IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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February 26, 2016

Joe Rudd Jr, Administrator
Marquis Care At Shaw Mountain
909 Reserve Street
Boise, ID 83712-6508

Provider #: 135090

Dear Mr. Rudd Jr:

On **February 19, 2016**, a survey was conducted at Marquis Care At Shaw Mountain by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided 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." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) 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 the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 7, 2016**. Failure to submit an acceptable PoC by **March 7, 2016**, may result in the imposition of civil monetary penalties by **March 7, 2016**.

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; and

- 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 the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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 **March 25, 2016 (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 **March 25, 2016**. A change in the seriousness of the deficiencies on **March 25, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 25, 2016** includes the following:

Denial of payment for new admissions effective **May 19, 2016**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, 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 **August 19, 2016**, 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, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; 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 **February 19, 2016** 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 non-compliance 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/NursingFa

cilities/tabid/434/Default.aspx

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

- BFS Letters (06/30/11)

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

This request must be received by **March 7, 2016**. If your request for informal dispute resolution is received after **March 7, 2016**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

David Scott, RN, Supervisor
Long Term Care

DJS/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135090	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUIS CARE AT SHAW MOUNTAIN	909 RESERVE STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility from February 16, 2016 to February 19, 2016. The surveyors conducting the survey were: Michael Case, LSW, QIDP, Team Coordinator Karen Marshall, MS, RD, LD Presie Billington, RN Survey Definitions: ac - Before meals ADL - Activities of Daily Living BIMS - Brief Interview for Mental Status CAA - Care Area Assessment cm - centimeters CNA - Certified Nursing Assistant CP - Care Plan DON - Director of Nursing ER - Emergency Room HS - Bedtime LN - Licensed Nurse MAR - Medication Administration Record MASD - Moisture Associate Skin Damage MDS - Minimum Data Set assessment MSDS - Material Safety Data Sheets NS - Normal Saline pc - After meals q - Every RCM - Resident Care Manager RN - Registered Nurse TAR - Treatment Administration Record	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of	F 167		3/25/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/07/2016

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F 167	Continued From page 1 the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure the results of the most recent surveys were readily accessible to residents. This deficient practice was true for any resident or their representative who may want to review the survey results, including 13 of 13 sample residents (#s 1-13). Findings included: 1. On 2/18/16 at 11:25 am, the survey results binder was observed on the wall at the end of the 200 hall, where the hall intersected with the 100 hall and 300 hall. The binder contained a Recertification survey, dated 6/27/14, and a Fire, Life, Safety survey, dated 6/3/14. The binder did not contain the results for a Complaint survey, dated 2/26/15, a Complaint Follow-up survey, dated 5/5/15, a Complaint survey, dated 5/15/15, a Complaint Follow-up survey, dated 9/2/15, a Fire, Life, Safety survey, dated 6/17/15, or a Fire, Life, Safety Follow-up survey, dated 8/4/15. On 2/19/16, the Administrator stated it was his	F 167	This plan of correction constitutes the facility'□s written allegation of compliance for the deficiencies cited in the CMS 2567. However, the submission of this plan is not an admission that a deficiency exists. The Plan of Correction is prepared and executed solely because it is required by federal and state law. This response and Plan of Correction does not constitute an admission or agreement by the provider of the facts alleged or set forth in the statement of deficiencies. Survey Definitions: Daily as used in Monitors = Monday - Friday Q = Daily IDT = Interdisciplinary Team LN = Licensed Nurse CNA = Certified Nursing Assistant DM = Dietary Manager LSW = Licensed Social Worker RCM = Resident Care Manager. DNS = Director of Nursing Services SSD = Social Services Designee / FHCC	

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F 167	Continued From page 2 responsibility to ensure survey results were available. The Administrator stated the survey results were not placed into the binder due to an oversight.	F 167	Friendship House Care Coordinator NP = Nurse Practitioner TAR = Treatment Administration Record MAR = Medication Administration Record ER = Emergency Room DC = Discharge PRN = As needed QA = Quality Assurance MDS= Minimum Data Set MASD=Moisture Associated Skin Damage F 167 Corrective Action: Most recent surveys have been placed in the Survey binder on 3/4/2016, and are readily accessible to the residents. Identification: All residents are identified as potentially being affected by this deficiency. Systemic Changes: Administrator to ensure a copy of Surveys are placed in Survey binder immediately after receiving Compliance Letter from the Department of Facility Standards/Fire and Life Safety. Monitor: DNS to conduct audit of Survey binder to ensure appropriate Surveys are in said binder. Frequency: One week after Substantial Compliance Letter is received from the Department of Facility Standards/ Fire and Life Safety following any Survey by same.	

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F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to maintain residents' dignity for 2 of 13 sample residents (#9 and #12) reviewed whose catheter collection bags were exposed. This resulted in the potential for a negative effect on their self-esteem. Findings included: 1. Resident #9 was readmitted to the facility on 10/21/15 with multiple diagnoses, including quadriplegia. His care plan, dated 10/30/15, documented he required the use of a suprapubic catheter. On 2/16/16 at 1:45 pm, Resident #9 was observed in bed with his catheter collection bag uncovered and on the floor. CNA #7, who was present at the time of the observation, stated the collection bag should not be on the floor, and that the bag should be covered. 2. Resident #12 was readmitted to the facility on 8/18/15 with multiple diagnoses, including dementia. His most recent MDS, dated 1/8/16, documented his cognitive skills for daily decision making were severely impaired. His Care Plan,	F 241	F 241 Corrective Action: 1. Residents #9 and #12 were provided with catheter bag covers. 2. 100% residents with catheter bags were audited to ensure appropriate covers were in place Identification: All residents who have a catheter in place are identified as potentially being affected by this deficiency. Systemic Changes: Nursing staff received inservice with regard to ensuring that all catheter bags are placed in a privacy cover to maintain the resident's dignity. 1. CNA staff in-serviced on 3/1/2016. 2. LN staff will receive in-service on 3/8/2016. Monitor: 1. DNS or designee to conduct audits to ensure that resident catheter bags are in privacy cover. 2. Audits to begin the week of 3/7/2016,	3/25/16

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F 241	Continued From page 4 dated 2/4/16, documented he required the use of a suprapubic catheter. On 2/19/16 at 9:57 am, Resident #12 was observed in his room with the door open. His uncovered catheter collection bag was attached to the side of the bed with the bottom of the bag in contact with the floor. LN #8, CNA #9 and CNA #10, who were present during the observation, all stated the catheter collection bag should have been covered to protect Resident #12's dignity.	F 241	and will continue at the following frequencies: Weekly x four (4) weeks Q two (2) weeks x four (4) weeks Monthly x three (3) months 3. Administrator to review audits and report findings to QA Committee	
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 provide necessary care and services to 3 of 13 sampled residents (#4, #5, and #8) who did not receive a sufficient assessment before being moved following a fall, and who were not provided compression stockings in accordance with their care plans. This failure had the potential for harm related to a lack of sufficient assessment and provision of treatment. Findings include:	F 309	F 309 Corrective Action: 1.Resident #8 re-admitted to the facility on 2/9/2016. Since her re-admission, she has been transferred with the Hoyer lift, using two-person assistance, and has been tolerating transfers well. On 2/22/2016, the DNS requested that the Attending Physician review the information related to Resident #8□s fall,	3/25/16

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F 309	Continued From page 5 1. Resident #8 was admitted to the facility on 8/21/15 with multiple diagnoses, including Alzheimer's, dementia, and a history of right hip fracture. Her most recent MDS, dated 12/21/15, documented severe cognitive impairment. Resident #8's record included a Fall/Post Fall Assessment, dated 2/4/16, that documented Resident #8 experienced an unwitnessed fall on 2/4/16 at 7:20 pm. The document stated Resident #8 was found on the floor of her room, lying on her right side. Vital signs were obtained, including blood pressure, respirations, pulse and temperature, and it was noted the resident was unable to stand due to injury. The Post Fall Assessment documented new pain was present, and that the resident was "Alert" and "Confused." The location of the pain was documented as the "right inner thigh and hip area" and the pain level was documented at "6" on a 10-point scale. The Post Fall Assessment documented, "Resident stated she was about 5 feet away from her bed when she stood up from her wheelchair to walk to her bed. She said her shoe caught on the carpet and she fell down to the floor on her right side." The Assessment further documented range of motion was not within normal limits and that the resident had an injury that was documented as "Potential Fracture." The document stated the resident "complained of pain when right leg was moved to a knee bent position," and "Possible right hip fracture."	F 309	and of the actions taken, to evaluate nursing processes and to request recommendations for potential changes. The Physician's letter, dated 2/22/2016, is as follows: "To Whom it May Concern, I have reviewed the incident and direct aftercare that was performed. It was within the Standard of Care. The oncall physician was consulted and appropriate actions were taken. The patient was appropriately evaluated at the Emergency Room. The Orthopaedic Surgeon was consulted. Conservative treatment was elected by the specialist and no surgical intervention was necessary. The same Hoyer lift that has always been used on this patient was used directly after the fall and has been used each time since the incident to move the patient without any signs of distress. There is no evidence to support the mode of transport would cause any further damage or changes in care. According to the Emergency Room Report, there is no evidence in which the patient was in any distress or pain. The report state, □'when I first walked in she was snoring loudly, breathing through her mouth□'. Unfortunately, due to the patient□s comorbidities, age and overall decline in health in the last few years, she was place on hospice per family□s wishes. One should not speculate on the patients condition, that is why doctors are consulted on what protocol and procedures to take care of the patient."	

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F 309	Continued From page 6 The document stated the physician was contacted on 2/4/16 at 7:30 pm. There was no indication what interventions were provided at the time of the incident when there was a suspected fracture involved. A section of the document, dated 2/17/16, documented, "Resident was transferred to ... [an] ER to be evaluated due to right leg pain. Resident was admitted [to the hospital] after determining she had a pelvic fracture." The documentation did not provide clear information as to what treatment had been provided to the resident prior to being transported to the hospital. On 2/18/16, RN #11 stated LPN #13 utilized a Hoyer lift to move Resident #8 from the floor to the bed following the fall and contacted the physician after Resident #8 was back in bed. Resident #8 was then transported to the ER where it was determined she had a fractured pelvis. RN #11 stated the fall report was not clear and did not provide sufficient documentation of the actions taken at the time of the fall. On 2/18/16, the DON stated LN #13 had the ability to assess Resident #8 following her fall and determine if it was safe to move her. When asked if LN #13 should have contacted the physician or an RN prior to moving Resident #8, the DON stated it was not required. On 2/19/16, LN #13 stated Resident #8 was found on the floor of her room on her right side. LN #13 stated he rolled the resident onto her	F 309	2.NP ordered dc of Compression Stockings for Resident #5 on 3/4/2016. 3.NP ordered dc of Compression Stockings for Resident #4 on 3/4/2016. Identification: 1.Residents who sustain a fall, with suspected major injury are identified as potentially affected by this deficient practice. 2.Residents who have Physician Orders for Compression Stockings are identified as potentially affected by this deficient practice. Systemic Changes: 1.Licensed Nurse Staff to receive in-service on 3/8/2016 regarding assessment and appropriate care of a resident who has sustained a fall with suspected major injury. Content to include appropriate care to make the resident comfortable on the floor, provide first aid, if indicated, and contact Physician for orders to transport to ER for evaluation. 2.Licensed Nurse Staff to receive in-service on 3/8/2016 regarding facility policy and procedure of documentation related to accidents and injuries. 3.IDT will continue to review and evaluate User Defined Assessments - Falls, during the facility s daily 24 Hour Report Process. 4.Licensed Nurse Staff to receive in-service on 3/8/2016 regarding donning Compression Stockings, and the appropriate follow-up documentation on	

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F 309	Continued From page 7 back and sat her up. When asked if the resident expressed pain, LN #13 stated she did not, but did complain about pain when he tried to bend Resident #8's knee up to her chest. LN #13 stated he was concerned she had re-fractured her right hip, so he laid her back down and completed range of motion on her leg. Resident #8 complained of pain, so he did not want her to put weight on her right side in case she had fractured her hip. LN #13 stated he then transferred Resident #8 from the floor to her bed with a Hoyer lift and called the physician. When asked how he knew it was safe to transfer Resident #8 from the floor to the bed when she had a possible injury, LN #13 stated it was acceptable to move someone after a fall based upon the assessment he completed. On 2/22/16, the facility faxed a letter from the physician, dated 2/22/16, that documented, "One should not speculate on the patients [sic] condition, that is why doctors are consulted on what protocol and procedures to take care of the patient." 2. Resident #4 was admitted to the facility on 11/28/12 with multiple diagnoses, which included heart failure. Resident #4's TAR for February 2016 included TED hose or tubigrips (compression stockings) to be applied each morning and removed each evening related to congestive heart failure. The documentation for 2/18/16 indicated the stockings had been applied. On 2/18/16 at 3:30 pm, Resident #4 was observed sitting in the center common area not	F 309	the TAR. Monitor: 1. DNS or Designee to conduct audits of Nursing Staff assessments and interventions provided to residents following a fall with suspected major injury. Audits to begin on week of 3/7/2016, and will continue at the following frequencies: Weekly x four (4) weeks Q two (2) weeks x four (4) weeks Monthly x three (3) months 2. RCM's to conduct audits to ensure that residents who are care planned for Compression Stockings are provided them according to their care plans. Audits to begin on week of 3/7/2016,and will continue at the following frequencies: Weekly x four (4) weeks Q two (2) weeks x four (4) weeks Monthly x three (3) months 3. Administrator to review audits and report findings to QA Committee.	

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F 309	Continued From page 8 wearing compression stockings. On 2/18/16 at 3:40 pm, RN #2 stated Resident #4 was not wearing compression stockings. When shown the TAR documenting the compression stockings were applied, RN #2 did not reply. 3. Resident #5 was admitted to the facility on 3/19/13. Resident #5's TAR for February 2016 included the application of Tubigrips each morning and removal each evening for edema. The TAR documented the stockings had been applied on 2/18/16. On 2/18/16 at 12:30 pm, Resident #5 was observed sitting in her room not wearing compression stockings. On 2/18/16 at 3:25 pm, RN #2 stated Resident #5 was not wearing her compression socks. When shown the TAR indicating the compression stockings were applied, RN #2 stated "Oh."	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		3/25/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents did not develop pressure ulcers. This was true for 1 of 6 (#3) sample residents reviewed for pressure ulcers. Resident #3 was harmed when a skin tear developed into a Stage III pressure ulcer. Findings included: Resident #3 was admitted to the facility on 1/6/15 with multiple diagnoses, including dementia with behavioral disturbances, altered mental status, and anxiety disorder. The 1/13/15 admission MDS coded moderate cognitive impairment, extensive two person assistance for toileting, always incontinent of bowel and bladder, at risk of developing pressure ulcers, no unhealed pressure ulcers, no MASD or other ulcers, wounds or skin problems, and pressure reducing device for the chair. The 2/9/15 significant change and 5/12/15 and 8/12/15 quarterly MDSs all coded the resident was at risk for pressure ulcers, and had no MASD or unhealed pressure ulcers. An 8/16/15 Skin Event Assessment documented a 3cm by 0.2cm skin tear injury to the coccyx and both bowel and bladder incontinence. The prevention plan section documented reposition frequently in the night and follow up with staff with turning and repositioning throughout the day and night, frequently incontinent of bowel and bladder and dependent on staff to anticipate needs. The Conclusion/Investigative Findings	F 314	F 314 Corrective Action: 1.Resident #8's care plan has been updated. RCM completed a comprehensive nursing assessment. 2.LSW has evaluated Resident #8 on 3/2/2016 for mood, behavior, or other issues that may contribute to her risk for new pressure ulcers and/or decline to current pressure ulcer. Changes to resident□s Care Plan by LSW, based on assessment, have been made. 3.As noted in the 2567 on page 12, Stage 2 pressure ulcer was identified on 12/18/2015. Though page 10 of 2567 noted that pressure ulcer was coded on 10/12/15 Significant Change MDS, this MDS was correctly coded that no pressure ulcers were present and MASD was correctly coded. Identification: 1.All residents who have a pressure ulcer are identified as being at risk for a pressure ulcer declining or worsening. 2.100% of residents with current pressure ulcers have been reviewed to ensure comprehensive assessment of current status, conditions, and risks have been completed with assessed, individualized interventions implemented within resident care planning.	

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F 314	Continued From page 10 section documented a 3cm x 0.2cm MASD on the coccyx on 8/16/15, dementia, unable to communicate needs at times, and required staff to anticipate her needs. An 8/25/15 Nursing Summary documented the resident required extensive one-to-two person assistance with most ADLs and declined from frequent incontinence of bowel and bladder to total incontinence with "rare continent/incontinent" this quarter. The most recent Braden Scale score, 10, documented the resident was at high risk for pressure ulcers. The Nursing Summary documented the resident was assessed on 8/16/15 with MASD to the coccyx measuring 3cm by 0.2cm, and noted, "A dressing will be placed on site and checked every shift." The 10/13/15 significant change and 1/12/16 quarterly MDSs both coded moderate cognitive impairment, always incontinent of bowel and bladder, and one unhealed Stage III pressure ulcer. A 12/1/15 - 12/19/15 Follow Up Question Report documented: 12/18/15 2:51 - Stage II length 1.0 cm, width 0.8 cm, depth partial thickness. Pressure Ulcer: Site: Coccyx, between gluteal folds, Stage III. A 1/27/16 - 2/17/16 Follow Up Question Report documented: 2/12/16 Stage III length 1.0 cm, width 0.5 cm, depth 0.25 cm. The resident's CP, with a 2/3/16 review date, documented: - Urinary and bowel incontinence: 1/6/15.	F 314	Systemic Changes: 1.RCMs have received inservice by DNS, on 3/7/2016, regarding comprehensive assessment of wounds, including additional review when pressure wounds decline. 2.LN Staff to receive inservice on assessment and measurement of pressure ulcers. It is facility policy that all LNs are able to assess and measure wounds. Additional education also provided to LN #12 on facility policy. Monitor: 1.DNS to audit all pressure ulcers for assessment and decline in wounds. Audits to begin on week of 3/7/2016 and will continue at the following frequencies: Weekly x four (4) weeks Monthly x 90 days 2.Administrator to review audits and report findings to QA Committee	

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Interventions, created 3/25/15, initiated and revised 4/20/15: Toilet upon rising, before and after meals, at bedtime, and every 3 hours.

- At risk for actual skin impairment/pressure ulcer, created and initiated 1/6/15. Pressure reduction on bed, pressure reduction on chair, float heals when in bed, and notify charge nurse of skin impairment, bruises and rashes.

The 1/11/16 Patient Wound Care Order Sheet documented: Coccyx pressure ulcer - Stage III, length 2.0cm by width 1.2cm and depth 0.1cm.

- Pressure/Other Ulcer/Wound: 1/26/16: Pressure Ulcer: Site: Coccyx, between gluteal folds Stage III.

The 2/12/16 Patient Wound Care Order Sheet documented a coccyx pressure ulcer - Stage III, length 1.2 cm by width 0.5 cm and depth 0.1 cm.

Progress Notes documented:

- 9/25/15 2:02 pm: Skin/Wound Note: Area to coccyx was not progressing towards healing. Area was open and measured 2.3cm by 1.0cm with about a 0.2cm measurable depth.

- 11/13/15 12:12 pm: Skin/Wound Note: MASD to coccyx was not healing and had shown no improvement.

- 11/20/15 3:45 pm: Skin/Wound Note: MASD to coccyx did not appear to be healing and there was no change in size. Most likely related to resident moisture risk.

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- 11/30/15 3:48 am: Behavior Note: CNAs offered to assist resident to bed, but resident refused.

- 12/15/15 8:31 am: IDT Progress Note - General: returned from a 12/14/15 dermatologist appointment with a diagnosis of frictional folliculitis [infected hair follicle in area subject to friction].

On 2/22/16 at 9:32 am, the dermatologist said the frictional folliculitis would not have affected the worsening of the pressure ulcer. He also said he was not asked to look at the pressure ulcer and was not made aware of the resident's MASD or pressure ulcer.

- 12/16/15 4:34 pm: IDT Progress Note - General: Stage III noted to coccyx and covered with Tegaderm foam dressing.

- 12/18/15 3:02 pm: Skin/Wound Note: Coccyx still open measuring 1.0cm by 0.8cm and no measurable depth. CP updated to Stage II pressure ulcer. Area cleansed and new Tegaderm foam dressing applied.

- 1/6/16 10:52 pm: Resident refused to lay in bed or in her recliner.

- 1/11/16 2:07 pm: Skin/Wound Note: Nurse in to evaluate resident's pressure ulcer to coccyx. Noted that ulcer was a Stage III rather than a Stage II. Care plan updated.

- 1/16/16 10:44 pm: IDT Progress Note - General: Monthly head-to-toe, no concerns at this point, continue with current CP.

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F 314	Continued From page 13 - 1/31/16 4:06 pm: IDT Progress Note - General: Old dressing on coccyx soiled with stool. New dressing applied. - 2/1/16 1:25 pm: IDT Progress Note - General: POA does not wish to pursue an air mattress at this time. On 2/17/16 at 7:43 am: RN #2 said the resident's skin condition began as MASD with a slit to the coccyx. The RN said the resident's skin condition worsened due to the resident's refusals to relieve pressure by lying in bed or in the recliner. On 2/18/16 at 2:37 pm, Resident #3's dressing change was observed. When asked to measure the wound, LN #12 said measurements were taken only by the wound nurse.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure harmful chemicals were securely stored and inaccessible to residents. This was true for all independently mobile and cognitively impaired residents who may encounter the chemicals. Failure to safely	F 323	F 323 Corrective Action: 1.Room identified as Janitor closet's doorknob was changed to a Janitor□s Closet style doorknob on 2/17/2016 to	3/25/16

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F 323	Continued From page 14 store harmful chemicals created the potential for residents to experience skin, respiratory tract and/or gastric irritation. Findings included: 1. On 2/17/16 from 2:00 - 3:10 pm, the following chemicals were found unlocked: a. An unlocked cabinet in the shower room located on the 100 hall contained the following: - A spray bottle of Lemon Crush disinfectant cleaner. The MSDS stated the product could cause eye or skin irritation, nausea, diarrhea, and burns to the mouth, throat and esophagus if ingested, and irritation to the respiratory tract if inhaled. - A spray bottle of Airlift Fresh Scent air freshener. The MSDS stated the product may be harmful if swallowed, and could cause eye and skin irritation. b. An unlocked janitor's closet contained the following: - Two 5 gallon boxes of Vectra Floor Finish. The MSDS stated the product could be irritating to eyes and skin. - One 5 gallon box of Pro Strip Heavy Duty Floor Stripper. The MSDS stated the product could cause severe skin burns and serious eye damage. - A 1.5 gallon bottle of Bonnet Buff. The MSDS stated the product may be irritating to eyes and skin.	F 323	ensure auto-locking on the doors. 2.Janitor□s Closet style doorknobs have been installed on the 100, 200 and 300 shower rooms. 3.All chemicals / wipes, identified in 2567, were immediately removed and placed in secure storage area / carts. Identification: All residents are identified as potentially being affected by this deficient practice. Systemic Changes: 1.CNA staff has received in-service regarding the monitoring and ensuring that all harmful chemicals are not accessible to the residents. This was completed on 3/1/2016. 2.A written in-service was posted on 2/22/2016, for all of the LN staff, to educate them that the Sani Wipes and the Bleach Wipes are to be kept in a medication cart drawer at all times. 3.LN staff will be in-serviced on 3/8/2016 that chemicals are to be locked at all times. 4.Facility staff to receive inservice regarding the new style doorknobs on the shower rooms and the need to keep chemicals inaccessible to residents. Monitor: 1.The Facility Administrator will conduct audits to ensure that all chemicals are securely stored and not accessible to the residents. Audits to begin on the week of 3/7/2016 and will continue at following frequencies:	

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F 323	Continued From page 15 - Two 1.5 gallon bottles of Snapback Spray Buff. The MSDS stated the product may be irritating to eyes and skin. The Environmental Services Supervisor, who was present during the observation, stated the chemicals should have been locked. 2. Chemical wipes stored on the medication carts were exposed and accessible to residents as follows: a. On 2/16/16 at 2:07 pm and 2:27 pm, a container of Sani Cloth germicidal disposable wipes was observed sitting in a slot on the left side of the 300 hall medication cart. The cart was unattended, and the container was open with a wipe sticking out of the top. The MSDS stated the product could cause eye irritation, and to seek prompt medical attention if ingested. b. On 2/16/16 at 2:17 pm and 2:25 pm, a container of Microdot Bleach wipes was observed on the 200 hall medication cart. The cart was unattended, and the container was open with a wipe sticking out of the top. The MSDS stated the product causes eye irritation and may cause gastrointestinal irritation and upset if ingested. On 2/16/16 at 2:30 pm, LN #4 stated the wipes should have been secured on both carts.	F 323	Weekly x 4 (four) weeks Q two (2) weeks x four (4) weeks Monthly x three (3) months 2.Audit findings to be reported to QA Committee.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		3/25/16

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F 329	Continued From page 16 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 by: Based on record review and staff interview, it was determined the facility failed to ensure parameters for administration of pain medications were clearly stated for 1 of 13 sample residents (#5) reviewed for pain management. This failure resulted in a lack of clear directions on what dose of pain medication to administer. Findings include: 1. Resident #5 was admitted to the facility on	F 329	F 329 Corrective Action: 1. Resident #5's Oxycodone order was clarified by her Physician on 2/22/2016 with the following parameters: "5mg for mild pain" "10mg for moderate pain" "15mg for severe pain" LN Staff to use facility Pain Assessment Tool to determine the resident's pain level.	

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F 329	Continued From page 17 3/19/13 with multiple diagnoses which included dementia, major depressive disorder, and spondylosis with myelopathy. Resident #5's record included Physician's Orders, dated 2/2/16, as follows: - Oxycodone HCl 5 mg every 4 hours as needed for pain. - Oxycodone HCl 10 mg every 4 hours as needed for pain. - Oxycodone HCL 15 mg every 4 hours as needed for pain. Resident #5's record did not include parameters regarding how to determine which dose to give. Resident #5's MAR for February 2016 documented Oxycodone HCL was administered as follows: - 2/3 at 4:25 am: 10 mg given, pain level 6 - 2/4 at 2:37 am: 10 mg given, pain level 8 - 2/5 at 4:29 am: 15 mg given, pain level 4 - 2/6 at 4:15 am: 5 mg given, pain level 5 - 2/7 at 4:33 am: 5 mg given, pain level 5 - 2/8 at 4:30 am: 5 mg given, pain level 5 - 2/9 at 4:38 am: 5 mg given, pain level 5 - 2/10 at 4:32 am: 5 mg given, pain level 5 - 2/11 at 4:42 am: 5 mg given, pain level 5 - 2/14 at 4:24 am: 5 mg given, pain level 5 - 2/14 at 8:09 pm: 5 mg given, pain level 5 - 2/15 at 4:00 am: 10 mg given, pain level 5 - 2/16 at 4:01 am: 5 mg given, pain level 4 - 2/17 at 4:24 am: 15 mg given, pain level 5 - 2/17 at 12:09 pm: 5 mg given, pain level 5 - 2/18 at 4:45 am: 5 mg given, pain level 5 - 2/19/at 4:30 am: 5 mg given, pain level 5	F 329	2. 100% of residents with multiple PRN medications have been reviewed to ensure clear parameters for medication administration details are present. Identification: Residents that have Physician PRN orders for pain medications with 1 or more tabs, and unclear parameters for medication administration are potentially affected by this deficiency. Systemic Changes: 1.All current Physician Orders for PRN pain medications will be reviewed RCM staff to ensure that each order contains parameters for administering medication. 2.All LNs and RCMs will receive in-service on 3/8/2015 to ensure that PRN pain medication orders received include parameters for administration. If no parameters are present, the nurse will contact the prescribing physician for clarification of parameters for medication administration. Monitor: 1.DNS or designee will conduct audit of new Physician Orders for PRN pain medication, to ensure that parameters for administering PRN pain medications are clearly stated and included in the order. Audits to begin on the week of 3/7/2016 and will continue at the following frequencies: Weekly x four (4) weeks Q two (2) weeks x four (4) weeks Monthly x three (3) months	

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F 329	Continued From page 18 The documentation did not demonstrate consistent dosing of the drug based upon Resident #5's recorded pain level. On 2/19/16 at 11:05 am, the DON stated there was usually a parameter for dosage based on pain level, but Resident #5's order did not include one.	F 329	2.Administrator to review audits and report findings to QA Committee.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431		3/25/16

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F 431	Continued From page 19 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure 2 of 4 medication carts did not contain outdated medications. This failure resulted in the potential for residents to receive expired medications with less than optimal efficacy. Findings included: 1. Expired medications were present in two medication carts as follows: a. On 2/18/16 at 11:40 am, the medication cart on the 200 hall was observed to contain a bottle of Melatonin 5 mg Adult Gummy tablets with an expiration date of January 2016. RN #5, who was present during the observation, stated the bottle needed to be removed. b. On 2/18/16 at 11:45 am, the medication cart on the 100 hall was observed to contain a bottle of certirizine hydrochloride with an expiration date of January 2016, and a bottle of meclizine hydrochloride with an expiration date of January 2016. RN #6, who was present during the observation, acknowledged the presence of the expired drugs.	F 431	F431 Corrective Action: Expired medications identified in 2567 were removed from the 100 Hall and 200 Hall medication carts on 2/18/2016. Identification: All residents are identified as potentially being affected by this deficient practice. Systemic Changes: 1. LN staff received in-service on 3/8/2016 regarding expired medication management. 2. LN staff will conduct monthly review of medication carts. 3. Pharmacy Nurse Consultant will continue to conduct quarterly audit of all medication carts. Monitor: 1. DNS or designee will conduct an audit of medication carts to ensure that all over the counter medications are current. Audits to begin on week of 3/7/2016, and will continue at the following frequencies: Weekly x four (4) weeks	

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F 431	Continued From page 20	F 431	Q two (2) weeks x four (4) weeks Monthly x three (3) months 2. Administrator to review audits and report findings to QA Committee.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (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. (c) Linens	F 441		3/25/16

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MARQUIS CARE AT SHAW MOUNTAIN	909 RESERVE STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 21 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure urinary bags did not come in contact with the floor for 3 of 13 sample residents (#8, #9 and #12) reviewed for infection control practices. This failure placed residents at risk for infections. Findings include: Potter and Perry, Fundamentals of Nursing, eighth edition, (p. 1062), documented "...the [catheter] bag hangs on the bed frame or wheelchair without touching the floor." 1. Residents' catheter collection bags were not maintained in a manner to prevent contact with the floor as follows: a. Resident #9 was readmitted to the facility on 10/21/5 with multiple diagnoses, including quadriplegia. His most recent MDS, dated 11/23/15, documented his cognitive skills for daily decision making were severely impaired. His Care Plan, dated 10/30/15, documented he required the use of a suprapubic catheter. On 2/16/16 at 1:45 pm, Resident #9 was observed in bed with his uncovered catheter collection bag sitting on the floor. CNA #7, who was present during the	F 441	F 441 Corrective Action: Catheter bags for residents #8,#9,and #12 were immediately adjusted so they were not touching the floor. Identification: All residents with catheter bags are identified as potentially being affected by this deficiency . Systemic Changes: 1. CNA staff have received in-service on 3/1/2016 with regard to ensuring that all catheter bags are suspended up off of the floor for infection control purposes. 2. LN staff will receive the above inservice on 3/8/2016. Monitor: 1. DNS or designee will conduct audits to ensure that catheter bags are suspended up off of the floor. Audits to begin the week of 3/7/2016 and will continue at the following frequencies: Weekly x four (4) weeks Q two (2) weeks x four (4) weeks Monthly x three (3) months 2. Administrator to review audits and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135090	A. BUILDING _____ B. WING _____	02/19/2016

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F 441	Continued From page 22 observation, stated the collection bag should not be on the floor. b. Resident #12 was readmitted to the facility on 8/18/15 with multiple diagnoses, including dementia. His Care Plan, dated 2/4/16, documented he required the use of a suprapubic catheter. On 2/19/16 at 9:57 am, Resident #12 was observed in his room with the door open. His catheter collection bag was noted to be attached to the side of the bed, uncovered, and the bottom of the bag was on the floor. LN #8, CNA #9 and CNA #10, who were present during the observation, all stated the catheter collection bag should not have been positioned on the floor. c. Resident #8 was admitted to the facility on 8/21/15 with multiple diagnoses. Her most recent MDS, dated 12/21/15, documented severe cognitive impairment. Her record documented the use of a Foley catheter. On 2/18/16 at 12:05 pm, Resident #8 was observed sitting in her wheelchair in the dining area. Resident #8's catheter collection bag was observed in a cloth cover attached to the back underside of her wheelchair dragging on the floor. On 2/19/16 at 12:20 pm, RN #11 stated Resident #8's catheter collection bag should not have been positioned where it could touch the floor.	F 441	report findings to QA Committee.	