoaffective disorder, anxiety, and diabetes mellitus Type II.</p> <p>The resident's admission Nursing Evaluation form completed on 3/20/13 documented the resident had bilateral upper extremity and lower extremity impairment on both sides.</p> <p>The resident's OT (Occupational Therapy) Evaluation &amp; Plan of Treatment dated 8/5/13, documented the resident's left hand was severely clenched, odorous, and her thumb was wedged between the first and second fingers. The plan was to implement a palm protector.</p> <p>The resident's care plan for risk of skin impairment related to diabetes, immobility, incontinence, and contractures of hands, dated 9/23/13, documented interventions which included carrots in hands at all times. The carrots were to be removed for hand hygiene and replaced.</p> <p>NOTE: The device called a "carrot" is cloth that is shaped like a carrot, thicker at the top and tapers to thinner at the opposite end.</p> <p>The resident's quarterly MDS', dated 6/3/14 and 8/26/14, documented the resident's cognition was severely impaired and she had bilateral upper and lower extremity impairments, with limited ROM.</p> <p>The resident's Quarterly Review and Care Conference (QRCC) information form dated 7/1/14, documented nursing's restorative plan was for the resident to receive a "PROM (Passive Range of Motion) program."</p> <p>The QRCC dated 9/24/14, documented nursing's restorative plan was for the resident to have</p>	F 318	<p><b>3. Systemic Changes</b></p> <p>Education provided to nurse supervisors on identifying residents with potential need for ROM program and implementation of ROM to prevent continued decline in extremities.</p> <p><b>4. Monitoring</b></p> <p>DNS or designee will audit weekly to ensure ROM programs in place and report findings to QA committee for 3 months.</p>	11/21/2014

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F 318	<p>Continued From page 21 "carrots in hands."</p> <p>On 10/6/14 at 1:32 PM, the resident was observed in bed with a carrot shaped device in both of her hands. The skinny end of the carrot was in the palm of the hands.</p> <p>On 10/7/14 at 11:30 AM in bed, and 4:42 PM in her wheelchair, the resident was observed with a carrot in both of her hands. The skinny end of the carrot was in the palm of the hands.</p> <p>On 10/8/14 at 10:05 AM, the resident was observed up in her wheelchair with a carrot in both of her hands. The skinny end of the carrot was in the palm of the hands.</p> <p>On 10/8/14 at 10:17 AM, the Rehabilitation Manager (RM) was asked how his department would become aware of a resident who required his department's services after the resident had been in the facility for a longer period of time. The RM stated the nursing staff would send them a referral, they would do the evaluation and then provide a plan. The plan would be for the RNA (Restorative Nurse Aide) program or for his department to provide the service.</p> <p>On 10/8/14 at 10:30 AM, RNA #2 was asked how she got referrals for the RNA program. RNA #2 stated when the resident comes in with PT (Physical Therapy) and their funds run out they get referred to the program. RNA #2 was asked when a resident is admitted with contractures how she would get the referral. She stated therapy would have to look at the resident first, nursing provides the information to therapy and therapy writes the resident's program for the RNA's to follow. When asked if Resident #7 was</p>	F 318			

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F 318	<p>Continued From page 22</p> <p>in the RNA program, she stated, "No, she is not." RNA #2 was asked if she knew why the resident had the carrots in both of her hands and she stated, "OT did that, they just put them on her because her hands are getting more contracted." She further stated the nurse staff managed the care of the carrots.</p> <p>On 10/8/14 at 3:30 PM, LN #6, who verified she was the RNA program manager, was asked how a resident with limited ROM was provided a ROM program after they had been in the facility for an extended period of time. LN #6 stated they would look at the significant change MDS, and evaluate if the resident was appropriate for the program. Once the numbers showed there was a decline, they would figure out a plan for the resident. When asked if it would be better to prevent the decline, LN#2 was agreed that it would be. LN#2 was asked why the resident, who had a limited ROM in all 4 extremities, was not on a program. She stated, "I am trying to search in my mind how [Resident's Name] got through the cracks." She stated she would look into it.</p> <p>On 10/8/14 at 3:50 PM, the DON was asked if she was aware the resident was not on a ROM program and she stated, "No." The QRCC dated 7/1/14 was reviewed with the DON and she stated she would look into it.</p> <p>On 10/9/14 at 10:55 AM, LN #6 provided documentation on the OT assessment for the carrots the resident was provided. She stated the carrots were preventive measures to allow hygiene to the resident's hands and to prevent further decline and closing of her hands. She further stated that ROM to the resident's hands was too painful and the resident was now on</p>	F 318			

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F 318	Continued From page 23 continuous pain medications which controlled her pain. LN #6 was asked if she was aware of the 7/1/14 documentation on the QRCC and she said was not, and she did not attend the meetings. When asked if she had a system to get a referral from the QRCC, and LN #6 stated, "I have a system with rehabilitation but I don't know that I have one with nursing. I do not have a formal system."	F 318		
F 322 SS=D	On 10/9/14 at 6:30 PM, the Administrator and DON were informed of the findings. No additional information was provided. 463.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that --  (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and  (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322	1. Identified Resident  Staff member immediately in-serviced regarding flushing feeding tube prior to administering medications. Resident #6 HOB was elevated to 30 degrees and indicator of 30 degrees placed on wall. Staff in-serviced regarding identifying a HOB at 30 degrees.	

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F 322	<p>Continued From page 24</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure the head of bed was elevated 30 degrees while a tube feeding was in progress and that the feeding tube was flushed with water prior to medication administration via the feeding tube. This was true for 1 of 1 residents (#6) reviewed for care and services related to feeding tubes. The failures created the potential for aspiration when Resident #6 vomited and the head of his bed was elevated less than 30 degrees; and, for the feeding tube to clog and the medication to interact with the tube feeding formula when the feeding tube was not flushed prior to a medication administration. Findings included:</p> <p>The Center for Medicare &amp; Medicaid Services (CMS) letter, S&amp;C:13-02-NH, directed facilities to flush feeding tubes before and between each medication administration.</p> <p>Resident #6 was admitted to the facility in May 2013, and readmitted 4/13/14, with multiple diagnoses which included chronic duodenal ileus, dysphagia, gastroparesis, cerebral palsy and contractures of multiple joints.</p> <p>The resident's October 2014 Order Summary Report of active orders included: * 7/22/14 - "Enteral feed...Isosource 1.5 - to run at 60 ml/hr x 22 hours [60 milliliters/hour for 22 hours]...on at 1500 [3:00 p.m.]...off at 1300 [1:00 p.m.]..."; * 4/28/14 - "Tube Feeding: Flush with 30 cc's [cubic centimeters] of H2O [water] prior to and after administration of meds [medications] every</p>	F 322	<p><b>2. Other Residents</b></p> <p>Resident with feeding tubes evaluated for proper flushing prior to medication administration. Residents receiving tube feeding audited for proper elevation of HOB.</p> <p><b>3. Systemic Changes</b></p> <p>Education provided to all LN staff regarding flushing feeding tubes prior to medication delivery. Staff will be evaluated on technique by the staff development coordinator. Any new residents admitted with tube feeding orders, or existing residents with new orders for tube feedings, will have 30 degree marking for HOB elevation placed on wall.</p>	11/21/2014	

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F 322	<p>Continued From page 25 shift..."; * 4/18/14 - "HOB [head of bed] elevated at least 30-45 degree [sic] during and 1 hr [hour] after feeding"; and, * 4/25/14 - "Tramadol...50 mg [milligrams] via G-Tube [gastrostomy tube, another term for a feeding or enteral tube] every 8 hours for pain."</p> <p>The resident's October 2014 MAR included the aforementioned orders for Tramadol and to flush the feeding tube before medication administration.</p> <p>a) On 10/8/14 at 9:45 AM, during the initial tour of the facility, Resident #6 was observed in bed with his tube feed being administered. The resident had yellow/tan colored vomitus on his face, and was moaning. At 9:50 AM., the DNS entered the room, observed the vomit and immediately raised the head of the bed. The DNS was asked if the head of the bed had been at a 30 degree angle and she stated, "It wasn't quite there." She was asked how the nursing staff would know where a 30 degrees position for the head of the bed would be. She stated the staff would be educated to look at the bed and know where 30 degrees was. NOTE: The head of bed remained in the proper position throughout the rest of the survey.</p> <p>b) On 10/8/14 at 3:45 p.m., LN #11 was observed as she poured, crushed, and dissolved a Tramadol 50 mg tablet in 30 ml of water. The LN then took the Tramadol to Resident #8's room, checked the resident's feeding tube for residual and found "3ccs" of residual formula which she returned via the feeding tube. LN #11 then administered the Tramadol via the resident's feeding tube; however, she did not flush the feeding tube with any amount of water before the</p>	F 322	<p>4. Monitoring</p> <p>DNS or designee will audit SDC evaluations monthly. SDC or designee will audit residents receiving tube feeding for proper HOB elevation weekly. Findings of audits and evaluations will be reported to QA committee for three months.</p>	

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F 322	<p>Continued From page 26</p> <p>medication administration. After that, the LN started the resident's tube feeding.</p> <p>On 10/8/14 at 3:52 p.m., when asked about the lack of a water flush before the medication administration, LN #11 stated, "I usually do but I didn't this time."</p> <p>On 10/8/14 at 4:40 p.m., the DNS was asked to provide the facility's policy regarding medication administration via feeding tube.</p> <p>Mid-morning on 10/9/14, the DNS provided an "Administering Medications through an Enteral Tube" policy. It documented, "...When correct tube placement and acceptable GRV [gastric residual volume] have been verified, flush tubing with 15-30 mL warm sterile water (or prescribed amount)...Dilute the crushed or split medication with 15-30 mL sterile water (or prescribed amount)...Administer medication..."</p> <p>On 10/9/14 at 6:25 p.m., the Administrator and DNS were informed Resident #6's feeding tube was not flushed with water prior to a medication administration.</p> <p>The facility did not provide any other information regarding the HOB elevation or water flush prior to medication administration via tube feeding issues.</p>	F 322			
F 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER  AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET 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 323	Continued From page 27 prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record reviews it was determined the facility failed to residents were assessed to determine if they were safe to use sideralls, a lap tray, and a wheelchair seatbelt for 7 of 13 sample residents (#s 2, 3, 4, 8-11 and 13); and, that handrails and a fire extinguisher in the 200 hallway were accessible for 6 of 13 sample residents (#s 1, 4, 6, 7, 11, and 12), and all other residents who lived in and moved about the 200 hallway. These failures created the potential for injury and possibly death should residents become entrapped in a siderail, seatbelt, or lap tray; for slips or falls when residents were unable to access handrails blocked by equipment not in use; and, for burns, smoke inhalation, and death for all residents in the 200 hallway if the response time to a fire was delayed when equipment blocked access to the fire extinguisher. Findings included:  1. Resident #3 was admitted to the facility in January 2010 and re-admitted on 2/2/14 with multiple diagnoses including late effects of acute poliomyelitis, mononeuritis, and neurogenic bladder.  The resident's most recent quarterly MDS assessment, dated 7/29/14, documented: * Moderately impaired cognition with a BIMS score of 10; * Extensive assistance for bed mobility, dressing,	F 323	1. Identified Resident Hallways immediately cleared to provide access to handrails and fire extinguishers for residents #1,4,6,7,11, and 12 and all other residents that live in or about the 200 hallway. Safety device assessments and consents were updated and completed for residents #2,3,4, 8,9,10,11, and 13.  2. Other Residents Residents with safety devices reassessed to determine safe use of the device. All common area hallways were evaluated for potential obstacles blocking access to handrails and fire extinguisher and any identified were removed.  3. Systemic Changes Staff educated on keeping hallways as clear as possible and removing unneeded equipment after use. Identified storage areas available for common area hallways for equipment when not in use. Equipment	11/21/2014	

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F 323	<p>Continued From page 28</p> <p>toileting, and personal hygiene; * Supervision on and off the unit; * Total assistance for transfers; * Functional limitation in both upper and lower extremities; and, * Wheelchair (w/c) use.</p> <p>The resident's care plan included "bed bars x 2 [2 siderails]" to assist with bed mobility; an electric w/c for mobility; and, a "[C]lip seatbelt when resident in w/c. Able to remove independently." All of these interventions were initiated 9/11/13.</p> <p>Bilateral 1/8 "bed bars" were observed in the raised position on the resident's bed on 10/6/14 at 1:00 p.m. and 2:17 p.m.; 10/7/14 at 9:10 a.m., 9:50 a.m., and 10:25 a.m.; and, 10/8/14 at 9:10 a.m., 10:00 a.m., and 10:15 a.m. And, the resident was observed in the electric w/c with the seatbelt in use on 10/7/14 at 7:45 a.m., 8:40 a.m., 1:15 p.m., and 4:50 p.m.; and, 10/8/14 at 7:12 a.m.</p> <p>Review of the resident's electronic medical record revealed there were no assessments regarding the siderails or w/c seatbelt.</p> <p>On 10/9/14 at 2:25 p.m., the Medical Records Nurse (MRN) was asked to provide safety assessments for the resident's siderail and w/c seatbelt. The MRN provided an "Acknowledgment of Psychoactive Medication Use" form which listed "siderail" as a psychoactive medication and "bed-mobility" as the medical symptom treated/bases for use. It was signed by the resident and dated 1/13/10. The MRN also provided an "Acknowledgment of Physical Restraint Use" form with risks and benefits for a "seat belt in wc" signed by the</p>	F 323	<p>that is in use by staff will be kept on one side of the hallway in order to keep one handrail and fire extinguisher unobstructed at all times. Staff educated regarding proper assessment of safety devices, and documentation that the devices are safe to use.</p> <p><b>4. Monitoring</b></p> <p>Administrator or designee will audit three times a week to ensure hallways are kept clear. DNS or designee will audit safety device assessments weekly to ensure completed and devices have been determined to be safe for use. Findings of audits will be presented to the QA committee for <u>three months</u>.</p>	

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NAME OF PROVIDER OR SUPPLIER  AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705	
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F 323	<p>Continued From page 29</p> <p>resident and dated 8/8/10. The MRN stated, "That's it. That's back when we did paper." The MRN said she would continue to look for safety assessments and confer with the MDS nurse.</p> <p>On 10/9/14 at 3:40 p.m., the MRN provided an Occupational Therapy discharge summary dated 9/13/13 and stated, "There's no specific documentation the w/c seatbelt was safe for the resident." The MRN said she did not find any other documentation regarding the siderails or the w/c seatbelt.</p> <p>2. Resident #10 was admitted to the facility in 2011 with multiple diagnoses including other persistent mental disorder due to conditions classified elsewhere, anxiety state, unspecified, and, dementia, condition classified elsewhere without behavior disturbance.</p> <p>The resident's most recent quarterly MDS assessment, dated 8/25/14, documented: * Severe cognitive impairment with a BIMS score of 4; * Extensive assistance for bed mobility, transfers, dressing, toileting, and personal hygiene; * Functional limitation in both lower extremities; and, * Wheelchair (w/c) use.</p> <p>The resident's Order Summary Report of active orders, dated 10/9/14, included, "Full lap tray in w/c to aid with positioning. Non-restrictive, resident unable to stand up unassisted." It was ordered 6/4/14.</p> <p>The resident's care plan included a lap tray on the w/c for positioning, initiated on *+8/8/14.</p>	F 323		

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F 323	<p>Continued From page 30</p> <p>The resident was observed in her w/c with the full lap tray in place on 10/7/14 at 5:35 p.m. while in the hallway between the Owyhee and Teton dining rooms; on 10/9/14 at 10:50 a.m. in her room; and, on 10/10/14 at 11:35 a.m. in the Owyhee dining room.</p> <p>A Safety Device Assessment and Consent (SDAC), signed by the responsible party and dated 9/22/14, documented the risks and benefits of the w/c lap tray. However, it did not include documentation that the resident was safe with the use of the lap tray.</p> <p>On 10/9/14 at 2:00 p.m., the MRN was asked to provide documentation that the resident had been determined to be safe with the use of the lap tray. The MRN reviewed the aforementioned SDAC then said the assessment did not document the lap tray was safe for the resident to use.</p> <p>3. Resident #8 was admitted to the facility in 2011 with multiple diagnoses including Parkinson's disease, senile and Lewy bodies dementia, muscular wasting and, hypothyroidism.</p> <p>The resident's annual MDS assessment, dated 9/8/14, documented: * Moderately impaired cognition with a BIMS score of 9; and, * Extensive assistance for bed mobility, transfers, dressing, and toileting.</p> <p>The resident's care plan for bed mobility documented, "[U]ses non-restrictive bilateral bed mobility bars to assist." The intervention was initiated 9/24/13 and revised 4/30/14.</p> <p>The resident was observed in bed with the</p>	F 323			

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F 323	<p>Continued From page 31</p> <p>bilateral bed cane type side rail "mobility bars" in the raised position on 10/6/14 at 1:25 p.m.</p> <p>The bilateral "mobility bars" were observed in the raised position when the resident was not in bed on 10/6/14 at 1:08 p.m. and 1:25 p.m., and on 10/7/14 at 8:25 a.m., 9:30 p.m., 10:20 a.m., 11:16 a.m., and 1:40 p.m.</p> <p>An SDAC form, signed by the resident and dated 10/23/13, documented the risks and benefits of the "mobility bars." However, it did not include documentation that the resident was safe with the use of the "mobility bars."</p> <p>On 10/9/14 at 6:25 p.m., the Administrator and DNS were informed of the safety assessment issue. The facility did not provide any other information regarding the issue.</p> <p>4. Resident #2 was admitted to the facility 3/19/14, with diagnoses that included diabetes, paralysis, dementia with Lewy Bodies and chronic kidney disease.</p> <p>The resident's quarterly MDS dated 9/8/14, documented the resident's cognition was severely impaired.</p> <p>The resident's ADL care plan dated 3/19/14, documented the resident used positioning mobility bars for transfers, ADLs, and bed mobility.</p> <p>The resident's SDAC form dated 3/27/14, documented the resident used mobility bars to assist with transfers and to assist with positioning for ADLs or other activities.</p>	F 323			

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F 323	<p>Continued From page 32</p> <p>The resident's medical record did not include the resident had been assessed to be safe with the use of the siderails.</p> <p>On 10/7/14 at 3:10 p.m., the resident was observed in bed with two 1/4 side rails up.</p> <p>5. Resident #13 was admitted to the facility on 10/1/14, with diagnoses which included Alzheimers, hypertension and dementia with behavioral disturbances.</p> <p>The resident's SDAC form dated 10/1/14, documented the resident used bilateral mobility bars for mobility.</p> <p>The resident's medical record did not include the resident had been assessed to be safe with the use of the siderails.</p> <p>On 10/8/14 at 3:14 p.m. the resident was observed in bed with two 1/4 side rails up.</p> <p>6. Resident #9 was admitted to the facility 12/19/11 and was readmitted on 9/3/13 and 11/30/13, with diagnoses which included upper limb amputation above elbow, history of traumatic brain injury, post traumatic stress disorder, and other convulsions.</p> <p>The resident's SDAC form dated 11/30/13, documented the resident used "bed rails" for bed mobility, to assist with transfers and to assist with positioning for ADLs or other activities.</p> <p>On 10/7/14 at 7:55 and 8:29 a.m., the resident was observed in bed with two 1/4 side rails up.</p> <p>On 10/9/14 at 6:30 p.m., the Administrator and</p>	F 323			

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F 323	<p>Continued From page 33</p> <p>DON were notified of the above concerns. No additional information was provided.</p> <p>7. Resident #11 was admitted to the facility 7/10/13 with diagnoses that included diabetes mellitus Type II, bipolar disorder, chronic pain, morbid obesity, muscular wasting and disuse atrophy.</p> <p>The resident's annual MDS dated 6/11/14, documented the resident's cognition was intact.</p> <p>The resident's care plan dated 9/27/14, documented the resident had a self care deficit in activity of daily living, with limited mobility. Interventions included a need for limited to extensive assistance of one person to reposition and turn in bed with the use of "nonrestrictive bilateral bed mobility bars to assist."</p> <p>The resident's SDAC dated 5/3/14, documented the resident used "1/2 mobility bars x 2," (side rails) and were used for bed mobility. The form documented the benefits of use of the bars. The form did not document the resident was assessed for safety with use of the bars.</p> <p>On 10/10/14 at 9:00 AM, the resident was observed in bed with two 1/4 side rails up. The resident was asked if she used the side rails, she stated she did use them to help get herself up in bed.</p> <p>8. Resident #4 was readmitted to the facility on 7/28/14 with diagnoses which included sleep apnea, acute respiratory failure, pneumococcal pneumonia, spina bifida, and history of venous thrombosis and embolism.</p>	F 323			

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F 323	<p>Continued From page 34</p> <p>The resident's Quarterly MDS dated 8/4/14, documented her cognition was intact.</p> <p>The resident's care plan dated 8/8/14, documented the resident had a self care deficit for ADLs and used 1/4 bed rails to reposition and turn in bed.</p> <p>The resident's SDAC dated 3/6/14, documented the resident used 1/4 bilateral side rails for bed mobility and the risks and benefits of side rails were provided to the resident. The form did not document the resident had been assessed to be safe with the use of the side rails.</p> <p>9. On 10/6/14 facility hand rails were blocked on the even numbered side of the 200 hall as follows:</p> <p>*1:10 PM &amp; 1:30 PM, two mechanical lifts were parked between rooms #216 &amp; #218; clean linen cart was parked between rooms #214 &amp; #212; a mechanical lift and a vital sign (VS) machine was parked between room #212 and a linen closet; the 200 hall kitchen cart was parked under the fire extinguisher box between a linen closet and room #210 and the medication cart was between room #208 and #204.</p> <p>*1:54 PM, one mechanical lift was between rooms #218 &amp; #216; a mechanical lift and a clean linen cart was between rooms #214 and #212; one mechanical lift and a VS machine was between room #212 and a linen room; the 200 hall kitchen cart was parked under the fire extinguisher box between a linen closet and room #210; housekeeper cart was between room #208 and a soiled linen closet and a medication cart was between room #204 and #206.</p>	F 323			

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F 323	<p>Continued From page 35</p> <p>*2:52 PM, one mechanical lift was between rooms #218 &amp; #216; a clean linen cart was between rooms #214 &amp; #212; a mechanical lift and a VS machine was between room #212 and a linen closet; an ice/water cart was parked under the fire extinguisher box between a linen closet and room #210 and a mechanical lift was between rooms #210 and #208.</p> <p>On 10/7/14 hand rails were blocked on the even numbered side of the 200 hall as follows:</p> <p>*8:05 AM, a mechanical lift and a VS machine was between rooms #214 &amp; #212; a mechanical lift was between room #212 and a linen closet and a medication cart and a clean linen cart was between rooms #206 &amp; #204.</p> <p>*9:05 AM, a mechanical lift and a VS machine was between rooms #214 &amp; #212; the 200 Hall kitchen cart was between rooms #210 &amp; #208 and a medication cart and a clean linen cart was between rooms #206 &amp; #204.</p> <p>*10:02 AM, a housekeeper cart and a VS machine were between rooms #214 &amp; #212; a mechanical lift was between room #212 and a linen closet; the 200 Hall kitchen cart and a mechanical lift were between rooms #210 &amp; #208 and a medication cart and a clean linen cart were between rooms #206 &amp; #204.</p> <p>*11:20 AM, a mechanical lift was between rooms #214 &amp; #212; a VS machine was between rooms #210 &amp; #208; and a medication cart and a clean linen cart was between rooms #206 &amp; #204. At 11:25 AM, Resident #11 and Resident #20 were propelling themselves in wheelchairs, single file</p>	F 323		

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F 323	<p>Continued From page 36</p> <p>past a medication cart and a clean linen cart, down the hall towards the door to outside. The bath aide was pushing a resident in a shower chair and started to pass the carts in the opposite direction the two residents were going, but had to stop due to the congested area. Resident #11 apologized for blocking the way and the bath aide told her it was ok. The two residents continued down the hall.</p> <p>*2:10 PM, a linen cart was between room #212 and a linen closet; a mechanical lift and a VS machine was between room #210 and a linen closet, which blocked the fire extinguisher box; a mechanical lift was between Rooms #210 &amp; #208 and a medication cart was between rooms #206 &amp; #204, 2 LN were counting medications.</p> <p>*4:45 PM and 5:30 PM, the ice/water cart was between #212 &amp; #214; a mechanical lift was between room #212 and a linen closet; a clean linen cart and a VS machine was between room #210 and a linen closet, which blocked the fire extinguisher box and a medication cart was between rooms #208 &amp; #210.</p> <p>On 10/7/14 at 5:37 PM, the door to the Recreational Therapy room on the 200 Hall was observed to have a sign which read, "Do not store the Hoyer lifts in this room. The door gets locked at night and day shift cannot get to the Hoyer lift til activities comes in." At 5:45 PM, the Recreational therapist was asked about the sign on the door. She stated, "I told them I needed a room to have social skill classes and to talk about healthy choices..." She was asked how long she had utilized the room and she stated it had been about 3 weeks and they had moved the equipment out into the halls and other places.</p>	F 323		

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F 323	Continued From page 37  On 10/7/14 at 5:50 PM, CNA #16 was asked where the mechanical lifts and equipment in the hallway was supposed to be stored. CNA #16 stated, "They used to be in the parlor but not any more. I don't know if they have a destination. I asked (Staff Development Coordinator name) about that also."  On 10/7/14 at 6:30 PM, the Administrant and DON were notified of the findings. No additional information was provided.  On 10/8/14 at 7:18 AM, a clean linen cart was between room # 210 and a linen closet which blocked the fire extinguisher box. At 7:24 AM, the DON moved the clean linen cart to between room #212 and a linen closet.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interview, it was determined the	F 328	1. Identified Resident  Resident #4 had CPAP immediately located and set up for use.  2. Other Residents  Residents with CPAP devices ordered surveyed for device location and use.	

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F 328	<p>Continued From page 38</p> <p>facility failed to ensure 1 of 1 (#4) residents reviewed for the use of a CPAP (Continuous Positive Airway Pressure), was provided CPAP as the physician had ordered. This practice created the potential for the resident to not sleep well at night. Findings include:</p> <p>Resident #4 was readmitted to the facility on 7/28/14 with diagnoses that included sleep apnea, acute respiratory failure, pneumococcal pneumonia, spina bifida, and history of venous thrombosis and embolism.</p> <p>The resident's Quarterly MDS, dated 8/4/14, documented the resident's cognition was intact and she had used a CPAP while not a resident in the facility and while she was a resident in facility.</p> <p>The resident's care plan, dated revised on 8/5/14, documented a focus of inadequate or compromised respiratory function related to a history of respiratory failure and included an intervention for CPAP per the physician order.</p> <p>The resident's "Active" orders dated October 2014, documented the resident was to have CPAP every hour of sleep for sleep apnea. The LN was to monitor the resident every 2 hours during the night to ensure equipment was in place.</p> <p>On 10/7/14 at 9:18 AM, the resident was asked if she used CPAP at night and she stated, "I am suppose to but I am claustrophobic and it drives me nuts." The resident was asked if the facility had talked to her physician about this and other options for her, she stated, "Oh probably noL." A CPAP machine was not observed in the room and the resident was asked where her machine was.</p>	F 328	<p>3. Systemic Changes</p> <p>LN staff educated on proper implementation and application of CPAP devices.</p> <p>4. Monitoring</p> <p>DNS or designee will audit residents with CPAP once a week to ensure proper use. Findings of audits will be reported to the QA committee for three months</p>	11/21/2014

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F 328	Continued From page 39 The resident stated the machine was in the suitcase which was in her room.	F 328		
F 329 SS=E	On 10/9/14 at 6:30 PM, the DON was asked if she had followed up on the resident's CPAP. The DON stated she had and the machine was where the resident stated it was, and they had set it up the night before (10/8/14) to give it a try.  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 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced	F 329	1. Identified Resident  Care plan for resident #9 was updated to reflect PTSD diagnosis. BMFS and care plan for resident #5 was updated to reflect current behaviors and possible interventions to assist with managing the resident's behaviors. Care plan for resident #13 was updated to reflect resident condition and medication profile reviewed and medication discontinued. Resident #8 care plan was updated to reflect diagnosis of psuedobulbar affect disorder. Medication review included nuedexta for psuedobulbar affect disorder, indicated target behaviors and sent to MD for review. Residents #7, 11 and	11/21/2014

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F 329	<p>Continued From page 40</p> <p>by: Based on record review and staff interview, it was determined the facility failed to ensure residents were free from unnecessary medications. The facility failed to monitor behaviors for which 7 of 13 sample residents (#s 5, 7, 8, 9, 11, 12 and 13) received antipsychotic or anti-anxiety medication. This practice placed the residents at risk for an unanticipated declines or newly emerging or worsening symptoms. Findings included:</p> <p>1. Resident #9 was admitted to the facility 12/19/11 and was readmitted on 9/3/13 and 11/30/13 with diagnoses which included upper limb amputation above elbow, history of traumatic brain injury, post traumatic stress disorder and other convulsions.</p> <p>The Resident's 10/7/14 Physician's Order Summary Report (recapitulation) included an order for Clonazepam (anti-anxiety) 1 mg at bedtime for Post Traumatic Stress Disorder (PTSD). The resident's medical record did not include a Care Plan for PTSD. On 10/9/14 at 2:15 the Social Worker (SW) stated the resident had a Care Plan for anger and verbal aggression. When asked if the anger was always related to PTSD the SW said it was not. The SW stated the resident may display the PTSD in other ways besides anger or verbal aggression. The SW stated there was not a Care Plan to identify triggers, behaviors, frequency for the PTSD. On 10/10/14 at 1:45 p.m., the Administrator and the DON were informed of the above concerns. The facility provided no further information.</p>	F 329	<p>12 BMFS updated and put into place.</p> <p>2. Other Residents</p> <p>Residents on BMFS, having a diagnosis of mental health disorder, or receiving an antipsychotic medication reviewed to ensure proper documentation is completed and review of medication need is reflected in the resident record.</p>	

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F 329	<p>Continued From page 41</p> <p>2. Resident #5 was admitted to the facility on 3/12/13 and readmitted on 7/26/14 with multiple diagnoses including diabetes type II, bipolar, schizoaffective disorder, and dementia.</p> <p>The resident's 8/4/14 Significant Change MDS assessment documented the following: *Required extensive assistance of one staff member for toilet use; *Experienced hallucinations, (perceptual experiences) and delusions (firm beliefs contrary to reality); and *Was severely cognitively impaired, BIMS=5.</p> <p>Resident #5's 10/7/14 Physicians Order Summary Report (recapitulation) included an order for Risperdal (antipsychotic) 0.25 mg two times a day for schizophrenia and an order for Seroquel (antipsychotic) 200 mg three times a day for schizoaffective disorder.</p> <p>Resident #5's 8/8/14 Care Plan documented, "Schizophrenia, bipolar disorder and dementia. Behaviors; Refusals of care, delusions, hallucinations...repetitive verbalizations, restless, medication side effects from long term antipsychotic med[ication] use, behavior." Interventions included: encourage verbalization of feelings, reinforce positive statements, reasons for negative statements, run money program when resident asked for her check, to give her blank forms to use as the resident was a nurse and believed she worked at facility, enjoyed caring for dolls, and no male caregivers as has delusions of being raped.</p> <p>Behavior Monthly Flow Sheets (BMFS) documented the resident was receiving Risperdal and Seroquel. The behaviors were to be</p>	F 329	<p>3. Systemic Changes</p> <p>Education completed regarding BMFS documentation to all LN staff. SW educated regarding BMFS to include behaviors that are accurate for the resident. Education completed with SW and supervisor LN staff regarding completing care plans to reflect psychotropic medications or mental disorders. SW educated to document components of family care meeting and discussion with family and or resident of behaviors and mental health needs in medical record. At the time of psychotropic drug committee review, the</p>	

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F 329	<p>Continued From page 42</p> <p>documented as false beliefs, hallucinations/paranoia/delusion and did not include intervention codes. Neither the care plan or BMFS addressed:</p> <ul style="list-style-type: none"> <li>* What the resident may be trying to communicate when she made negative statements or what a negative statement was such as pain or concerns regarding peers or staff;</li> <li>* It was unclear what staff were to do if they were able to determine the reason for the negative statement such as redirection, assuring resident the concerns would be addressed;</li> <li>*How to run the money program when the resident requested a check; or</li> <li>*Any interventions for hallucinations. The only intervention to address delusions was to not have a male care provider for Resident #5.</li> </ul> <p>The BMFS documented the following for August and September 2014:</p> <p>August 2014 - Hallucinations *Documented 1 hallucination each day from 8/11 through 8/14 (4), 8/18 through 8/21 (4), and continuous on 8/23/14. The total for the month was documented as 11.</p> <p>Nursing Notes (NN) on 8/22/14 and 8/25/14 documented the resident reported seeing animals (bears). On 8/25/14 she was in the doorway to her room yelling at the empty room to "get out of there." The NN documented on 8/24/14, the resident "continues to have delusions. Tonight was about kittens in her room. Pleasant and calm."</p> <p>August 2014 - Delusions *The BMFS documented 3 delusions on 8/20,</p>	F 329	<p>committee will ensure that all medications are listed for MD review. Medication for drug review will be identified by drug class. Prior to being sent out to the MD, the DNS or designee will review medication list to ensure accurate reflection of medications are listed.</p> <p>4. Monitoring</p> <p>DNS or designee will audit BMFS weekly for completion and accuracy of resident behavior. DNS or designee will audit care plans weekly for psychotropic medication, mental health needs and behaviors. DNS or designee will audit documentation of family care meetings. SDC or designee will audit psychotropic medication reviews monthly. Findings of audits will be reported to the QA committee for the next three months.</p>	

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F 329	<p>Continued From page 43</p> <p>continuous delusions on 8/23 and 2 delusions on 8/24/14. The monthly total was documented as 15.</p> <p>NN on 8/22/14 documented the resident stated, "Someone used the wrong key and let all the babies out in the building. Resident is pleasant and calm."</p> <p>The BMFS were left blank and did not include any documentation on 8/3, 8/9, 8/16/8/17, 8/21, 8/22, 8/28 and 8/30/14.</p> <p>The BMFS did not define "continuous", such as each behavior was documented when displayed for more than 15 minutes.</p> <p>September 2014 - Hallucinations/Delusions *Documented continuous hallucinations and delusions from 9/1 through 9/4/14, 2 hallucinations/delusions each day on 9/10 and 9/11 (4) and 1 hallucination/delusion on 9/13/14. The total hallucinations for the month was documented as 75 and delusions was documented as 81.</p> <p>NN on 9/19/14 documented the resident was, "...afraid of the cow and that there were too many cats in her room."</p> <p>The BMFS was left blank on 9/30/14.</p> <p>On 10/9/14 at 1:50 PM, the Social Worker (SW) stated the Care Plan (CP) did not distinguish between hallucinations or delusions. The SW stated the CP only identified the delusion the resident was raped and did not identify hallucinations or delusions regarding animals (bear, kittens, babies). Additionally, the SW</p>	F 329		

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F 329	<p>Continued From page 44</p> <p>stated there was no documentation to indicate whether or not all of the incidents were distressful to the resident. The SW stated she was aware antipsychotic medication was not to be given to a resident with diagnosis of dementia, unless the hallucinations/delusions were distressful. The SW stated some of the hallucinations were distressful. The SW stated the BMFS did not always document the resident's hallucinations on days they were documented in NN. The SW stated the BMFS did not include an area to document when the money program was implemented and evaluate the effectiveness. The SW stated the NN would be used to determine if the antipsychotic medication needed to be reduced or increased.</p> <p>On 10/10/14 at 8:00 a.m. the DON was informed of the above concern. The facility provided no further information.</p> <p>3. Resident #13 was admitted on 10/1/14 with diagnoses which included Alzheimer's disease, hypertension, and dementia with behavioral disturbances.</p> <p>The resident's 10/9/14 Physician's Order Summary Report included an order for Risperdal (antipsychotic) 0.5 mg for diagnosis of dementia with behavioral disturbance.</p> <p>The resident's medical record did not include the facility had discussed the underlying behaviors with the family. Additionally the medical record did not include a temporary Care Plan to determine the nature, frequency, or risks of the behaviors.</p> <p>On 10/9/14 at 3:50 p.m., LN #6 stated the facility had not implemented a care plan to baseline the</p>	F 329		

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F 329	<p>Continued From page 45</p> <p>frequency of the behaviors or assess the need for the antipsychotic but they were aware "there should be."</p> <p>4. Resident #8 was admitted to the facility in 2011 with multiple diagnoses which included, Parkinson's disease, senile dementia, Lewy bodies dementia, major depressive disorder, unspecified anxiety state and insomnia.</p> <p>The annual MDS assessment, dated 9/8/14, documented the resident's cognition was moderately impaired, with a BIMS score of 9, and she received antipsychotic, antianxiety, antidepressant, and hypnotic medications 7 of the past 7 days.</p> <p>The resident's Psychotropic Drug Use CAA, dated 9/9/14, care plan considerations documented, "...receives abilify [sic], xanax [sic], Cymbalta and ambien [sic] for...major depression and anxiety...followed by a community psychiatrist and receives in house counseling with a psychologist. Also with dx [diagnosis] of pseudobulbar affect [uncontrolled crying or laughing which may be disproportionate or inappropriate to the social context] for which she receives neudexta [sic]..."</p> <p>The resident's Order Summary Report of active orders included:            * Abilify 10 milligrams (mg) by mouth (PO) 2 times/day for major depressive disorder, started 5/12/14;            * Alprazolam (generic Xanax) 0.25 mg PO 4 times/day for anxiety, started 6/11/13;            * Cymbalta delayed release capsule 60 mg PO every morning for major depressive disorder, started 4/17/13;</p>	F 329		

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F 329	<p>Continued From page 46</p> <p>* Neudexta capsule 20-10 1 PO every 12 hours for pseudobulbar affect, started 4/16/13; and, * Ambien discontinued 9/18/14.</p> <p>A Psychotropic Medication Review and Physician Communication Form, dated 8/9/14, documented the resident received the Abilify, Xanax, Cymbalta, and Ambien 5 mg at bedtime. The target behaviors were agitation and anxiety.</p> <p>A Psychotropic Medication Review and Physician Communication Form, dated 9/23/14, documented the resident received Abilify, Xanax, and Cymbalta 60. The target behaviors were agitation and anxiety.</p> <p>The aforementioned Psychotropic Medication Review and Physician Communication Forms did not include Neudexta for pseudobulbar affect and the target behaviors listed did not include uncontrolled crying or laughing.</p> <p>a) The resident's care plan did not include pseudobulbar affect or uncontrolled crying or laughing. And, there were no care planned interventions which addressed the problem.</p> <p>b) The resident's Behavior Monthly Flow Sheets for August, September and October 2014 documented alprazolam (Xanax), Cymbalta, Ambien, and Abilify as the medications, and "agitated" and "anxiety" as the behaviors to be monitored.</p> <p>The behavior monitor flow sheets did not document consistent monitoring of the number of episodes, interventions, and outcome on all 3 shifts (days, evenings, and nights) as follows: - August:</p>	F 329		

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F 329	<p>Continued From page 47</p> <p>* "Agitated" - blank 15 of 31 day shifts, 19 of 31 evening shifts, and 14 of 31 night shifts.</p> <p>* "Anxiety" - blank 19 of 31 day and evening shifts and 14 of 31 night shifts.</p> <p>-September:</p> <p>* "Agitated" and "Anxiety" - both blank 18 of 30 day shifts, 14 of 30 evening shifts, and 13 of 30 night shifts.</p> <p>- October 1st- 8th:</p> <p>* "Agitated" and "Anxiety" - both blank 3 of 8 day shifts and 2 of 8 evening and night shifts.</p> <p>The aforementioned Behavior Monthly Flow Sheets did not include uncontrolled crying or laughing.</p> <p>On 10/9/14 at 12:25 p.m., the DNS was asked about inconsistent behavior monitor documentation. The DNS nodded "yes" with her head and stated, "We're working on that. These are paper monitors, not electronic, and I think sometimes they forget." The facility did not provide any other information regarding the issue.</p> <p>5. Resident # 7 was admitted to the facility on 3/20/13 with diagnoses that included schizoaffective disorder, anxiety state unspecified, and depressive disorder.</p> <p>The resident's physician "Active" orders dated October 2014, documented:</p> <p>*Haloperidol Decanoates Solution. Inject 125 mg (milligrams) IM (intramuscularly) in the afternoon every 28 days. Schizoaffective disorder.</p> <p>*Ativan tablet 1 mg. Give 1 tablet by mouth at bedtime. Anxiety.</p> <p>* Depakote Sprinkles Capsule. Give 500 mg by mouth at bedtime. Schizoaffective disorder.</p> <p>*Zoloft Tablet. give 150 mg by mouth in the</p>	F 329		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  136077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/10/2014
NAME OF PROVIDER OR SUPPLIER  AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705	
(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 329	<p>Continued From page 48 morning. Depressive disorder.</p> <p>January and February 2014 monitoring forms for the resident being "Agitated" and "Suspiciousness" included numerous blanks in the documents. The facility provided no further documentation for March - October 2014.</p> <p>A facility incident report dated 9/13/14, documented the resident stated that a male care giver was going to 'touch her' but a female caregiver came in 'on time and nothing happened thanks to her.' The NP (Nurse Practitioner) was notified and the resident's Haloperidol was increased from the 15th of every month to every 28 days "due to increased behaviors and extensive psych background." The facility had not documented any other "behaviors" for the resident, and with the one statement pertaining to the male giver had changed the resident's Haloperidol from every 15th of the month to every 28 days.</p> <p>The resident's care plan revised 9/18/14, documented the resident had problematic behaviors characterized by ineffective coping with verbal aggression related to cognitive impairment, schizophrenia, anxiety. Interventions included: do not engage in arguments or be defensive with the resident; when the resident is hostile stop giving care...; monitor and report decline in mood or increased behaviors; behavior monitoring, followed in the psychotropic meeting and if male caregiver is to provide cares, must have another female CNA present.</p> <p>The resident's Psychotropic Medication review and Physician Communication form dated 9/23/14, documented the resident received Zoloft;</p>	F 329		

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NAME OF PROVIDER OR SUPPLIER  AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 329	<p>Continued From page 49</p> <p>Depakote; Ativan and Haloperidol which was increased from once a month to every 28 days. The team review documented the resident had a "possible increased paranoia-will continue to monitor," and the team recommendation was for, "no changes at this time."</p> <p>On 10/9/14 at 12:30 PM, the LSW (License Social Worker) was asked why the Haldol was changed to be given every 28 days instead of one time a month. She stated it was because the resident had some paranoia. The LSW was asked to provide the documentation that monitored the behaviors.</p> <p>On 10/10/14 at 9:30 AM, the LSW provided documentation for the resident's psychotropic medications. The LSW stated the Haldol was not really an increase it was a day period change. (NOTE: Haldol was given more frequently due to the days of the month, some months longer than others.) The LSW stated the resident had seen [Psychiatrist's name] when she first came to the facility but did not any longer. The LSW was asked to provide the notes. The LSW stated she did not have behavior monitors since March of 2014, the resident had fell through the cracks.</p> <p>6. Resident #12 was admitted to the facility on 3/3/12 with diagnoses that included schizophrenia, depressive disorder, and other persistent mental disorder.</p> <p>The resident's Psychotropic Medication Review and Physician Communication form dated 9/23/14, documented the resident's current medication were Depakote 125 mg two times a day; Zoloft 150 mg every morning; Lorazepam .5 mg as needed and Zyprexa 20 mg at bedtime.</p>	F 329			

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F 329	<p>Continued From page 50</p> <p>The target behaviors were identified as agitation and anxiety.</p> <p>The resident's care plan, revised on 9/4/14, documented a focus of, "sadness and depression or makes negative statements related to schizophrenia and depression." The documented interventions included monitor behaviors to assist in assuring lowest possible therapeutic dose, assess for any acute medical conditions if behaviors worsen, to provide medications as ordered and to assess and document for side effects and effectiveness.</p> <p>The resident's Behavior Monthly flow sheets dated July, August, September and October 2014 documented the medications which required to be monitored were Sertraline (Zoloft), Lorazepam and Zyprexa.</p> <p>July through October 2014 monitoring forms for the resident being "Agitated" and "Anxiety" included numerous blanks in the monitoring as follows: -July: 78 of 186 opportunities for documentation.  -August: 98 of 186 oportunites for documentation.  -September: 93 of 180 oportunties for docuementation.  -October 1st- 9th: 14 of 54 oportunites for documentation.</p> <p>On 10/9/14 at 4:15 PM, the LSW was asked how the psychotropic medication team was able to track behaviors for drug monitoring when there were so many holes in the tracking form. The</p>	F 329		

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F 329	Continued From page 51 LSW agreed there were holes in the documentation and stated the LN will sometimes document in the nurse notes too. The LSW was asked to provide the documentation; however, no further documentation was provided.  5. Resident #11 was readmitted to the facility on 7/10/13 with diagnoses that included bipolar disorder.  The resident's Psychotropic Medication review and Physician Communication form dated 9/23/14, documented the resident received: Seroquel 800 mg at bedtime, Haldol 10 mg in the morning, Trazodone 150 mg at bedtime and Lamictal 200 mg two times a day. The target behaviors were agitation, anxiety, and depressed withdrawn.  August through October 2014 monitoring forms for the resident being "Agitated," "Anxiety" and "Depressed withdrawn" included numerous blanks in the monitoring as follows:  -August: 152 of 279 opportunities for documentation.  -September: 146 of 270 opportunities for documentation.  -October 1st- 9th: 21 of 81 opportunities for documentation.  On 10/9/14 at 6:30 PM, the Administrator and DON were notified of the findings. No additional information was provided.	F 329			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371			

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F 371	Continued From page 52  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure dishes used for the serving of food were washed and maintained under sanitary conditions. This had the potential to affect 12 of 13 sampled residents (#s 1-5 and 7- 13) and any other resident who dined in the facility. This practice created the potential for contamination of food and exposed residents to potential sources of disease causing pathogens. Findings include:  On 10/8/14 at 10:00 a.m., the Dishwasher #1 (D1) was observed wearing an apron, scraping food off of dirty dishes, and placing them in the dishwashing machine. Without removing her apron, D1 washed her hands and began putting the clean dishes away. At that time, D1 stated she did not know she was to take the dirty apron off, and put on a clean apron prior to touching the clean dishes.  On 10/10/14 at 1:45 p.m., the Administrator, DON, Dietitian and Dietary were informed of the concern. The facility provided no further information.	F 371	F371  I. Identified Residents Re-educated D1 on proper apron changing before handling clean dishes  II. Other Residents All residents reviewed for food borne illness.  III. Systemic Changes In-service all dishwashing staff on changing aprons before handling clean dishes. a notice will be posted to remind staff to change aprons as necessary. New employees will be educated on apron use during orientation.  IV. Monitoring Dietary manager will audit dish washing procedure three times a week and findings will be reported to the QA committee for three months	11/21/2014

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F 441 SS-E	<p><b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b></p> <p>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.</p> <p>(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.</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>	F 441	<p><b>1. Identified Resident</b></p> <p>The K-pad was immediately sanitized and cover to heel lift pad replaced for resident # 21. Walkie Talkies are sanitized at the end of each shift and prn. SDC immediately educated staff on proper infection control techniques while assisting with meals.</p> <p><b>2. Other Residents</b></p> <p>All residents with K-pads reviewed for proper placement. Walkie Talkies remain on cleaning schedule every shift. Meal assistance observed/reviewed for proper infection control techniques.</p>	11/21/2014

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F 441	<p>Continued From page 54</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure staff performed hand hygiene for 2 of 13 sample residents (#s 3 and 7) and 1 random resident (#19) during dining or after incontinence care, and that a K-pad (non-electric heating pad) was not in contact with the floor for another random resident (#21). These failures created the potential for the spread of infection. Findings included:</p> <p>1. On 10/6/14 at 1:20 p.m., Resident #21 was observed in bed. The resident said she frequently felt cold and used a heating pad on her feet. A K-pad was observed on the floor near the foot of the resident's bed.</p> <p>A moment later, CNA #3 entered the room. When the CNA was about to leave the room she was asked if the K-pad should be on the floor. CNA #3 stated, "Probably not." The CNA moved the K-pad off the floor and placed it on a black heel lift pad on the resident's bed. When informed the heel lift pad was now contaminated, CNA #3 removed the K-pad from the heel lift pad then removed the cover from the heel lift pad. The CNA said she would sanitize both items and get a new cover for the heel lift pad. The CNA left the room briefly and returned with sanitizer wipes. The CNA sanitized the K-pad and the heel lift pad. A few moments later, another staff brought a new cover for the heel lift pad and CNA #3 put it on the pad.</p> <p>2. On 10/8/14 at 10:15 a.m., CNA #4 was observed as he provided incontinence care for Resident #3 with CNA #5's assistance. After the incontinence care, CNA #4 removed his used</p>	F 441	<p><b>3. Systemic Changes</b></p> <p>Staff educated to not place K-pads on floor and if they are dropped to the floor, how to sanitize. Staff educated to not touch walkie talkies during cares without first washing hands and ongoing sanitizing procedure. Residents who require assistance with fluids during meals will have lids placed on cups in order to secure the straw reducing the need to touch the straw. Staff educated to sanitize their hands while assisting with meals when they believe hands have been contaminated and that hand sanitizer is available in wall dispensers in each dining room.</p>	

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F 441	<p>Continued From page 55</p> <p>gloves. However, CNA #4 did not perform any type of hand hygiene before he touched his walkie-talkie twice to summon the wound nurse and assisted CNA #5 to apply the resident's padded heel protectors. After that, the CNA washed his hands.</p> <p>On 10/8/14 at 10:30 a.m., CNA #4 was informed of the observation. The CNA nodded yes in acknowledgment and stated, "Oh okay, I'll watch that."</p> <p>On 10/9/14 at 6:25 p.m., the Administrator and DNS were informed of the infection control issues. The facility did not provide any other information regarding the issues.</p> <p>3. On 10/8/14 between 8:10 AM and 8:15 AM, CNA #3 was observed to assist Resident #7 and #19 with their breakfast. CNA #3 provided fluids to Resident #7 by holding the resident's straw with her hand. When Resident #7 was done drinking, the CNA assisted Resident #19 with fluid by holding the resident's straw with the same hand and provided food with his spoon. The CNA went back and forth between the residents and assisted with fluids and food, without washing or sanitizing her hands.</p> <p>On 10/9/14 at 3:55 PM, the SDC/ICN (Staff Development Coordinator/ Infection Control Nurse) was asked if she would expect a CNA, whom assisted two residents at one time with their meal, to wash or sanitize her hands between the assist with each resident. The SDC/ICN stated, "No," because she had been told by someone, a surveyor or dietitian, several years ago that they could not have alcohol sanitizers on the tables. She was asked if they were not</p>	F 441	<p><b>4. Monitoring</b></p> <p>DNS or designee will audit K-pads once a week for proper placement. DNS or designee will audit handwashing and walkie talkie sanitizing weekly. DNS or designee will audit assistance with meals once a week for proper infection control to include hand sanitizing prn and lid/straw cup placement. Findings of audits will be reported to the QA Committee for the next three months.</p>		

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F 441	Continued From page 56 supposed to sanitize their hands, how would they prevent infections. She stated she would "expect them to be careful."  On 10/9/14 at 6:30 PM, the Administrator and DON were notified of the findings. No additional information was provided.	F 441			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/10/2014
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NAME OF PROVIDER OR SUPPLIER  AVAMERE TRANSITIONAL CARE & REHAB - B	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83706
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C 000	16.03.02 INITIAL COMMENTS  The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The surveyors conducting the survey were: Sherri Case, BSW, LSW, QIPD, Team Coordinator Linda Kelly, RN Susan Gollobit, RN Kirsti Stephenson, RN  The following deficiencies were cited during the State licensure and complaint survey of your facility.	C 000		
C 119	02.100.03,c,iii Informed of Medical Condition by Physician  iii. Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research; This Rule is not met as evidenced by: Refer to F154 related to informed consent for the use of side rails.	C 119	C 119 02.100,03,c,iii  Refer to POC for F-154	11/21/2014
C 159	02.100,09 RECORD OF PTNT/RSDNT PERSONAL VALUABLES  09. Record of Patient's/Resident's Personal Valuables. An inventory and proper accounting shall be kept for	C 159	C 159 02.100,09  Refer to POC for F-204	11/21/2014

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michelle B...</i>	TITLE Admin.	(X5) DATE 11-6-14
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STATE FORM If continuation sheet 1 of 8

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001250	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/10/2014
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NAME OF PROVIDER OR SUPPLIER  AVAMERE TRANSITIONAL CARE & REHAB - B	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705
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C 159	Continued From page 1  all valuables entrusted to the facility for safekeeping. The status of the inventory shall be available to the patient/resident, his conservator, guardian, or representative for review upon request. This Rule is not met as evidenced by: Refer to F204 as it related to an accounting of residents' belongings.	C 159		
C 282	02.107,02,d Required Clean Cloths and Hair Covering  d. No person who has worked in any other area of the facility shall assist with the preparation or serving of food inside of the kitchen without first putting on a clean uniform or gown and a hairnet or cap. Hands must be thoroughly washed. This Rule is not met as evidenced by: Please refer to F 371 as it relates to clean clothes when handling clean dishes.	C 282	C 282 02.107,02,d  Refer to POC for F-371	11/21/2014
C 393	02.120,04,b Staff Calling System at Each Bed/Room  b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room	C 393	C 393 02.120,04,b  Refer to POC for F-246	11/21/2014

Bureau of Facility Standards

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C 393	Continued From page 2 shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Refer to F246 related to the use of call lights.	C 393		
C 644	02.150,01,a,i Handwashing Techniques  a. Methods of maintaining sanitary conditions in the facility such as:  i. Handwashing techniques. This Rule is not met as evidenced by: Refer to F441 as it related to hand hygiene	C 644	C 644 02.150,01,a,i  Refer to POC for F-441	11/21/2014
C 661	02.150,01,d,vii CONTROL TECHNIQUES UTILIZED  vii. Control techniques utilized. This Rule is not met as evidenced by: Refer to F441 as it related to resident equipment on the floor.	C 661	C 661 02.150,01,d,vii  Refer to POC for F-441	11/21/2014
C 664	02.150,02,a Required Members of Committee  a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of Infection Control Committee (ICC) meeting attendance records, it was determined the facility did not ensure the Pharmacist attended/participated in quarterly ICC meetings. This failure created the	C 664	C 664 02.150,02,a  I. Identified Residents Pharmacist to be notified to attend via telephone system the QA meeting scheduled on 11-13-14.  II. Other Residents  Residents with active infections reviewed to determine need for a Pharmacist consult.	11/21/2014

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 10/10/2014
NAME OF PROVIDER OR SUPPLIER  AVAMERE TRANSITIONAL CARE & REHAB - B		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET 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 664	Continued From page 3  potential for a negative effect for all residents, staff and visitors in the facility when the Pharmacist was not involved in the ICC meetings. Findings included:  On 10/9/14 at 2:45 PM, the ICN (Infection control Nurse) was asked who the members of the ICC were. The ICN did not include the Pharmacist and was asked if the Pharmacist attended and she stated "No, he use to before we were (Facility name), but not anymore."  On 10/9/14 at 4:10 PM, the Administrator provided the sign in sheets for the ICC meetings dated 2011, 2012 and until 4/25/13. No other sign in sheets were provided to verify who had attended the meetings since 4/25/13.  On 10/17/14 at 2:25 PM, the administrator was contacted by phone and asked to fax the last 6 months of sign in sheets for the ICC meetings.	C 664	III. System Changes A sign-in sheet will be kept for monthly QA meeting indicating who attends in person and/or via telephone system. Monthly QA meeting is to be held on the 2 <sup>nd</sup> Thursday of each month. Pharmacist shall attend in-person on an every other month basis and by telephone system on the opposite months.  IV. Monitoring Administrator will review QA committee meeting sign-in sheets on a monthly basis to ensure Pharmacist attends/participates in the quarterly QA committee meeting. Results will be reported to QA committee for two quarters.	
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-280 as it relates to care plans.	C 782	C782 02.200,03a,iv  Refer to POC for F-280	11/21/2014
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	C 784	C784 02.20003,b  Refer to POC for F-322	11/21/2014

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001250	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/10/2014
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NAME OF PROVIDER OR SUPPLIER  AVAMERE TRANSITIONAL CARE & REHAB - B	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705
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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) COMPLETE DATE
C 784	Continued From page 4  Is not limited to: This Rule is not met as evidenced by: Please see F 309 as it pertains to dementia care, and providing care for a wound. Refer to F322 as it related to head of bed positioning during tube feedings and water flush prior to medication administration via feeding tube.	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: Refer to F312 as it related to nail care.	C 785	C785 02.200,03,b,i  Refer to POC for F-312	11/21/2014
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: Refer to F328 related to treatment with CPAP at night.	C 788	C788 02.200,03,b,iv  Refer to POC for F-328	11/21/2014
C 790	02.200,03,b,vi Protection from Injury/Accidents  vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as it related to safety assessments for bed siderails, a wheelchair seat belt, a lap tray, and blocked handrails and a fire	C 790	C790 02.200,03,b,vi  Refer to POC for F-323	11/21/2014

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001250</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/10/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>AVAMERE TRANSITIONAL CARE &amp; REHAB - B</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1001 SOUTH HILTON STREET BOISE, ID 83705</b>		
(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 790	Continued From page 5 extenguisher.	C 790		
C 795	02.200,03,b,xi Bowel/Bladder Evacuation/Retraining  xi. Bowel and bladder evacuation and bowel and bladder retraining programs as indicated; This Rule is not met as evidenced by: Please see F 315 as it pertains to toileting care plans.	C 795	<b>C795 02.200,03,b,xi</b>  <b>Refer to POC for F-315</b>	11/21/2014
C 796	02.200,03,b,xii Rehabilitative Nursing Standards  xii. Rehabilitative nursing current with acceptable professional practices to assist the patient/resident in promoting or maintaining his physical functioning. This Rule is not met as evidenced by: Refer to F318 related to resident Range of Motion.	C 796	<b>C796 02.200,03,b,xii</b>  <b>Refer to POC for F-318</b>	11/21/2014



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 208-334-6826  
FAX 208-364-1888

February 23, 2015

Mark Barglof, Administrator  
Avamere Transitional Care & Rehabilitation - Boise  
1001 South Hilton Street  
Boise, ID 83705-1925

Provider #: 135077

Dear Mr. Barglof:

On **October 10, 2014**, an unannounced on-site complaint survey was conducted at Avamere Transitional Care & Rehabilitation - Boise. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey, which was conducted from October 6 - 10, 2014.

The following information was reviewed:

- Staffing records for November 2013 and the three-weeks prior to the Recertification and State Licensure survey;
- Medication Administration Records and Nursing Care Notes (NCN) for nine residents, which included those of the identified resident;
- Facility's incident/accident reports (I/As); and
- Resident Council Minutes and grievances from November 2013 through October 5, 2014.

Interviews were conducted with the residents attending a group meeting, individual residents, family members and nursing staff. Observations were conducted throughout the survey.

The complaint allegations, findings and conclusions are as follows:

**Complaint #6274**

Mark Barglof, Administrator  
February 23, 2015  
Page 2 of 3

#### ALLEGATION:

The complainant stated that an identified resident, who was terminally ill and given ordered Ativan for agitation, fell twice while trying to get out of bed. Facility staff stated that they did not have enough staff to meet his needs.

#### FINDINGS:

The Licensed Nurses (LNs) identified by the complainant were not on the list of the facility's current staff; however, three LNs and four Certified Nurse Aides (CNAs) interviewed stated there was enough staff to meet the needs of the residents. The CNAs stated the facility would find other staff to work if someone called in sick.

Staffing records documented that the facility exceeded the State's minimum staffing requirement at the time of the resident's falls.

Observations throughout the survey revealed that residents' call lights were answered timely.

The resident's record included NCNs that described the following:

On November 12, 2013, at 7:50 p.m. the identified resident began yelling out and attempting to get out of bed. Staff was unable to redirect the resident with a 1:1 staff and the resident was checked every ten minutes. On November 13, 2013, at 12:30 a.m. a "Late Entry" documented the resident was eating a sandwich. On November 13, 2013, at 2:30 a.m. the NCN documented the resident was found on the floor beside the bed. According to the note, the resident fell at 10:35 p.m. on November 12, 2013.

Nurses' notes documented the resident fell on November 13, 2013, at 6:45 a.m. The I/A documented that at 4:30 a.m. the nurse administered an anti-anxiety medication to the resident due to "restlessness." The anti-anxiety medication was on the resident's hospice admission orders but was changed after talking with the family to a medication the resident "was used to taking" at home. The investigation documented an alarm was used to alert staff if the resident attempted to get out of bed. The nurse was outside the room when the alarm went off, and the resident was already on the floor when the nurse went into the room.

The facility's investigations into the falls, as documented on I/A's, did not address how the identified need for the 1:1 staffing pattern and the need for the resident to be checked every ten minutes prior to the first fall on November 12, 2013, was taken into consideration in determining the root cause of the falls or plans to prevent recurrence.

Mark Barglof, Administrator  
February 23, 2015  
Page 3 of 3

This allegation was substantiated.

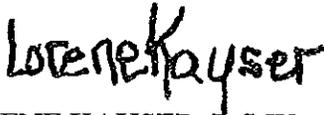
CONCLUSIONS:

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.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2. 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, slightly slanted style.

LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor  
Long Term Care

LKK/dmj



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February 23, 2015

Mark Barglof, Administrator  
Avamere Transitional Care & Rehabilitation - Boise  
1001 South Hilton Street  
Boise, ID 83705-1925

Provider #: 135077

Dear Mr. Barglof:

On **October 10, 2014**, an unannounced on-site complaint survey was conducted at Avamere Transitional Care & Rehabilitation - Boise. The complaint allegations, findings and conclusions are as follows:

**Complaint #6721**

**ALLEGATION:**

Residents are not provided with appropriate bathing services or oral, catheter and feeding tube care.

**FINDINGS:**

During the survey, observations and residents and staff interviews were conducted. Records, including resident clinical records, abuse reports, incident and accident reports, grievances and Resident Council meeting minutes were reviewed with the following results:

The facility's abuse reports for July 2014 through October 7, 2014, Incident and Accident reports for April 2014 through October 12, 2014 and Resident Council meeting minutes and grievances for November 2013 through October 5, 2014, were reviewed. None of the records included

Mark Barglof, Administrator  
February 23, 2015  
Page 2 of 2

concerns regarding bathing or oral, catheter and feeding tube care.

Observations of 13 residents were conducted throughout the survey. No concerns with the residents' oral or body hygiene were noted during the observations. Four residents, two resident advocates, seven Certified Nurse Aides, eight Licensed Nurses and the Director of Nursing Services were interviewed. No concerns regarding hygiene issues or oral, catheter and feeding tube care were expressed during the interviews.

The records of the 13 observed residents were reviewed. Concerns regarding bathing and oral care were not identified for any of the residents. Of the 13 records reviewed, three documented residents had an indwelling urinary catheter and one had a feeding tube. Concerns regarding the residents' catheter and feeding tube care were not identified for any of the residents. All of the records documented appropriate care and treatment. Additionally, October 6, 2014 through October 20, 2014, records of one resident who used both a catheter and a feeding tube were reviewed again on November 7, 2014, after the survey exit conference.

It could not be established that residents were not being provided with appropriate personal hygiene or oral, catheter and feeding tube care. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

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,



LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor  
Long Term Care

LKK/dmj