IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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March 16, 2016

REVISED LETTER

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

Provider #: 135077

Dear Mr. Barglof:

On **March 4, 2016**, a survey was conducted at Avamere Transitional Care & Rehab - 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 a widespread deficiency 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. 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 26, 2016**. Failure to submit an acceptable PoC by **March 26, 2016**, may result in the imposition of penalties by **April 20, 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 **June 2, 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 **June 2, 2016**. A change in the seriousness of the deficiencies on **April 18, 2016,** may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by

June 2, 2016 includes the following:

Denial of payment for new admissions effective **June 2, 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 **September 20, 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 **June 2, 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/NursingFacilities/tabid/434/Default.aspx

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

following:

- BFS Letters (06/30/11)

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

This request must be received by **March 26, 2016**. If your request for informal dispute resolution is received after **March 26, 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,

D. L Scott

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 03/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	**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 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from February 29 to March 4, 2016. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Evelyn Floyd,JD, MSN, RN Juanita Stemen, MSN, RN, LNFA Linda Roper, RN Beverly Briggs, RN Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CDC= Center for Disease Control and Prevention CDM = Certified Dietary Manager CNA = Certified Nurse Aide DM = Dietary Manager DNS = Director of Nursing Services d/t = Due To ESBL=Extended spectrum beta-lactamase F = Fahrenheit ICN= Infection Control Nurse IDT= Interdisciplinary Team LN = Licensed Nurse MAR = Medication Administration Record MDRO= Multi-drug Resistant Organisms MDS = Minimum Data Set assessment MRSA= Methicillin-resistant Staphylococcus aureus PRN = As Needed QA= Quality Assurance PPE = Personal Protective Equipment RN=Registered Nurse SD= Staff Development	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/25/2016

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F 000	Continued From page 1 ua/c/s = Urinalysis Culture and Sensitivity UTI = Urinary Tract Infection	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.	F 156		5/6/16

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F 156	Continued From page 2 The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility	F 156		

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F 156	Continued From page 3 written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure residents were informed of their rights prior to signing informed consent forms. This was true for 2 of 28 sampled residents (#8 and #16) and had the potential to cause harm by allowing treatment of residents who were not provided necessary information prior to the start of treatments. Findings include: 1. Resident #8 was most recently admitted to the facility on 1/18/16 with diagnoses that included paraplegia, traumatic brain injury, and autonomic dysreflexia. Resident #8's informed consent forms documented the resident ' s signatures on 8/18/15; however each of the spaces provided for the resident to initial he received information related to the treatments he consented to receive were left blank. A signed informed consent form documenting the resident received information related to the treatments he consented to receive was dated 8/29/15, eleven days after the actual commencement of the treatments. 2. Resident #16 was admitted to the facility on 8/11/15 with diagnoses that included cognitive impairment, renal failure, and Type II diabetes. The resident signed an Informed consent form on 8/11/15; however the spaces provided for the	F 156	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Avamere Transitional Care and Rehab of 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 deficiences. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific Resident #8 and #16 file have been reviewed and a finalized informed consent is present. Other Residents All current records have been audited for informed consent documentation and any found to be out of compliance were resigned and initialed by the appropriate	

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F 156	Continued From page 4 resident to initial she received information related to the treatments she consented to receive were left blank. On 3/1/15 at 10:42 am, the Medical Records Specialist stated that consents to treat are pre-signed so the facility could start treating residents upon admission and that an office staff member reviewed the necessary information with the resident at a later time; the resident would then initial the informed consent form at that time.	F 156	resident or responsible party. Systemic Changes Admissions Coordinator or designee reviews admission packet with all new admissions and has informed consent initialed and signed by resident or responsible party prior to initiation of treatment. Monitoring At least 3 to 4 random audits of new admission packets will be conducted per week for one month, or on weeks that have less admissions than that amount, all admission packets will be audited by Medical Records or designee to ensure all have initials and signatures in appropriate places. After the first month, random audits will be conducted monthly and results will be reported to the QAPI committee for 4 months or longer if needed for sustained compliance.	
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, and resident and staff interview, it was determined the facility failed to ensure meals were provided in a timely manner to maintain or enhance residents' dignity. This	F 241	Resident Specific Resident #7 and #21 observed at meal times being served their meal at the same time at the same table to respect their	5/6/16

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F 241	Continued From page 5 was true for one random resident (#21). This deficient practice had the potential to cause a decrease in the resident's sense of self-worth. Findings included: On 3/1/16 at 5:20 pm, Resident #s 7 and 21 were observed seated at the same table in the Teton Dining Room and were engaged in conversation with no other residents at that table. At 5:52 pm, Resident #7 received his meal and began to eat. At 6:10 pm, Resident #21 received his meal. At 6:13 pm, Resident #7 finished his meal and left the dining room while Resident #21 was still eating. On 3/1/16 at 6:18 pm, Resident #21 said the late service bothered him and that the food "comes when it comes." On 3/2/16 at 3:30 pm, the CDM with the Dietitian present said staff try to serve residents at the same table at the same time. When informed of the above observation, the Dietician said that was a "problem." Please refer to F353 regarding insufficient staffing.	F 241	dignity. To ensure meals are provided in a timely manner the Teton dining room is now appropriately staffed. Resident tray cards are organized by table to allow meals be served out from the kitchen one table at a time. Other Residents All residents who dine in the Teton dining room have potential to be affected by a delay of passing trays. Rounds have been completed and dining room observations conducted have confirmed meals are being served to residents at the same time that sit at the same table. Systemic Changes To improve the dining experience department managers or designee have been assigned to dining rooms to supervise and assist staff during meal service to ensure trays are timely and staff is available. Monitoring Meal service audits will be completed three times a week for four weeks, then once a week for the following three months, at various meal times. Results will be reported to the QAPI committee for 4 months or longer if needed for sustained compliance.	
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;	F 242		5/6/16

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F 242	Continued From page 6 interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to provide timely meals to residents who preferred to eat in their rooms on two of four halls (Hall 200 and Hall 300). Residents who opted to receive meals in their rooms on the 200 and 300 halls received their meals as much as 90 minutes later than residents who ate their meals in either of the two dining rooms. This deficient practice disregarded the residents' rights to choose to eat in their rooms without forfeiting proper food temperature or food quality of the meals they received. Findings include: During the initial tour on 2/29/16 at 9:17 am, two anonymous residents on the 300 hall stated they "always" received late meals. They stated their hall was "always the last" hall serviced. One of the anonymous residents told surveyors the breakfast meal was scheduled for 7:30 am, yet he/she had yet to receive his/her breakfast tray. This resident further stated he/she did not know why his/her hall was consistently the last to be served. On 2/29/16, Resident #3 on the 200 hall was observed receiving his/her noon meal at 1:35 pm (an hour after staff served residents in the restorative dining room). Resident #3 stated his/her food was "lukewarm." He/She stated staff	F 242	Specific Residents Resident #3 reported to DNS on 3/2/16 that her dinner meal received in her room was good and at the appropriate temperature. To ensure residents with a preference to dine in their rooms are provided timely meals, staffing levels on the halls have been adjusted and CNA□s assigned to specific halls during meal service. Upon meal cart arrival to each hall an announcement per the walkie talkies is made informing the CNA to begin meal service. Meal service is now served according to the times posted for dining rooms and hall carts. Other Residents All residents with a preference to dine in their rooms have the potential to be affected by a delay of passing meal trays. Systemic Changes To improve the dining experience department managers or designee have been assigned to meal observation to include dining rooms and hall carts to supervise and assist staff during meal service to ensure trays are timely and staff is available.	

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F 242	Continued From page 7 appeared "put out" when he/she requests they reheat his/her food. On 2/29/16 at 1:45 pm, in the 200 hall, Resident #3 stated he/she prefers to eat in his/her room as he/she is a solitary person by choice. Resident #3 stated that his/her breakfast eggs were cold, as were any other foods that should be hot. Resident #3 stated cold foods are warm when they get to his/her room and that there are so few CNAs that he/she regularly doesn't receive his/her noon meal until after 1:30 pm. On 2/29/16 and throughout the survey meal times were posted outside of the Owyhee and Teton dining rooms. The Owyhee dining room documented breakfast at 7:30 am, lunch at 12:30 pm, and dinner at 5:30 pm. The Teton dining room documented breakfast at 7:40 am, lunch at 12:40 pm, and dinner at 5:40 pm. On 3/1/16 at 12:00 pm, the CDM stated the restorative dining room receives their meals first, followed by the main dining room, then halls 100, 200, and 300. During the Group Interview on 3/1/16 at 2:15 pm, 9 of the 16 residents attending stated they ate in their rooms and when they received their food it was often cold. They stated that staff at times refused to reheat their food. The residents who participated in the interview reported that meals served on the 300 hall are "late and cold." Observations on the 300 hall on 3/1/16 revealed staff served the last evening meal tray at 6:40 pm. The evening meal service began at 5:30 pm in the restorative dining room.	F 242	Monitoring Meal service audits will be completed three times a week for four weeks, then once a week for the following three months, at various meal times. Results will be reported to the QAPI committee for 4 months or longer if needed for sustained compliance.	

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F 242	Continued From page 8 On 3/2/16 at 7:37 am, empty meal delivery carts for the 100, 200, and 300 halls were observed lined against a wall in the kitchen. Meal service to the residents had not begun nor had the staff prepared the hall trays. The CDM stated dietary staff were waiting for residents to arrive in the main dining room. Surveyors observed the 300 hall meal cart arriving in that area to serve residents at 9:05 am, more than an hour after the main dining room meal service. On 3/2/16 at 3:30 pm, the surveyor informed the CDM and the consultant dietitian of the observations and complaints regarding late meals for residents, particularly those on the 300 hall, eating in their rooms. The CDM stated staff stops preparing hall meal carts when late residents arrive in the main dining room. She stated once staff serves those late arrivals, they begin preparing the hall carts for delivery. The CDM denied having a scheduled time for the delivery of the hall trays, and stated the order in which the meals are delivered begins with the restorative dining room, then 10 minutes later the main dining room. The CDM stated staff served the Owyhee restorative dining first, then the Teton dining room next as residents arrived and that the hall tray service time depended on residents' arrival time in the dining room. When asked if they were aware hall trays were over an hour later than the meal service in the dining room, the CDM and consultant dietitian stated that all residents who eat in their rooms are more than welcome to eat their meals in the dining room so they can get their meals earlier. The consultant dietitian stated the facility's goal is to serve food at the right temperature.	F 242		

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F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive 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. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to provide and/or make accessible personal living space equipment (chairs) for 5 of 9 sampled semi-private resident rooms (rooms 206, 218, 219, 305 and 318). This deficient practice interfered with the ability of family, visitors and staff to sit while in conversation with residents in their rooms and had the potential to adversely affect residents' sense of social well-being. Findings include: On 2/29/16 at 1:45 pm, Resident #3 told the surveyor to sit on her bed or clear off her wheelchair to sit and talk. When asked if she had a chair for visitors, the resident, who resided in a double-occupancy room, replied "No." On 3/2/16 at 8:10 am, two metal folding chairs were observed behind the privacy curtain separating Resident #3 from her roommate. The resident stated she did not know there were chairs for visitors in the room as the privacy curtain between her and her roommate was almost always pulled closed.	F 246	Resident Specific Chairs were placed in rooms 206, 218, 291, 305, and 318 one per resident in each room. Other Residents All resident rooms audited to determine the availability of a chair per resident and a chair was provided where found to be absent. Systemic Changes Educated staff on the importance of maintaining a chair in each room per resident and if a chair is removed from a room it is to be immediately replaced. Staff also educated on the location of surplus chairs in order to replace missing chair. Monitoring Maintenance director to audit ten resident rooms weekly for three consecutive months and results reported to the QAPI committee monthly for 3 months or longer	5/6/16

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F 246	Continued From page 10 The following was observed on 3/2/16 beginning at 8:15 am: * Semi-private Room 218 had only one folding chair in the room; * Semi-private Room 219 had no chairs in the room; * Semi-private Room 305 had only one folding chair in the room; * Semi-private Room 318 had no chairs in the room. During a group interview on 3/1/16 at 2:15 pm, residents stated they should have a chair in their rooms for visitors. On 3/2/16 at 8:00 am, the Administrator stated he expected each resident in a room to have one guest (folding) chair. The Administrator stated he did not know that some residents had no chairs in their rooms.	F 246	if needed for sustained compliance.	
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	F 280		5/6/16

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F 280	Continued From page 11 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, it was determined the facility failed to ensure resident care plans were reviewed and revised to reflect residents' current needs and status. This was true for 2 of 23 sampled residents (#1, and #8) and had the potential to cause harm to Resident #8 for complications due to autonomic dysreflexia (sudden onset of excessively high blood pressure). Findings include: 1. Resident #8 was readmitted to the facility on 1/18/16 with diagnoses of paraplegia, neurogenic bladder and autonomic dysreflexia. A History and Physical, dated 8/25/15, and a progress note, dated 1/15/16, also both documented the resident had been diagnosed with autonomic dysreflexia. The resident's current care plan did not identify or contain documentation regarding autonomic dysreflexia. On 2/29/16 at 11:30 am, Resident #8 stated he had autonomic dysreflexia and had called 911 on 10/27/15 when his suprapubic catheter became clogged, causing him to experience a seizure when he got to the hospital. During a subsequent interview on 3/3/16 at 3 pm, the resident stated issues with his catheter usually triggered his	F 280	Resident Specific Resident #8 care plan was updated to reflect the diagnosis of autonomic dysreflexia and care needs associated with this condition. Resident #1 care plan was updated to reflect therapy services that are being provided. Other Residents All other residents with spinal cord injuries at T6 or above care plans were reviewed and updated with autonomic dysreflexia diagnosis and care needs associated with this condition. All other residents receiving therapy services identified and their care plans were updated to reflect those services being provided. Systemic Changes Staff responsible for care plan updates were educated on the importance of accurate and updated care plans. Resident condition changes or additions are noted on the RCM 24 hour follow-up form and reviewed in our daily stand-up meeting to ensure that they have been updated on the care plan.	

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F 280	Continued From page 12 autonomic dysreflexia. He said he tried to get staff to flush his catheter before calling 911, but they refused, so it was flushed in the emergency room. The resident said he was aware of the signs and symptoms of the condition and could alert staff, but that staff also knew what autonomic dysreflexia was and what to look for. On 3/3/16 at 10:00 am, the medical director stated that autonomic dysreflexia was a standard risk for those with paraplegia. He stated that the care plan was "adequate" if it addressed the individual components of autonomic dysreflexia. At 2:00 pm, the DNS stated that autonomic dysreflexia should have been specifically addressed on the resident's care plan. 2. Resident #1 was readmitted to the facility on 2/11/16 with multiple diagnoses, including muscle weakness. The resident's February and March 2016 Order Recap Report and Physical and Occupational Therapy progress notes documented the resident received therapy five-to-six times per week. The resident's care plan did not document the resident received therapy services. On 2/29/16 at 11:45 am, the resident said he participated in physical and occupational therapy nearly every day. On 2/29/16 at 3:12 pm and on 3/3/16 at 11:30 am, the resident was observed participating in occupational therapy exercises in the therapy	F 280	Monitoring DNS or designee to review 4-6 care plans weekly x 4, then monthly X 3, to verify if resident□s medical diagnoses are addressed in the care plan as well as any therapy services that are being provided. Results of care plan reviews will be reported to the QAPI committee monthly for 4 months or longer if needed for sustained compliance.	

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F 280	Continued From page 13 room. On 3/3/16 at 10:55 am, the DNS said she could not find a care plan for the resident's physical and occupational therapy, which she said should have been care planned.	F 280		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, Resident Group Interview, resident and family interviews, and staff interviews, it was determined the facility failed to ensure there was adequate staffing to	F 353	Resident Specific Residents #6, #2, #3, #7 and #8 had necessary care provided at the time of survey.	5/6/16

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F 353	Continued From page 14 provide for the needs and well-being of all residents. This affected 3 of 13 sampled residents (#s 2, 3, & 6), and 10 of 16 residents who attended the group interview, and had the potential to affect all other residents who lived in the facility. This failure created the potential for psychosocial and physical harm to residents if call lights were not answered in a timely manner and care needs were not addressed. Findings included: Observations: On 2/29/16 at 1:05 pm, Resident #6's call light was observed to be on. Two staff members were observed walking down the hall, looking into the room and walking by without answering the light. At 1:20 pm, a staff member was observed answering Resident #6's call light. On 3/2/16 from 8:02 to 8:35 am, Resident #2's call light was observed to be on before it was answered by a staff member at 8:35 am. Refer to F242 and F368 regarding insufficient staff to deliver hall trays in a timely manner and bedtime snacks not offered. Resident and Family Interviews: 1. Clinical record review for Resident #3 revealed the resident fell prior to being admitted to the facility. The fall resulted in a fracture of the lumbosacral spine and pelvis and a closed fracture of the lumbar vertebra. On 2/29/16 at 11:40 am, Resident #3 stated that call lights were not answered in a timely fashion.	F 353	Other Residents All residents have the potential to be affected, and it was determined that necessary care has been provided. Systemic Changes The administrator and DNS reviewed the current nursing staffing schedule and made adjustments to ensure that the facility has an adequate number of staff to meet the needs of residents. Educated staff regarding: meeting resident needs, the importance and expectation of call light response time, and that it is the responsibility of all staff to answer call lights and if they are unable to meet the resident's needs to leave the call light on until their care needs are resolved. Monitoring The nurse staffing schedule is reviewed daily by the DNS or designee and appropriate adjustments are made according to resident census and acuity level. Call lights will be monitored 3 times per week on various shifts to ensure resident□s needs are being met in a timely fashion. Results of audits and interviews will be reported to our QAPI committee monthly for 4 months or longer if needed for sustained compliance. Refer to F242 & F368 for other plans of correction.	

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F 353	Continued From page 15 The resident said it took staff 25 minutes that morning to respond to her call light. The resident stated she requires a back brace before getting out of bed. On 2/29/2016 at 1:45 pm, Resident #3 stated she tried to "time" when she went to the bathroom because during meal times "all" staff are at the Dining Room and she cannot get help to the bathroom. The resident stated because most staff were in the dining rooms during meal times there were not enough staff to deliver hall meal trays. She said her lunch was typically delivered after 1:30 pm, an hour later than the time of dining room delivery. On 3/1/2016 at 12:15 pm, Resident #3 said staff did not respond the previous night or that morning when she put her call light on to go to the bathroom. She said that if she had waited until staff arrived, she would have had an "accident" in her pants so, without staff assistance, she put on her own back brace, transferred into her wheelchair and then to her walker, and then ambulated to the bathroom. She said she left the call light on and went back to bed with the call light still on. She stated she cannot always put on the brace when she needs toileting and has gone without it because she didn't have help. On 3/1/2016 at 5:40 pm, Resident #3 said she puts worries of falling out of her mind because if she waits for staff assistance she will "poop or pee" on herself. Resident #3's care plan, dated 11/9/15, documented staff assistance was required for transfers; extensive assistance of 1 staff for toileting related to stress bladder incontinence and impaired mobility. Staff were directed to keep the resident clean, dry and odor free, and to offer	F 353		

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toileting before- and after meals and prior to bedtime. The care plan documented the resident was to remain free from skin breakdown due to incontinence.
On 3/1/2016 at 5:40 pm, Resident #3 stated she had a "rash" and was "uncomfortable" in her peri area, which was "raw" and "swollen" because she stays wet from leaking urine into her brief. With the wound nurse at that time, the resident stated the right side of her labia and groin was red. The wound nurse stated that she would contact the physician for an order for a barrier cream.
The resident said there was also not enough staff to provide a shower outside of her regular shower days and if she had an appointment on her shower days, and was not showered, she had to wait for her next scheduled shower day to bathe.
A Minimum Data Set Assessment, dated 12/26/15, documented Resident #3 was not steady and only able to stabilize herself with staff assistance.
During survey, Resident #3 provided instructions for her use of the two-piece back brace that read, "You have severe degeneration in the bones of your spine. You are at high risk for spontaneous fracture and the (back) brace is there to help prevent such an event. Risk of spontaneous fracture include but are not limited to: Severe back pain, numbness and tingling in lower body, one-sided numbness, death. It is very important that you wear your brace when you are out of bed. Anytime you get out of bed to go to the bathroom, anytime you get out of bed into your wheelchair or other chair, anytime you get out of bed to go for a walk and anytime you sit up on the edge of your bed."

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F 353	Continued From page 17 On 3/1/16 at 12:15 pm, the resident said she put her call light on that morning, but it was not answered in a timely manner and she ended up putting her back brace on herself, getting in her wheelchair herself and then transferring herself to her walker and onto the toilet so she would not have an episode of incontinence. After she used the toilet, she said she got back into bed independently and her call light was still on. She said she was sometimes unable to put the back brace on by herself and required, but did not always receive, assistance with it. 2. On 3/1/16 at 2:15 pm, 10 residents in the Group Interview said call lights can take up as long as 2 to 4 hours before staff responded. 3. On 3/1/16 at 2:15 pm, a resident's family member, who wished to remain anonymous, said he/she has witnessed call lights take as long as 90 minutes before "overworked" staff were able to respond. Staff Interviews: 1. On 3/1/16 at 7:40 and 8:05 pm, CNA #6 said the facility was short-staffed about half of the time. She said call lights took more than 15 minutes after dinner and during shift change. She said staff did not have time to pass out snacks to residents. 2. On 3/1/16 at 8:10 pm, CNA #7 said the evening shift was short-staffed and needed more help. 3. On 3/2/16 at 10:25 am, CNA #8 said there was not enough help on day shift and that some days	F 353		

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F 353	Continued From page 18 were worse than others when short-staffed. 4. On 3/3/16 at 9:40 am, the DNS and Administrator said the facility conducted call light audits, but did not document the findings. 5. On 3/3/16 at 10:45 am, the DNS was informed of the above concerns and said the facility was in the process of trying to hire more CNAs and nurses and offer incentives to staff. She said the facility did not have enough staff to fill the budgeted positions. When asked if the facility had looked at contracting agency staff to help fill the positions, she said she wanted to offer permanent positions and did not want to use temporary staff. 6. On 3/3/16 at 2:20 pm, the Administrator said to compensate for the lack of staff, current staff often worked overtime. He said he would be "more comfortable" hiring temporary agency staff if those staff agreed to longer terms of service in order to maintain consistency. When asked if he had looked into this option, he said he had not.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 356		5/6/16

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F 356	Continued From page 19 - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to display the nurse staffing posting in a prominent place readily accessible to residents and visitors. This affected 13 of 13 (#s 1-13) sampled residents and had the potential to affect all residents who resided in the facility and any visitors who came to the facility. Findings included: On 2/29/16 at 9:30 am, the nurse staffing information was not found in the facility. On 2/29/15 at 9:45 am, CNA #11 said he completed the staffing schedule and said it was not posted anywhere in the facility.	F 356	Resident Specific Immediately posted the nurse staffing notice in a prominent place to be readily accessible to residents and visitors. Other Residents All residents have the potential to be affected by not posting the daily nurse staffing. Systemic Changes Nurse staffing coordinator or designee to post daily staffing notice with total number and the actual hours worked per nursing category. Education was provided to nurse staffing coordinator on completion	

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F 356	Continued From page 20	F 356	of job task. Monitoring Administrator or designee will monitor the posting of daily nurse staffing information weekly for one month, then monthly times two, and report results to the QAPI committee monthly for three months or until sustained compliance.	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on the Resident Group interview, resident interviews, test tray evaluation and staff interview, it was determined the facility failed to serve food at a palatable temperature. This affected 1 of 13 (#3) sampled residents, 9 of 16 residents who attended the Resident Group interview, and had the potential to affect most residents who dined in the facility. This failed practice created the potential to negatively affect residents' nutritional status and psychosocial well-being related to unpalatable food. Findings included: On 2/29/16 at 1:45 pm, Resident #3 said she preferred to eat in her room and her food was generally "lukewarm" or "cold." She said the hall trays were "always" delivered late. Refer to F242	F 364	Specific Residents Resident #3 reported to DNS on 3/2/16 that her dinner meal received in her room was good and at the appropriate temperature. The facility provides residents palatable foods served at proper temperatures to ensure residents satisfaction and decrease the potential risk of affecting nutritional status and psychosocial well-being. Other Residents Any resident receiving meals has potential to be affected by food served at unpalatable temperatures. Systemic Changes	5/6/16

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F 364	Continued From page 21 for late hall tray delivery. On 3/1/16 at 2:15 pm, during the Resident Group interview, 9 of 16 residents said food delivered to their rooms was cold. On 3/1/16 at 6:43 pm, a dinner meal test tray was evaluated by the survey team with the CDM and dietician present. The test tray included tuna casserole, peas, carrots, and French fries. The fries had a temperature of 106-degrees F. The CDM said the fries were "a little crunchy" and that it was difficult to keep French fries hot. It was determined the fries were unpalatable.	F 364	All meals after being plated receive a dome cover and are then delivered to the appropriate location. Dietary staff utilize the walkie talkies to notify the CNAs to deliver meals to residents in the facility. Dietary staff have been educated on the importance of maintaining tray line and food temperatures. Dietary staff and nursing have been educated on the importance of utilizing the system described above and getting trays passed timely to ensure food is palatable and served at appropriate temperatures. Monitoring The dietary manager or designee will conduct weekly and random resident food interviews for four consecutive weeks to ensure food is palatable and served at proper food temperatures. Thereafter, monthly nutrition services quality improvement audits will be completed to ensure resident meal satisfaction. During monthly menu meetings the Dietary Manager will meet with residents to ask for feedback on palatability of foods. Results will be reviewed and reported along with any corrective action taken to the monthly QAPI committee for further review and recommendations for four months or until sustained compliance.	
F 367 SS=E	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician.	F 367		5/6/16

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F 367	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility's dietary services failed to provide appropriately prepared diets to 9 of 9 residents (#s 6, 19, 22, 23, 24, 25, 26, 27, and 28) ordered to receive pureed meals. The facility also failed to follow prescribed recipes to ensure pureed food retained nutritive value. Findings include: On 3/1/16 at 5:00 pm, Cook #1 was observed pureeing the evening meal of tuna noodle casserole and a peas and carrots mixture. After scooping a random number of scoops of the casserole into the blender canister and adding hot water, Cook #1 stated he/she measured the amount of water by the water level markings on the canister. Without first measuring the water separately, Cook #1 repeated the process at least two more times throughout the meal service to provide enough of the pureed entrée for residents receiving a pureed diet. The facility's 2016 recipes for pureed tuna noodle casserole documented the number of scoops measured should be correlated to the number of residents receiving the pureed meal. The recipe further instructed that one cup of milk was to be used in the process rather than water. Cook #1 did not refer to the recipe in the observed preparation of the pureed tuna noodle casserole. During the pureed meal preparation on 3/1/16 at 5:00 pm, Cook #1 was also observed pureeing the peas and carrots blend for those residents receiving pureed foods. Cook #1 scooped a random number of portions of peas and carrots	F 367	Specific Residents Resident #6, #19, #22, #23, #24, #25, #26, #27, and #28 have been provided appropriately prepared pureed meals according to standardized recipes to preserve nutritive value. Other Residents All residents on altered diet textures have the potential to be affected by failure to provide appropriately prepared diets as outlined with the planned menu. Systemic Changes Dietary staff have been educated on the importance of appropriately preparing pureed meals and following the recipes and therapeutic spreadsheets in order to preserve the meals nutritive value. Additional education was provided on the importance of diet textures related to resident safety. Monitoring The dietary manager or designee will conduct random audits three times a week for four weeks of food preparation process to ensure recipes and therapeutic spreadsheets are being followed. Thereafter, these audits will be completed weekly for the following three months. The results will be reviewed and reported along with any corrective action taken to the monthly QAPI committee for further review and recommendations for four months or until sustained	

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F 367	Continued From page 23 blend and then added an unmeasured amount of hot water to the blender canister. The facility's 2016 recipe for pureed peas and carrots mixture did not call for additional fluid, but rather for a thickener if the mixture was thinner than the consistency of mashed potatoes. On 3/2/16 at 3:35 pm, neither the DM nor the consultant dietitian explained why Cook #1 prepared the pureed food with hot water rather than by the recipes' directions.	F 367	compliance.	
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observation, Resident Group interview, and resident and staff interview, it was	F 368	Specific Residents Resident # 20 is offered a bedtime snack	5/6/16

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F 368	Continued From page 24 determined the facility did not offer a bedtime snack and allowed residents in the 300 hallway to go more than 14 hours between meals. This was true for one random resident (#20), 16 of 16 residents in the Resident Group interview, and residents in the 300 hallway who ate in their rooms. The deficient practice had the potential to impact any residents in the facility who wanted a snack or who were at risk for nutritional compromise. The deficient practice also had the potential to cause harm if residents experienced hunger, low blood sugar levels between dinner and breakfast, or did not receive adequate nutritional to support healing or prevent weight loss. Findings included: 1. On 3/1/16 at 2:15 pm, 16 of 16 residents in the group interview said they were not offered snacks at night and that snacks were only available for those residents with diabetes. On 3/1/16 at 7:33 pm, the nurses station fridge was observed containing several sandwiches, cheese sticks, yogurt, pudding and a few other items for resident use. From 6:25 pm to 8:20 pm the 100, 200, and 300 hallways were observed for distribution of snacks and only one resident was observed to be offered a snack. On 3/1/16 from 7:50 pm to 8:17 pm, the following interviews were completed: *CNA #6 said staff did not have time to offer snacks to residents and those with diabetes must ask staff for a snack; *LN #17 said if residents wanted a snack they had to ask for one; *CNA #18 said only the residents with diabetes received snacks, but others could ask for them;	F 368	daily. Other Residents All residents have potential to be affected by not offering bedtime snacks daily. Systemic Changes Staff educated on facility policy to verbally offer all residents snacks at bedtime daily. Implemented a process for passing and storing snacks, snack options and where to document acceptance or refusal in resident chart. Monitoring The dietary manager or designee will conduct weekly and random resident interviews for four consecutive weeks to ensure residents are being offered bedtime snacks. Thereafter, monthly resident interviews will be completed to ensure residents are being offered bedtime snacks. During monthly menu meetings the Dietary Manager will meet with residents to ask for feedback on being offered bedtime snacks routinely. DNS or designee will audit resident ADL records five times a week for four weeks. Thereafter, weekly for three months to ensure residents were offered bedtime snacks daily. Findings will be investigated further by DNS or designee for potential need for staff re-education or performance improvement plans as indicated. Results will be reported to the monthly QAPI committee for further review and recommendations for four months or until sustained compliance	

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F 368	Continued From page 25 and, *CNA #19 said staff don't offer snacks to the residents. If a resident asks, then one of the nurses makes the CNA check with them before giving the resident a snack. On 3/3/16 at 11:35 am, Resident #20 said staff does not offer snacks to residents, including those with diabetes. She said she was diabetic and had to ask for a snack and then is questioned by the nurse as to why she wants a snack and/or if she was showing signs or symptoms of low blood sugars. 2. On 3/1/16 at 6:40 pm, the 300 hallway food cart was observed as the dinner meal for residents was delivered to their rooms. On 3/2/16 at 9:05 am, the 300 hallway food cart was observed as the breakfast meal for residents was delivered to their rooms. Refer to F242 regarding late meals. On 3/2/16 at 3:30 pm, the CDM and dietician were informed of the 14 hour and 25 minute delay between meals without snacks; said the issue was of concern.	F 368		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		5/6/16

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F 371	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to ensure the staff stored, prepared and served food in a safe and sanitary manner to prevent foodborne illnesses for all residents who received their meals from the kitchen. Findings include: On 2/29/16 at 9:07 am, an uncovered, unlabeled container of an unknown substance was observed in the walk-in freezer. The CDM stated the substance was a pork roast cooked earlier in the month. A 2/23/16 "use by" date was observed on the container, which had build-up of frost within. The following was observed during the noon meal tray line service of 3/1/16: * After placing food on thermal plates, Cook #5 placed the dishes on the ledge of the steam table for dietary aides to place in one of three food carts or on a push cart for the main dining room. The dietary aides did not immediately cover the prepared dishes, which sat for one-to-two minutes before being covered and placed in a cart. Meals placed on the push carts for service into the main dining room also sat for one-to-two minutes uncovered and in the direct flow of cold air blowing through an open door into the food preparation area of the kitchen. This cool breeze blowing in the direction of the uncovered plates could be detected coming from the main dining room vents.	F 371	Specific Residents It is the policy of this facility to ensure that dietary staff store, prepare, and serve food under sanitary conditions. The uncovered, unlabeled container of an unknown substance found on 2/29/16 was immediately removed from the freezer and thrown away during survey. After plating food from tray line, prepared dishes are covered by the dietary staff. Dietary staff consistently utilize good hygienic practices and techniques during food operations. All food is labeled, dated, covered, and monitored so it is used by its use-by date, or discarded. Other Residents All residents have potential to be affected from not storing, preparing, and serving food under sanitary conditions. Systemic Changes The dietary staff received education regarding food safety and sanitation policies and procedures. Handwashing and personal hygiene procedures were reviewed to prevent the potential for food borne illness. Monitoring Dietary manager or designee will conduct weekly SPOT (Sanitation, Production, Observation, Temperatures) audits for four weeks to ensure dietary staff is	

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F 371	Continued From page 27 * Kitchen staff repeatedly left the kitchen and returned to continue food operations without first washing their hands. Please refer to F364 regarding food palatability.	F 371	serving and preparing food under sanitary conditions. Thereafter, monthly nutrition services quality improvement audits will be completed to ensure food is stored, prepared, and served in a safe and sanitary manner. Results will be reported to the monthly QAPI committee for further review and recommendations for four months or until sustained compliance	
F 441 SS=F	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	F 441		5/6/16

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F 441	Continued From page 28 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens 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 upon record review, observation, and interviews, it was determined the facility failed to establish an infection control and prevention program which investigated, monitored, evaluated, and analyzed incidents of infection. The facility also failed to implement infection control measures for a resident's room and failed to keep catheter tubing from dragging on the floor. This was true for 23 of 28 sampled residents (#1- #23) and had the potential to affect all residents in the facility. This failure created the potential for more than minimal harm by exposing all residents to the risk of infections. Findings include: 1. Infection Control and Prevention Program Infection Control Logs for September 2015-February 2016 revealed the monthly average census was 63 residents; the monthly average of infections was 24 for an average infection rate of 38%; the monthly average of nosocomial [acquired within the facility] infections was 18, or 75%, of all infections; the monthly average of UTIs was 11, or 46%, of all infections; and the monthly average of nosocomial UTIs '	F 441	Resident Specific Resident #7 catheter tubing was sanitized and is not touching the floor. Resident #8 was moved to a private room and the room that resident #8 shared with Resident #11 was deep cleaned. Resident #11 is without any signs or symptoms of infection. The catheter tubing and drainage bag for resident #7 was evaluated for possible modification of tube length and determined it cannot be altered. A leg bag was trialed, which failed d/t resident #7 refusing to use d/t discomfort. Changed privacy bag model/style to one that accommodates the drainage bag and tubing better, keeping the tubing from touching the floor. Other Residents All residents with indwelling catheters were reviewed to ensure the catheter tubing or drainage bags were not touching the floor. Reviewed all other residents with contact precautions in	

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F 441	Continued From page 29 was 9, or 82% of all UTIs. * In September 2015 the average census was 61: There were 21 documented infections (34%), 19 of the 21 infections were nosocomial, or 90%, of all infections; 13 of the 21 infections were UTIs (62%); of which 12 of the 13 UTI infections were nosocomial, or 92%. * In October 2015 the average census was 67: There were 35 documented infections (52%), 28 of the 35 infections were nosocomial, or 80%, of all infections; 11 of the 35 infections were UTIs (31%); of which 9 of the 11 UTIs were nosocomial, or 82%. * In November 2015 the average census was 66: There were 31 documented infections (47%); 22 of the 31 infections were nosocomial, or 71%, of all infections; 13 of the 31 infections were UTIs (42%); of which 11 of the 13 UTIs were nosocomial, or 85%. * In December 2015 the average census was 61: There were 22 documented infections (36%); 19 of the 22 infections were nosocomial, or 86%, of all infections; 13 of the 22 infections were UTIs (59%); which 11 of the 13 UTIs were nosocomial, or 85%. * In January 2016 the average census was 61: There were 17 documented infections (28%); 11 of the 17 infections were nosocomial, or 65%, of all infections; 8 of the 17 infections were UTIs (47%); of which 7 of the 8 UTIs were nosocomial, or 88%. * In February 2016 the average census was 64: There were 15 documented infections (23%); 10 of the 15 infections were nosocomial, or 67%, of all infections; 6 of the 15 infections were UTIs (40%); of which 5 of the 6 UTIs were nosocomial, or 83%.	F 441	place and they were all in private rooms. This has the potential to effect all residents. Systemic Changes Staff educated on infection control and UTI prevention, hand washing procedure, catheter tubing management, and enhanced precautions procedures. The IDT infection control subcommittee meets monthly prior to and separate from QAPI meeting, to review active infections and any enhanced precautions in order to evaluate and analyze incidents and rates of infections as well as to identify any trends. Staff competencies performed for hand hygiene, catheter management, and use of personal protective equipment for individuals with enhanced precautions. Residents who develop infections requiring enhanced precautions are evaluated for appropriate room placement and culture results are reported to infection control nurse or designee for guidance on which precautions to put in place. Signs are placed on resident room doors to inform staff, residents, and visitors of the type of precautions required. Also, in order to remind staff, residents, and visitors, signs are placed in resident rooms for required hand hygiene prior to exiting room. Monitoring DNS or designee will perform audits for hand hygiene, catheter management, and implementation of enhanced precautions weekly X 4, then monthly X 3. Any	

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F 441	Continued From page 30 The facility also experienced a Viral Gastroenteritis outbreak in December 2015, which involved 29 residents, or 48% of the total resident population. Infection control logs documented: * September 2015: 4 cases of E-coli in each of the 200 and 300 units; and 1 case in the 100 unit. In addition, there were 2 cases of ESBL in each of the 100 and 200 units. * October 2015: 3 cases of E-coli in the 200 unit, and 1 case in each of the 100 and 300 units. * November 2015: 2 cases of E-coli in each of the 100, 200, and 300 units. * December 2015: 3 cases of E-coli in the 200 unit; 2 cases in the 300 unit; and 1 case in the 100 unit. In addition, there were 3 cases of ESBL in the 200 unit; 2 cases in the 100 unit; and 1 case in the 300 unit. * January 2016: 3 cases of E-coli in the 200 unit, and 2 cases in the 300 unit. In addition, there were 2 cases of ESBL in the 200 unit and 1 case in the 300 unit. Infection control maps contained documentation that conflicted with the Infection Control Logs as follows: * September 2015: two E-coli infections in each of the 100, 200, and 300 units. The 100 unit had 1 ESBL infection, and the 200 unit had 2 ESBL infections. * Maps for October 2015- February 2016 did not completely identify specific organisms. A Peri-Care & Cath [eter]-Care In-service, dated 9/11/15, documented a "rash of E-coli Urinary Tract Infections in the building. These infections can be tracked back to improper peri-care and	F 441	concerns identified by these audits or by the IDT infection control subcommittee will be addressed immediately and will be presented to the QAPI committee monthly for 4 months or longer if needed for sustained compliance.	

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F 441	Continued From page 31 catheter care." Federal regulations define an outbreak as trends that are 10% higher than the historical rate of infection for the facility, or occurrence of three or more cases of the same infection over a specified length of time on the same unit or other defined areas (42 CFR 483.65 Infection Control). On 3/01/16 at 2 pm, the ICN stated resident infections were identified based on symptoms, labs, and chart audits. She stated that when a resident has signs and symptoms of infection, nurses assess the resident, documents in alert charting and 24 hour charting, and then contacts the physician for orders. Infections were "line" logged on a monthly Infection Control Log. The ICN stated the facility's IDT meets daily to discuss infection issues and decide a course of action. The ICN said the IDT then communicates necessary information and interventions to staff via direct care notes on status forms and staff inservices. The ICN stated all staff are required to check an assignment binder at the front desk before each shift for care updates and that information from the Infection Control Log had been addressed in the facility's QA meetings. She stated that although the IDT discussed infection control, the team's investigations, interventions, monitoring measures, and evaluation of the interventions had not been documented. On 3/02/16 at 1:55 pm, in an interview with the DNS, the ICN, and the corporate infection control specialist, the DNS and ICN could not explain the facility's infection rates. The DNS and ICN stated the facility had an infection control "problem" but	F 441		

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that the problem had been addressed in QA meetings and the rates were declining. The DNS stated when an issue is identified, the IDT observes staff, conducts walking rounds, educates staff, and monitors staff exercise of standard precautions.

On 3/03/16 at 2 pm, the DNS stated there was no formalized documentation regarding IDT meetings, interventions, monitoring, or evaluations. Other than inservice records, there was no documentation of any intervention prior to consideration in the QA meetings.

a. Contact Precautions
The Isolation-Categories of Transmission-Based Precautions policy, dated August 2012, documented that Standard Precautions were required at all times during resident care. "Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others." In addition to standard precautions, contact precautions required the donning of gloves and gowns before entering the room and their proper disposal before exiting the room. Residents on contact precautions should be in a private room if possible.

The Multidrug-Resistant Organisms policy, dated August 2012, documented the initiation of contact precautions for residents known or suspected of having a MDRO should occur on a case-by-case basis.

A Precaution inservice, dated 10/1/15, documented, "There has been some confusion

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	135077	A. BUILDING _____ B. WING _____	C 03/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	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 441	Continued From page 33	F 441		

on requirements for maintaining contact precautions. Questions have arisen on when to glove and gown, and who is and is not required to do so. To alleviate this confusion, nurse management has simplified the process ... anyone [capitalized and bold faced] entering the room for any [capitalized and bold faced] reason is required [bold faced] to gown and glove."

On 2/29/16 at 9 am, three resident rooms were observed with contact precaution signage posted on the doors, and gowns and gloves in a container hanging from the door. Residents #8 and #11, who shared a room, were observed with contact precaution signs on the door. The signs instructed visitors and personnel to talk to a nurse before entering the room. Contact precautions required gloves and gowns if contact with blood, body fluids or other infectious materials and mucous membranes were likely.

On 2/29/16 at 10:17 am, the 300 unit LN #14 stated Resident #18 had a UTI and contact precautions required anyone entering the room to "always gown and glove."

On 2/29/16 at 11:15 am, the SDRN stated that contact precautions required anyone entering the room to don a gown and gloves outside the door before entering the room. Gowns and gloves were to be removed inside, placed in a trash bag and taken to the laundry room across the hall.

On 3/1/16 at 1:30 pm, 200 unit LN #15 stated two resident rooms had contact precautions, which required all staff to gown and glove to perform cares. The residents were told to wash their hands before leaving the room, LN #15 said.

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F 441	Continued From page 34 On 3/1/16 at 11:30 am, Resident #8 stated he had not been told to wash his hands before leaving his room, and not everyone who entered wore gowns and gloves. On 3/2/16 at 9:30 am, CNA #12 was observed entering Residents #8 and #11's' room without gowning or gloving. The CNA did not wash her hands before entering or exiting the room, or use an alcohol-based sanitizer. The CNA entered the hall from the residents' room, retrieved ice from the hall cooler, went to the nurses' station and then returned to the residents' room to deliver a drink to Resident #11. The CNA stated she was not required to glove and gown since Resident #8 was on contact precautions, but Resident #11 was not. On 3/2/16 at 9:50 am, CNA #13 stated the ICN clarified contact precautions that morning. Before the clarification, she said, staff had been required to don a gown and gloves, but gowns and gloves were now required only when caring for Resident #8. CNA #13 stated hand washing was only required if she came into contact with the resident on contact precautions [#8], and hand sanitizer could be used otherwise. During an interview with the DNS, the ICN, and the corporate infection control specialist on 3/2/16 at 1:55 pm, the ICN stated she contacted the corporate infection specialist a few weeks prior to clarify contact precautions. The infection specialist stated gloves and gowns were not required when caring for a non-infected resident cohabitating with a resident on contact precautions. Federal guidelines (42 CFR 483.65	F 441		

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Infection Control) specify precautions are to be taken when entering a room in which contact precautions have been placed regardless of whether staff are caring for the infected resident or the non-infected roommate. The DNS and ICN stated staff were confused as to what to do regarding contact precautions.

b. Handwashing
The facility's Handwashing/Hand Hygiene policy, dated April 2012, directed staff to wash their hands or use an alcohol-based hand rub before- and after direct resident contact, and before- and after entering isolation precaution settings.

A Hand Hygiene inservice, dated 9/15/15 instructed the staff to "wash your hands!" or use an alcohol-based sanitizer when entering a room to care for a resident and after caring for the resident. CNA meetings on 9/22/15 and 9/24/15 instructed CNAs to read and sign an in-service on hand hygiene. CNA meetings on 10/20/15 and 10/23/15 instructed CNAs to complete a hand hygiene competency based on a previously conducted mock survey conducted 10/15/15.

On 3/2/16 at 9:30 am, CNA #12 was observed entering Residents #8 and #11s' room without gowning or gloving. The CNA did not wash her hands before entering or exiting the room, nor did she use an alcohol-based sanitizer. The CNA entered the hall from the residents' room, retrieved ice from the cooler, walked to the nurses' station and returned to the resident's room to deliver a drink to Resident #11.

c. Ill Staffing Protocols
Review of the Viral Gastroenteritis policy and

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procedure, dated 1/25/16, documented that staff were not to report to work with any gastroenteritis symptoms. It further stated that staff who developed symptoms should be sent home immediately. On 3/2/16 at 7:30 am, LN #14 stated she was "vomiting" and "sick today," but could not go home because the facility's annual recertification survey was underway at the facility. At 10 am, LN #14 was observed to still be working.

2. Resident #7 was admitted to the facility on 3/20/15 with multiple diagnoses, including retention of urine.

a. The resident's 2/26/16 urinary lab results documented he tested positive for MRSA in his urine.

The resident's Progress notes and February and March 2016 Order Report documented he was receiving Macrobid for a UTI.

On 2/29/16 at 1:35 pm and 2:40 pm, the resident's room was observed and the door did not contain any signage or any PPE near the door or in the room.

The resident's Progress notes dated 2/29/15 at 11:01 pm and 3/1/16 at 2:49 pm, documented, "Res[ident] placed on precautions d/t results of ua/c/s. Cont[inue] on macrobid..." and "P[atien]t cont[inue] on contact precautions to MRSA/urine. Catheter patent..."

On 3/1/16 at 1:05 pm and throughout the survey,

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the resident's room door contained signs which documented contact precautions were in place and PPE was hung on the door.

On 3/1/16 at 1:25 pm, LN #15 said the resident tested positive for MRSA in his urine and was on contact precautions.

On 3/2/16 1:55 pm, the DNS said the facility obtained the MRSA lab results on 2/26/16 and infection control precautions should have been implement at that time, but were not in place until the evening of 2/29/16.

b. On 3/1/16 at 12:26 pm, the resident was observed in his wheelchair in the dining room with his catheter tubing resting on the floor. At 1:00 pm, the resident left the dining room with the tube dragging on the floor. The resident ambulated into the hallway when CNA #11 assisted the resident back to his room. When the resident placed his right foot on the wheelchair foot pedal, the catheter tubing lifted off the floor. CNA #11 stopped at the resident's door to put on a PPE gown and gloves and the resident self-ambulated into the room with the catheter tubing dragging on the floor. CNA #11 noticed the tube and told the resident the tubing was dragging. CNA #11 then entered the room, adjusted the catheter tubing with his gloved hands then picked up the resident's phone and call light from the tray table and gave the call light to the resident without removing the gloves or washing his hands after handling the tube.

On 3/1/16 at 1:08 pm, CNA #11 said he adjusted the catheter tubing and picked up the phone and call light without washing his hands after

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F 441	Continued From page 38 adjusting the tube. On 3/2/16 at 3:25 pm, the resident was observed in his wheelchair in his room with the catheter tubing on the floor. On 3/3/16 at 11:00 am, when informed of both observations, the DNS said the tubing should not have been on the floor. She said after the first incident was reported to her by staff, she personally went to the resident's room and wiped down the catheter, phone and call light. She said she would try and find a solution to keep the tubing off the floor when the resident's foot was not on the foot pedal.	F 441		

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	MDS001250	A. BUILDING: _____ B. WING _____	C 03/04/2016

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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the State licensure and complaint survey of your facility. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Evelyn Floyd,JD, MSN, RN Juanita Stemen, MSN, RN, LNFA Linda Roper, RN Beverly Briggs, RN	C 000		
C 703	02.152,03,a,i Idaho Licensed Social Worker i. Is a social worker licensed by the state of Idaho as a social worker or who receives regular consultation from such a qualified social worker. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not have a licensed social worker on staff nor did the facility have a licensed consultant social worker. This affected 13 of 13 (#s 1-13) sampled residents and had the potential to affect all residents in the facility. Findings included: On 2/29/16 at 2:10 pm and 4:15 pm, the Administrator said the facility's social worker had a masters degree, but was not licensed because he/she failed the licensing test in March 2015. He said the social worker consulted with a corporate social worker, but that individual was not licensed either.	C 703	Resident Specific A contract has been obtained between the facility and an Idaho licensed consultant social worker for social services to be provided to residents #1 through #13. Other Residents All residents who receive social services by a social worker that is not an Idaho licensed social worker have the potential to be affected. Systematic Changes Contracted Idaho licensed social work consultant makes routine monthly visits with current social worker to discuss resident social needs or issues. This will continue to occur until current social worker becomes an Idaho licensed social worker.	5/6/16

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C 703	Continued From page 1	C 703	Monitoring Contracted Idaho licensed social worker will exit with current social worker and Administrator to review their site visit report and discuss any identified issues. Once current social worker obtains an Idaho license, a copy will be kept in his personnel file, and audited annually for active status. Audit findings will be reported to the QAPI committee monthly for 4 months.	

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

April 18, 2016

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

Provider #: 135077

Dear Mr. Barglof:

On **March 4, 2016**, an unannounced on-site complaint survey was conducted at Avamere Transitional Care & Rehab - Boise. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006996

The complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted on February 29 to March 4, 2016.

Observations were made of facility cleanliness, meal services, response to call lights, and handwashing practices.

The record of the identified residents and 15 other sample residents were reviewed. The facility grievance file and Resident Council meeting minutes were reviewed from December 2015 through February 2016. Infection control records were reviewed, along with staff education and in-service records. Housekeeping policies were reviewed.

A resident group interview was conducted with 16 residents in attendance. Topics discussed included quality of care, resident rights, meals, and facility cleanliness. Four individual residents were interviewed privately regarding the same topics. Two resident family members were interviewed regarding quality of care and resident rights. The facility's management team were interviewed, as well as individuals from the nursing, housekeeping, and maintenance departments.

Allegation#1: The Reporting Party alleged the facility informed an identified resident had incurred liability above and beyond Medicare and Medicaid Insurance.

Findings #1: Review of the resident's medical record and an interview with the Business Office Manager revealed the resident did not have any out of pocket expenses or liabilities during the alleged time period.

Based on the identified resident's medical records and interviews, it was determined the facility was in compliance with Federal guidelines.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation#2: The Reporting Party said the facility had not made any discharge arrangements for an identified resident.

Findings #2: The identified resident's medical record documented the resident was to be discharged to the community and family would be reassured of plan of care before discharge. The medical record documented the Nurse Practitioner had spent 30 minutes with the resident discussing the discharge plan a week before the resident discharged, then social services had met with the resident to coordinate discharge arrangements including home health, home care and Meals on Wheels, follow-up appointments with community clinics, medication refills, and durable medical equipment and supplies.

Based on the identified resident's medical records, it was determined the facility was in compliance with Federal guidelines.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation#3: The Reporting Party alleged an identified resident's physician had not seen the resident for over a month.

Findings #3: The identified resident was in the facility for just over 90 days. During that time, the resident was seen by the attending physician twice, the would clinic physician four times, and the nurse practitioner at least five times. The frequency of these visits exceeded the federal requirement. The resident's primary care physician in the community had opted not to follow the resident in the facility during his/her stay at the facility, but a follow-up appointment with that provider was scheduled for the day he/she discharged, and records were sent to that provider with an update on her status as a result of his/her stay in the facility.

Based on the identified resident's medical record, it was determined the facility was in compliance with Federal guidelines.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation#4: The Reporting Party alleged the facility had an odor.

Findings #4: Three surveyors were present in the facility at various times over a five day period. No odors were noted during that time.

Sixteen residents in the resident group reported the facility was usually clean and free from odors.

One individual resident reported the facility used to have transient odors, but had recognized that issue, and had started cleaning with bleach. The resident stated there had been no further difficulties with odors since that time. Other individual residents interviewed reported no difficulty with odors in the facility.

There were no resident grievances regarding odors in the facility, and no reports of odors in the Resident Council meeting minutes.

Based on observations and resident interviews during the survey, it was determined the facility was in compliance with Federal guidelines.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation#5: The Reporting Party alleged the food was not palatable.

Findings #5: Many residents in the facility reported ongoing difficulties with food palatability. Observations were made of the food preparation and delivery services, and the survey team sampled a test tray. Some of the food on the test tray was cold and unpalatable.

Substantiated. Federal deficiencies related to the allegation are cited. Please refer to F 364 regarding the failed practice.

Conclusion #5: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation#6: The Reporting Party alleged the facility's nutritionist had told an identified resident she required another week to learn to manage the resident's tube feeding, but the resident was discharged within the week.

Findings #6: The resident was evaluated by the nurse practitioner a week before discharge, to review the resident's plan and preparedness for discharge. The nurse practitioner's progress note from that visit confirmed the resident was able to meet her nutritional needs through oral intake of foods, and the use of the feeding tube had been discontinued. Review of the identified resident's medical record documented the resident did not require assistance for eating or additional management of the feeding tube. The resident had gained weight while at the facility. The medical record did not contain documentation noting the need for the resident to stay longer.

Based on the identified resident's medical record, it was determined the facility was in compliance with Federal guidelines.

Conclusion #6: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this 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 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,

D. L Scott

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt

IDAHO DEPARTMENT OF
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April 19, 2016

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

Provider #: 135077

Dear Mr. Barglof:

On **March 4, 2016**, an unannounced on-site complaint survey was conducted at Avamere Transitional Care & Rehab - Boise. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007047

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from February 29, 2016 to March 4, 2016.

During the survey, observations were made of call light response times, residents receiving physical and occupational therapy, the provision of showers and assistance with oral hygiene, overall facility cleanliness including bed linens, and mail delivery service.

The record of the identified resident and nine other residents were reviewed. The facility's Grievance file was reviewed from September 2015 through March 2016, and the Resident Council meeting minutes were reviewed from December 2015 through February 2016.

Five individual residents and one resident family were interviewed. Sixteen residents participated in a Resident Group interview. The Ombudsman, Business Office Manager, Director of Nursing, Administrator, and Physical Therapy Manager were interviewed. Multiple CNA, nursing and dietary staff were interviewed regarding staffing, quality of care and dietary concerns.

Allegation #1: The Reporting Party said physical therapy was not consistently provided for an identified resident and the resident was no longer able to walk because of the inconsistencies.

Findings #1: The identified resident was no longer in the facility at the time the complaint was investigated. Physical therapy and occupational therapy was observed for three other residents and no concerns were identified. The identified resident's medical record and three other residents' records documented therapy had been provided as ordered by the physician. The facility's grievance file did not document concerns with therapy. Sixteen residents in the group interview, five other residents and one family member did not express concerns regarding therapy. The Physical Therapy Manager said the identified resident received appropriate therapy. The resident did have a physical illness that could result in a decline in her ability to walk.

Based on observations, record review, resident, family and staff interview, it was determined the allegation could not be substantiated.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The identified resident was billed for therapy the resident did not receive.

Findings #2: The identified resident's medical record was reviewed for therapy and no concerns were identified. The Physical Therapy Manager said the identified resident received appropriate therapy services. The Business Office Manager said the therapy services billed had been verified as correct. The State Agency does not regulate therapy billing, but no cause was found to alert other regulatory entities.

Based on record review and staff interview, it was determined the allegation could not be substantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The identified resident was left on the commode and briefs were not changed quickly enough because call lights were not answered in a timely manner.

Findings #3: Based on observation, record review, resident, family and staff interviews, it was determined the allegation was substantiated and cited at F353.

Conclusion #3: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #4: An identified resident had not received showers as scheduled and did not receive oral hygiene assistance as needed.

Findings #4: Several residents were observed to receive showers and oral hygiene care, during the survey. The identified resident's medical record was reviewed for showers and oral hygiene care and no concerns were identified. Two other residents' records were reviewed for showers and oral hygiene care and no concerns were identified. The grievance file did not document an issue with showers or oral hygiene care. A shower aide was interviewed and she said residents were given an adequate number of showers and residents received showers per their schedule and when needed.

Based on observation, record review and staff interview, it was determined the allegation could not be substantiated.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The identified resident's room was not cleaned and bed linens were not changed.

Findings #5: Rooms and bed linens were observed to be clean and housekeeping staff were observed to clean rooms, during the survey. Linen closets were observed to have sufficient amount of bed linens for the residents' beds. The grievance file did not document an issue with cleanliness of rooms or bed linens. Four individual and 16 residents in the group interview said cleanliness and bed linens were not a concern. Several housekeeping and CNA staff said rooms were cleaned daily and bed linens changed on residents' shower days or as needed.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: There are not enough staff and meals are delivered late due to lack of staffing.

Findings #6: Based on observation, record review, resident, family and staff interviews, it was determined the allegation was substantiated and cited at F353 and F368.

Conclusion #6: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #7: The identified resident was retaliated against for bringing concerns to an outside advocate, and staff open the mail and read it without the resident's permission.

Findings #7: During the survey residents' mail delivery was observed and mail was unopened. The grievance file did not document issues with retaliation or opened mail. Three individual and 16 residents in the group interview said they could report complaints to an outside advocate without retaliation and mail came to them unopened, unless they asked staff to help them open it.

The Business Office Manager said mail was delivered unopened, but staff would help residents with mail when requested. The resident did have a physical illness that would require her to have assistance to open and hold her mail. The Administrator said residents were free to complain to staff or outside advocates and will not be retaliated against. The Ombudsman's office had identified no concerns that residents experienced retaliation after contacting them.

Based on observations, record review, resident and staff interview, it was determined the allegation could not be substantiated.

Conclusion #7: Unsubstantiated. Lack of sufficient evidence.

Allegation #8: Concerns for the identified resident were brought to facility staff attention, but were not resolved.

Findings #8: The grievance file did not document concerns for the identified resident. Sixteen residents in the group interview said the administration would look into complaints and would address them. A nurse who worked with the identified resident said the resident never expressed complaints to her.

Based on record review, resident and staff interview, it was determined the allegation could not be substantiated.

Conclusion #8: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this 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 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,

D. L Scott

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt

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DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
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May 23, 2016

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

Provider #: 135077

Dear Mr. Barglof:

On **March 4, 2016**, an unannounced on-site complaint survey incident was conducted at Avamere Transitional Care & Rehab - Boise. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007151

The complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted from February 29 to March 4, 2016.

The following observations were conducted:

- Handwashing;
- Response to call lights;
- Facility's cleanliness; and,
- Meal services.

The following documents were reviewed:

- The entire clinical record of the identified resident and 15 other residents;
- The facility grievance file for December 2015 to February 2016; and,
- Resident Council meeting minutes from December 2015 to February 2016;
- Infection control records;

- Inservice records; Admission and discharge records; and, Housekeeping policies.

The following interviews were conducted:

- Sixteen residents were interviewed at a group meeting regarding quality of care issues, resident rights, and meals;
- Four individual residents were interviewed regarding quality of care issues, resident rights, and meals;
- Two residents' family members were interviewed regarding quality of care issues and resident rights;
- Facility's Inter disciplinary Team members were interviewed regarding quality of care issues, resident rights and meals; and,
- Facility staff were interviewed regarding quality of care issues, resident rights and meals.

Allegation#1: The reporting Party said an identified resident did not receive appropriate therapy for a urinary tract infection which resulted in hospitalization.

Findings #1: The identified resident was no longer residing in the facility at the time of the complaint investigation.

The identified resident's admission records documented the resident had been admitted to the hospital with an acute kidney injury and bladder infection prior to transferring to the skilled nursing facility (SNF). On admission to the SNF, the resident did not have an order for an antibiotic. Nursing Progress Notes documented the monitoring for signs or symptoms of infection. The Nurse Practioner's (NP), assessment noted the resident was slightly confused. Nursing Progress Notes documented the resident had increased incontinence, with medium yellow, strong smelling urine. A urinary analysis (UA), with culture and sensitivity (C&S) were obtained. Laboratory results documented the resident did not have a UTI. Subsequent Progress Notes documented no signs or symptoms of infection and no complaints of urgency, frequency, burning or increased incontinence. The identified resident was discharged to an assisted living facility.

Based on the identified resident's clinical records, it was determined the facility was in compliance with federal guidelines.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The Reporting Party said an identified resident contracted an infection at the facility due to lack of handwashing.

Findings #2: The identified resident's clinical records did not document evidence the resident had obtained any infective organisms while at the facility.

Staff handwashing practices were observed throughout the facility and for 15 sampled residents during the survey. Infection control and in-service records were reviewed for handwashing issues. The facility's policies on general infection control and handwashing were reviewed. The Director of Nursing, Infection Control Nurse, and staff were interviewed regarding handwashing practices.

The facility's infection control program was reviewed, with problems noted.

Substantiated. Federal deficiencies related to the allegation are cited. Please refer to F 441 regarding the failed practice.

Conclusion #2: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation#3: The Reporting Party alleged an identified resident had to wait for call lights to be answered, which resulted in the resident experiencing an episode of urinary incontinence.

Findings #3: There was no documented evidence the identified resident had to wait for his/her call light to be answered or had experienced a related episode of urinary incontinence. Staff response to call lights were observed for 13 sampled residents and other random residents using their call lights. Three residents were found to have waited too long for call lights to be answered in a timely manner. In addition, one resident was observed to have his dignity compromised while dining.

Interviews with four sampled residents, two family members, and resident council were conducted regarding call lights and dignity issues.

Interviews with facility staff revealed the facility did not have adequate staff.

The facility was cited for these failures.

Substantiated. Federal deficiencies related to the allegation are cited. Please refer to F 353 and F 241 regarding the failed practices.

Conclusion #3: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #4: The Reporting Party alleged the facility was dirty and smelled badly.

Findings #4: The identified resident's clinical record did not document complaints regarding cleanliness and smells.

Review of grievance records from December 2015 to February 2016 did not contain documentation regarding cleanliness or smells.

Observations during the complaint investigation did not reveal dirty surfaces or floors. There were no lingering smells of urine or feces.

Interviews with four sampled residents, two family members, and resident council were conducted regarding cleanliness and smells.

Housekeeping was interviewed regarding cleaning practices and routines.

Based on record review, interviews, and observations, it was determined the facility was in compliance with federal guidelines.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The Reporting Party alleged an identified resident's admission and discharge lacked communication.

Findings #5: The identified resident's clinical record contained an inventory list signed by the resident and documentation regarding her admission to the facility. In addition, it contained documentation regarding discussions with family and a friend of the resident, who was also listed as the resident's contact person. The identified resident's clinical record documented discussions with the resident, family and resident's friend regarding the resident's planned discharge with issues noted. Interviews with four sampled residents, two family members, and resident council were conducted regarding admission and discharge. Staff were interviewed regarding admission and discharge planning.

Based on record review, interviews, and observations, it was determined the facility was in compliance with federal guidelines.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: The Reporting Party alleged food was not palatable and cold.

Findings #6: The identified resident's clinical record did not contain documentation of complaints regarding food, or the refusal of food.

Grievance records were reviewed regarding food and meal service.

Meal service was observed during the complaint investigation. Two separate meal trays, breakfast and dinner, were tested for palatability and temperature.

Interviews with four sampled residents, two family members, and sixteen resident council attendees were conducted regarding food palatability and temperature.

Kitchen staff was interviewed regarding menus, recipes, meal service, and food temperatures. The survey team discovered problems with food palatability.

Substantiated. Federal deficiencies related to the allegation are cited. Please refer to F 364 regarding the failed practice.

Conclusion #6: Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this 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 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,

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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April 18, 2016

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

Provider #: 135077

Dear Mr. Barglof:

On **March 4, 2016**, an unannounced on-site complaint survey was conducted at Avamere Transitional Care & Rehab - Boise. The complaint allegation, findings and conclusion are as follows:

Complaint #ID00007194

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from February 29, 2016 to March 4, 2016.

Observations were made of the facility's kitchen for food preparation purposes. Resident's personal refrigerators were observed for storage issues.

The medical record of the identified resident and nine other residents were reviewed. The facility's Grievance file and Resident Council minutes were reviewed from January 2015 through March 4, 2016 were reviewed.

Interviews were conducted with 16 residents in a Resident Group and five individual residents. The Registered Dietician and Dietary Manager were interviewed.

Allegation: The Reporting Party said the facility did not provide the proper diet to an identified resident with food allergies, did not provide refrigerator space for the special foods the resident required, and the resident was not given adequate nutrition even after the issues were brought to the staffs' attention.

Findings: The identified resident was no longer residing in the facility at the time the complaint was investigated. Observations of the kitchen did not reveal a concern with special diets. Observations and resident interviews of personal refrigerators revealed residents were able to keep food in their refrigerators without issues. The grievance file did not document concerns with special diets or adequate nutrition. The identified resident's medical record did not contain evidence of food allergy concerns or weight loss. Nine other residents' records did not document concerns with weight loss. Sixteen residents in the group interview and five other residents, one of which had a special diet due to allergies, did not have a concern regarding special diets. The dietitian and Dietary Manager said the facility provides a low-gluten diet to those residents who need it and makes sure any residents with allergies are provided with adequate nutrition.

Based on observations, record review, resident and staff interview, it was determined the allegation could not be substantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

D. L Scott

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt

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March 15, 2016

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

Provider #: 135077

Dear Mr. Barglof:

On **March 4, 2016**, an unannounced on-site complaint survey was conducted at Avamere Transitional Care & Rehab - Boise. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007219

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from February 29, 2016 to March 4, 2016.

The following observations were completed:
Call lights were observed throughout the survey,
Ambient temperatures were observed, and
Staff were observed for pulling residents' wheelchairs backwards.

The following documents were reviewed:
The facility's Grievance file from September 2015 to March 2016, and
Resident Council minutes from December 2015 to February 2016.

The following interviews were completed:
Four residents were interviewed regarding staffing and dignity concerns;
The Maintenance Director was interviewed regarding ambient temperatures;

Two CNAs were interviewed regarding pulling residents in wheelchairs; and
Sixteen residents in the Group Interview were asked about staffing, dignity and environmental concerns.

Allegation #1: The Reporting Party said the facility is cold for two identified residents and staff was not responding to their concerns.

Findings #1: The identified residents said temperatures were no longer an issue. Ambient temperatures were taken throughout the facility and resident rooms and were all within the proper range. The Maintenance Director said he reviews temperatures every week and adjusts thermostats if needed to maintain the proper temperature.

Based on observation and resident and staff interviews, it was determined the allegation could not be substantiated.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Two identified residents were wheeled backwards down the hallway in their wheelchairs.

Findings #2: The identified residents said they had not been wheeled backwards in their wheelchairs. Residents were observed throughout the survey and none were wheeled backwards. Sixteen residents in the Group Interview said they were treated with dignity and respect. Two CNAs said residents were front-facing when they were wheeled down the hallway.

Based on the observation and resident and staff interview, it was determined the allegation could not be substantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: There are not enough staff to meet the residents' needs.

Findings #3: Based on observation, resident and staff interviews, it was be determined the allegation was substantiated and cited at F353.

Conclusion #3: Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this 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 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,

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt

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April 19, 2016

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

Provider #: 135077

Dear Mr. Barglof:

On **March 4, 2016**, an unannounced on-site complaint survey was conducted at Avamere Transitional Care & Rehab - Boise. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007235

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from February 29, 2016 to March 4, 2016.

During the survey, wound care and tube feeding administration were observed by multiple residents on multiple residents over several days and shifts. The medical record of the identified resident was reviewed, along with the record of one additional resident requiring a feeding tube and four other residents requiring wound care. The facility's Grievance file was reviewed from September 2015 through March 2016, and the Resident Council meeting minutes were reviewed from December 2015 through February 2016. Interviews were conducted with multiple licensed nurses throughout multiple shifts, regarding their knowledge of the individual resident, wound care, and tube feeding administration.

Allegation: The Reporting Party said an identified resident did not receive appropriate tube feedings and wound care.

Finding: The identified resident was no longer residing in the facility at the time the complaint was investigated. Observations of another resident's tube feeding administration revealed no concerns. Observations of several residents' wound care was observed and no concerns were identified.

The identified resident's record contained documentation that the tube feeding was stopped or held at times due to the resident's intolerance of the procedure in the days leading up to his hospitalization. This was consistent with the resident's history since 2013. The resident's physician was aware of this. When the resident began to develop additional symptoms, consistent with indicators that the resident was experiencing a more acute illness, the physician gave the facility an order to have the resident evaluated at the emergency room.

The identified resident's record documented that the resident had been admitted to the facility with multiple wounds, most of which had improved and healed over time. The resident still had one of those wounds at the time he was sent to the hospital. The resident was seen by a wound care physician while a resident of the facility, and no concerns were identified by that team with the wound care the resident received. The other four residents' records did not contain concerns regarding wound care. Several nurses were interviewed regarding tube feedings and wound care and were able to answer questions appropriately regarding physician's orders and wound care techniques.

Based on observations, record review and staff interview, it was determined the allegation could not be substantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As the allegation was not substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

D. L Scott

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt