



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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May 18, 2017

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

Provider #: 135077

Dear Mr. Schneider:

On **May 4, 2017**, 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. 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

Brent Schneider, Administrator
May 18, 2017
Page 2 of 4

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 **May 30, 2017**. Failure to submit an acceptable PoC by **May 30, 2017**, may result in the imposition of penalties by **June 22, 2017**.

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 8, 2017 (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 **August 2, 2017**. A change in the seriousness of the deficiencies on **June 18, 2017**, may result in a change in the remedy.

Brent Schneider, Administrator
May 18, 2017
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **August 2, 2017** includes the following:

Denial of payment for new admissions effective **August 2, 2017**. [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 **October 31, 2017**, 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 **August 2, 2017** 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>

Brent Schneider, Administrator
May 18, 2017
Page 4 of 4

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 **May 30, 2017**. If your request for informal dispute resolution is received after **May 30, 2017**, 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,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

David Scott, R.N., Supervisor
Long Term Care

DS/lj
Enclosures

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

PRINTED: 06/08/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint investigation survey conducted at the facility from May 1, 2017 to May 4, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Edith Cecil, RN Dennis Burlingame, RN Teresa Kobza, RDN, LD</p> <p>Abbreviations:</p> <p>ADL = Activities of Daily Living CNA = Certified Nursing Assistant DNS = Director of Nursing Services e-MAR = Electronic Medical Record GDR = Gradual Dose Reduction LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set Mg = Milligrams mL = Milliliters MS = Multiple Sclerosis NP = Nurse Practitioner PASRR = Preadmission Screening and Resident Review PEG tube = Percutaneous Endoscopic Gastrostomy tube (feeding tube) PRN = As Needed RCM = Resident Care Manager ROM = Range of Motion RCNA = Regional Clinical Nurse Assistant s/sx = signs and symptoms TAR = Treatment Administration Record</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

05/26/2017

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

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F 000	Continued From page 1 TV = Television Tx RCM = Treatment Resident Care Manager UTI = Urinary Tract Infection	F 000			
F 246 SS=E	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, review of residents' records, and resident and staff interviews, it was determined the facility failed to ensure residents' a) call lights were within reach and could be used when needed, and b) were answered in a timely manner. This was true for 4 of 13 (#8, #9, #16, and #17) residents reviewed for call light accessibility and created the potential for harm if residents could not summon staff for assistance when needed. Findings include: 1. Resident #9 was re-admitted to the facility on 1/24/17 with diagnoses which included Multiple Sclerosis [MS - progressive neurological disease] and convulsions. Resident #9's Significant Change Minimum Data Set [MDS] assessment, dated 4/8/17, documented she had severe cognitive impairment, contractures and/or range of motion impairments with both upper and lower	F 246	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 the deficiencies on form CMS 2567 exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F 246 Residents: Resident #9's call light is within reach. Residents #'s 8, 16 and 17 call lights have been answered and needs	6/7/17	

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F 246	<p>Continued From page 2</p> <p>extremities [arms/legs], and totally depended or required extensive assistance from staff for all cares.</p> <p>Resident #9's Activities of Daily Living [ADL] Care Plan, revised 4/29/16, documented she experienced ADL deficits and limited mobility related to advanced MS, weakness, and seizure disorder.</p> <p>Resident #9's Chronic Pain Care Plan, revised 12/29/16, documented she experienced chronic pain related to a contracted left hand, which staff was to stretch and apply a blue "cone" to help avoid a worsening of the left hand contracture, initiated 9/21/16.</p> <p>On 5/1/17 from 12:49 pm to 3:45 pm, Resident #9 was observed in her room watching television. She was sitting in a wheelchair in front of her bed near the television with the call light on the floor between her roommate's bed and her own bed. None of the various staff observed entering the room relocated Resident #9's call light to a more accessible position.</p> <p>On 5/1/17 at 3:50 pm, the Licensed Social Worker [LSW] stated Resident #9 was chair or bed bound and required staff assistance with all cares. The LSW stated Resident #9's ability to communicate had decreased recently and she did not talk often.</p> <p>On 5/2/17 from 9:50 am to 11:34 am, Resident #9 was observed in her room listening to music. A wheelchair was located next to her bed near the curtain separating Resident #9 from her roommate, and the call light was on the floor</p>	F 246	<p>met.</p> <p>Other Residents: All residents reviewed for proper call light placement.</p> <p>Systemic Changes: CNA staff check out with nurse prior to going on break to ensure resident needs will not be effected. Staff educated on keeping call lights within reach or in a place of easy access for the resident. Staff educated on importance of answering call lights timely in order to meet resident's needs and maintain safety.</p> <p>Monitoring: DNS or designee will audit call light placement 3 times a week to ensure proper placement and report findings to the QA committee for 3 months. Administrator or designee will conduct call light audits 3 times a week to ensure timely answering of call lights and report findings to the QA committee for 3 months.</p>		

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F 246	<p>Continued From page 3</p> <p>between the chair and bed. During the observation, 3 different staff members entered the room, but did not relocate the call light to a more accessible position. At 11:34 am, Resident Care Manager [RCM] #1 entered Resident #9's room and placed the call light onto the resident's lap near her right hand.</p> <p>On 5/2/17 at 1:32 pm, Certified Nursing Assistant [CNA] #4 stated Resident #9 was dependent on staff for all her needs. As CNA #4 and CNA #3 assisted Resident #9 into her bed, the call light was observed above her left shoulder near the pillow. Resident #9's left hand was observed contracted.</p> <p>On 5/2/17 at 2:49 pm, Resident #9 was observed in bed with the call light located in the same position above her left shoulder near her pillow.</p> <p>On 5/4/17 at 1:30 pm, the Director of Nursing Services [DNS] stated Resident #9 had a decreased ability to talk and required total care.</p> <p>On 5/4/17 at 2:30 pm, the DNS stated Resident #9 could not reach her call light when it was located above her shoulder on the left side. She stated residents should be able to access call lights to summon staff for assistance.</p> <p>2. Resident #16 was admitted to the facility on 9/26/16, with diagnoses which included heart failure, diabetes, and depression.</p> <p>Resident #16's quarterly MDS assessment, dated 4/5/17, documented she was cognitively intact and required extensive assistance with cares.</p>	F 246		

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F 246	<p>Continued From page 4</p> <p>On 5/1/17 from 1:00 pm through 1:25 pm, Resident #16's hallway call light was observed on. At 1:25 pm, the call light was answered by a staff member who assisted her to the commode. Resident #16 was told to turn the call light back on when she was finished. At 1:35 pm, Resident #16 turned on her call light, which staff responded to at 1:45 pm.</p> <p>Resident #16 was assisted to the bathroom 25 minutes after she initiated a call light request for assistance.</p> <p>3. Resident #17 was admitted to the facility on 8/13/16, with diagnoses which included anemia, multi-drug resistant organism, asthma, and a fracture.</p> <p>Resident #17's significant change MDS assessment, dated 4/18/17, documented he was cognitively intact and required extensive assistance with cares.</p> <p>On 5/2/17 from 8:29 am to 8:48 am, Resident #17's call light was observed on. At 8:35 am, CNA #4 told CNA #3 to answer Resident #17's call light "after" taking his/her break. CNA #3 returned from break at 8:48 am and provided Resident #17 with assistance, 19 minutes after Resident #17 requested assistance.</p> <p>4. Resident #8 was re-admitted to the facility on 2/3/17, with diagnoses which included major depression, schizoaffective disorder, and bipolar disorder.</p> <p>Resident #8's 2/23/17 quarterly MDS assessment documented she had no cognitive impairment</p>	F 246			

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F 246	Continued From page 5 and showed minimal signs of depression. On 5/4/17 at 3:26 pm, Resident #8 stated she was happy in the facility, except for call lights which she stated took staff sometimes up to 30 minutes to answer. Resident #8 stated slow staff response times to call lights usually occurred during the lunch hour or shift changes when staff were "busy doing their jobs." On 5/4/17 at 5:00 pm, RCM #1 stated call lights should be answered as soon as possible and that 15 minutes was the maximum time residents should have to wait for staff to respond to a call light. RCM #1 stated she had recently educated staff on answering call lights before going on break. On 5/4/17 at 5:25 pm, the DNS stated call lights should be answered as soon as possible and that 5-10 minutes was an acceptable wait time. She stated staff should not go on breaks before answering call lights so residents did not wait for their needs to be met.	F 246			
F 279 SS=E	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans	F 279		6/7/17	

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F 279	Continued From page 6 (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 279			

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F 279	<p>Continued From page 7</p> <p>community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, facility guidelines, and record review, it was determined the facility failed to develop a resident-specific care plan for a residents receiving psychoactive medications. This was true for 9 of 11 residents (#1 through #9) sampled for care plan development. The deficient practice had the potential to cause more than minimal harm if residents experienced continued depression or a deterioration in mental health status. Findings include:</p> <p>The facility's Psychotropic Management Guideline, dated October 2015, documented that residents receiving psychotropic medication would:</p> <ul style="list-style-type: none"> * Have a supporting diagnosis and target behavior(s) for use * Receive daily monitoring for possible side-effects and effectiveness of medication therapy. <p>This policy was not followed. Examples include:</p> <p>1. Resident #5 was admitted to the facility on 8/13/14, and readmitted on 4/26/17, with multiple diagnoses, which included major depressive disorder with psychotic features.</p>	F 279	<p>F 279</p> <p>Residents: Residents # 5's care plan was revised to include interventions for staff to manage behaviors if observed and to include individualized target behaviors for which the antipsychotic medication was used. Resident #6's care plans was revised to include individualized target behaviors for which the antidepressant medication was ordered. Resident #7's care plan was revised to provide target behaviors for the antipsychotic and antidepressant medications used as well as how to manage observed behaviors. Resident #1's care plan was revised to include resident specific signs and symptoms of depression as well as individualized target behaviors and interventions for any exhibited signs of anxiety. Residents # 3, 4 and 8's care plans were revised to include individualized signs and symptoms of depression. Resident # 2's care plan was revised to include individualized target behaviors for which the antianxiety medication was ordered. Resident #9's care plan was revised to include resident</p>		

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F 279	<p>Continued From page 8</p> <p>Resident #5's MDS assessment, dated 2/22/17, documented Resident #5 was cognitively intact with minimal depression.</p> <p>Recapitulated Physician Orders for May 2017 documented Resident #5 received Abilify [antipsychotic] 15 mg at bedtime, Sertraline [antidepressant] 150 mg in the morning, and Trazodone [antidepressant] 100 mg at bedtime.</p> <p>Resident #5's Care Plan, dated 12/2/14 and revised 4/5/17, documented Resident #5 received antidepressant medication related to a diagnosis of major depression and directed staff to monitor behaviors to assist in assuring the lowest possible therapeutic dose, and to monitor for withdrawal, decreased activity attendance, decreased appetite, and verbalizations of feeling down. It did not direct staff how to manage those behaviors if observed.</p> <p>Resident #5's Care Plan also documented Resident #5 received antipsychotic medication related to behavior management for major depressive disorder. Staff were directed to monitor/document side effects and effectiveness of the medication. The care plan did not provide individualized target behaviors for which the antipsychotic medication was used.</p> <p>On 5/3/17 at 12:00 pm, the DNS [Director of Nursing Services] stated she was unaware the resident-specific target behaviors and interventions were on the TAR, but generalized on the care plan. The DNS said the care plan should be resident-specific, as well.</p>	F 279	<p>specific signs and symptoms of depression as well as target behaviors to monitor for.</p> <p>Other Residents: All residents that receive psychoactive medications care plans were reviewed for individualized target behaviors and interventions. Any that were in need of revision were updated.</p> <p>Systemic Changes: At the time of admission, residents receiving psychotropic medications will be reviewed for appropriate diagnoses, target behaviors and interventions for any behaviors observed and they will be documented in their comprehensive care plan. These will be reviewed on a quarterly basis through psychotropic med review and CP review for possible GDR, appropriate diagnoses and target behaviors. Educated RCMs and social services to this process.</p> <p>Monitoring: DNS or designee will audit care plans on a weekly basis for psychoactive medications, supporting diagnoses, target behaviors and interventions and report findings to QA committee for 3 months.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 279	<p>Continued From page 9</p> <p>2. Resident #6 admitted to the facility on 2/21/17 with multiple diagnoses which included depression.</p> <p>Physician Orders, dated 2/21/17, documented Resident #6 was to receive Lexapro [antidepressant] 20 mg each morning for depression.</p> <p>The 4/6/17 MDS documented Resident # 6 was cognitively intact with minimal depression.</p> <p>A Care Plan, dated 4/5/17, documented Resident #6 received antidepressant medication related to depression and directed staff to report symptoms of depression to Social Services and to monitor for side effects and effectiveness. The care plan did not provide individualized target behaviors for which the antidepressant medication was ordered.</p> <p>On 5/3/17 at 12:00 pm, the DNS stated she was unaware the resident-specific target behaviors and interventions were on the TAR [Treatment Administration Record], but generalized on the care plan. The DNS said the care plan should be resident-specific, as well.</p> <p>3. Resident #7 admitted to the facility on 11/11/16, with multiple diagnoses which included major depressive disorder.</p> <p>A Physician Order, dated 11/11/16, documented Resident #7 was to receive Aripiprazole [antipsychotic] 5 mg and Celexa [antidepressant] 20 mg each morning for major depressive disorder.</p>	F 279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 279	<p>Continued From page 10</p> <p>A Care Plan, dated 11/19/16, and revised 1/11/17, documented Resident #7 received antipsychotic medication related to behavior management. Staff were directed to monitor/document for side effects and effectiveness. The care plan documented a list of potential side effects, but did not provide target behaviors for which the antipsychotic medication was used.</p> <p>A Care Plan, dated 11/14/16 and revised 1/11/17, documented Resident #7 received antidepressant medication related to depression and directed staff to monitor, document, and report to the physician ongoing signs and symptoms of depression unaltered by the antidepressant medications. The intervention listed 25 potential behaviors, but did not provide individualized target behaviors for which the antidepressant medication was used or management of observed behaviors.</p> <p>On 5/3/17 at 12:00 pm, the DNS stated she was unaware the resident-specific target behaviors and interventions were on the TAR, but generalized on the care plan. The DNS said the care plan should be resident-specific, as well.</p> <p>4. Resident #1 was admitted to the facility on 1/8/15 with multiple diagnoses, including anxiety and depression.</p> <p>a. The quarterly MDS assessment, dated 4/19/17, documented Resident #1 experienced mild depression with no anxiety-related behaviors exhibited.</p> <p>Recapitulated May 2017 Physician Orders</p>	F 279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 279	<p>Continued From page 11</p> <p>documented Resident #1 received Fluoxetine HCL [Prozac-antidepressant] 20 mg daily for depressive disorder, initiated 7/31/16.</p> <p>Resident #1's current care plan, revised 4/17/17, documented a goal of, "Resident will be free from adverse reactions related to antidepressant therapy through the review date of 7/26/17." I interventions included:</p> <ul style="list-style-type: none"> * Staff were to monitor, document, and report to the physician and Registered Nurse ongoing signs and symptoms of depression unaltered by antidepressant medications. * Staff were to monitor side effects and effectiveness of the antidepressant, and whether the resident exhibited an unsteady balance; the pharmacist was to review Resident #1's drug regime every month. <p>The care plan did not include resident-specific signs and symptoms of depression for staff to monitor and report to the physician or Registered Nurse.</p> <p>b. Recapitulated May 2017 Physician Orders documented Resident #1 was to receive Buspirone HCL [Buspar-antianxiety medication] 15 mg twice daily for anxiety, initiated 11/19/15.</p> <p>Resident #1's current care plan, revised 1/7/16, documented a goal of, "The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy through the next review date of 7/26/17." Interventions included:</p> <ul style="list-style-type: none"> * Staff were to monitor behaviors to assist in 	F 279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 279	<p>Continued From page 12 assuring the lowest effective dose.</p> <p>* Staff were to monitor and document side effects and effectiveness of antianxiety medications per Physician Order.</p> <p>Resident #1's May 2017 TAR provided specific target behaviors and interventions for licensed staff to monitor and document when Resident #1 exhibited behaviors related to anxiety.</p> <p>The care plan did not include resident-specific target behaviors for staff to monitor and interventions staff were to initiate if Resident #1 exhibited signs of anxiety.</p> <p>On 5/3/17 at 12:00 pm, the DNS stated she was unaware the resident-specific target behaviors and interventions were on the TAR, but generalized on the care plan. The DNS said the care plan should have been resident-specific, as well.</p> <p>5. Resident #3 was admitted to the facility on 8/24/16, and re-admitted to the facility on 3/24/17, with multiple diagnoses, including cellulitis, diabetic foot ulcers, and depression.</p> <p>Resident #3's quarterly MDS assessment, dated 3/3/17, documented Resident #3 experienced mild depression with no behaviors exhibited.</p> <p>An NP [Nurse Practitioner] Progress Note, dated 4/19/17, documented Resident #3 was more depressed and at times wanted to "give up" and other times wanted to "keep fighting." The NP documented an assessment and plan for palliative care, hospice, or increasing the</p>	F 279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 279	<p>Continued From page 13</p> <p>antidepressant to help with Resident #3 with her mood and feeling depressed. Resident #3 decided to have the Zoloft increased and the NP was to re-evaluate in a month or two.</p> <p>A Physician's Order, dated 4/19/17, documented an increase in Zoloft [antidepressant] from 50 mg daily to 100 mg daily for 7 days, initiated 4/20/17, then another increase in Zoloft to 150 mg daily, initiated 4/27/17, for major depression.</p> <p>The current care plan, revised 1/5/17, documented a goal of, "The resident will be free from discomfort or adverse reactions related to antidepressant therapy and the resident will show decreased episodes of s/sx (signs/symptoms) of depression through the review date of 6/6/17." Interventions included:</p> <ul style="list-style-type: none"> * Staff were to monitor behaviors to assure the lowest possible therapeutic dose. *Staff were to monitor, document, and report to the physician, as needed, ongoing s/sx of depression unaltered by antidepressant medication. * Pharmacist to review drug regime quarterly. <p>The care plan did not include resident-specific signs and symptoms of depression for staff to monitor and report to the physician or nurse.</p> <p>On 5/3/17 at 11:30 am, the LSW was unable to identify resident-specific target behaviors on Resident #3's care plan.</p> <p>6. Resident #4 was readmitted to the facility on</p>	F 279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 279	<p>Continued From page 14 2/3/16 with multiple diagnoses, including depression and pain.</p> <p>The quarterly MDS assessment, dated 4/5/17, documented Resident #4 had minimal depression with no behaviors.</p> <p>Physician Orders, dated 5/4/17, documented Resident #4 was to receive Duloxetine HCL [Cymbalta-antidepressant medication] 60 mg daily for chronic pain and major depression.</p> <p>Resident #4's current care plan, revised 10/20/15, documented a goal of, "Patient will show decreased episodes of s/sx of depression and will be free from discomfort or adverse reactions related to antidepressant therapy through the review date of 6/8/17." Interventions included:</p> <ul style="list-style-type: none"> * Staff were to monitor behaviors to assure the lowest possible therapeutic dose. * Staff were to monitor, document, and report behaviors to the physician or nurse for ongoing s/sx of depression unaltered by antidepressant medications. * Staff were to monitor for side effects and effectiveness of the antidepressant therapy. <p>The care plan did not include resident-specific signs and symptoms of depression for staff to monitor and report to the physician or nurse.</p> <p>On 5/2/17 at 3:30 pm, the DNS, RCNA, and LSW said the facility did not monitor behaviors or effectiveness for antidepressants. The RCNA</p>	F 279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 279	<p>Continued From page 15</p> <p>said nurses chart in the nurse's notes if a resident experienced a change in behavior.</p> <p>7. Resident #8 was re-admitted to the facility on 2/3/17 with diagnoses which included major depression, schizoaffective disorder, and bipolar disorder.</p> <p>Resident #8's 2/23/17 quarterly Minimum Data Set [MDS] assessment documented no cognitive impairment and minimal signs of depression.</p> <p>Resident #8's Physician Orders, dated 12/21/16, documented she was to receive Lexapro [antidepressant] 20 milligrams [mg] each morning for depression.</p> <p>Resident #8's Antidepressant Care Plan, dated 8/16/16, documented she received an antidepressant related to depression and that staff were to "monitor side effects and effectiveness," and document, as well as report "ongoing" signs and symptoms of depression to the physician.</p> <p>Resident #8's care plan did not document resident-specific signs and symptoms of depression for staff to monitor and report to the physician.</p> <p>On 5/3/17 at 12:00 pm, the DNS stated she was unaware the resident-specific target behaviors and interventions were on the TAR, but generalized on the care plan. The DNS said the care plan should have been resident-specific, as well.</p> <p>8. Resident #2 was admitted to the facility on</p>	F 279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 279	<p>Continued From page 16 6/22/16, with diagnoses which included major depressive disorder and dementia.</p> <p>Resident #2's quarterly MDS assessment, dated 3/21/17, documented severe cognitive impairment with signs of mild depression.</p> <p>Resident #2's Physician Orders, dated 3/5/17, documented she was to receive Ativan [antianxiety] 0.5 mg every 6 hours as needed for agitation.</p> <p>Resident #2's Anti-anxiety Care Plan, dated 3/20/17, documented staff were to "monitor side effects and effectiveness." The care plan did not document Resident #2's identified "anxiety behaviors" that were to be monitored.</p> <p>On 5/4/17 at 2:05 pm, the Director of Nursing Services stated Resident #2's anxiety presented as exit seeking, wandering, and fearfulness and that those signs/symptoms should have been documented on the care plan.</p> <p>9. Resident #9 was readmitted to the facility on 1/24/17 with diagnoses which including Multiple Sclerosis [MS - progressive neurological disease], convulsions, bipolar disorder, anxiety, and major depression.</p> <p>Resident #9's Significant Change MDS assessment, dated 4/8/17, documented severe cognitive impairment. The Mood Section of the MDS was not completed. The MDS documented she was totally dependent on, or required extensive assistance from, staff with all cares, including locomotion. The MDS documented she did not exhibit behaviors of wandering or</p>	F 279			

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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 279	<p>Continued From page 17 rejection of cares.</p> <p>The Care Area Assessment for the 4/8/17 MDS, dated 4/17/17, did not document the Mood section was triggered. On 5/4/17 at 2:05 pm, the DNS stated the Mood Section should have been completed by staff or with the resident.</p> <p>a. Resident #9's Physician Orders, dated 1/24/17, documented she was to receive Lexapro [antidepressant] 10 mg two times a day related to bipolar disorder and major depression, and Lamictal [anticonvulsant] 150 mg two twice daily for bipolar disorder, anxiety, and major depression.</p> <p>Resident #9's Depression Care Plan, revised 4/27/17, documented she received two antidepressant Lexapro and Lamictal, related to depression. Staff were to "monitor side effects and effectiveness" beginning 8/24/16. Staff were to also monitor, document, and report "ongoing" signs and symptoms of depression to the physician, initiated 8/24/16.</p> <p>Resident #9's Depression Care Plan did not documented resident-specific signs and symptoms of depression staff were to monitor and report to the physician.</p> <p>b. Resident #9's Physician Orders, dated 1/24/17, documented she was to receive Seroquel [antipsychotic] 300 mg at bedtime related to bipolar disorder.</p> <p>Resident #9's Behavior Management Care Plan, revised 4/27/17, documented she received Seroquel for behaviors and that staff were to</p>	F 279			

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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 279	Continued From page 18 "monitor side effects and effectiveness," initiated 8/24/16. The care plan documented staff was to also monitor Resident #9's "behaviors," initiated 8/24/16; however, Resident #9's Behavior Management Care Plan did not identify resident-specific behaviors staff was to monitor.	F 279			
F 280 SS=D	On 5/4/17 at 2:21 pm, the DNS stated Resident #9's targeted behaviors should have been documented on the care plan. 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the	F 280		6/7/17	

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F 280	<p>Continued From page 19</p> <p>right to participate in his or her treatment and shall support the resident in this right. The planning process must--</p> <p>(i) Facilitate the inclusion of the resident and/or resident representative.</p> <p>(ii) Include an assessment of the resident's strengths and needs.</p> <p>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.</p> <p>483.21</p> <p>(b) Comprehensive Care Plans</p> <p>(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident</p>	F 280			

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F 280	<p>Continued From page 20 and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents' care plans were revised to reflect their current behavioral status, level of assistance required for activities of daily living [ADLs], frequency of catheter changes, time frames for use of hand orthotics, and nutritional status. This was true for 2 of 11 residents (#7 and #9) sampled for care plan revision. This had the potential to cause harm if residents did not receive appropriate care and interventions due to outdated and/or incomplete information on their care plans. Findings include:</p> <p>1. Resident #9 was readmitted to the facility on 1/24/17, with diagnoses that included Multiple Sclerosis [MS-progressive neurological disorder], convulsions, neurogenic bladder, and anxiety.</p> <p>a. Antianxiety Care Plan:</p> <p>Resident #9's Significant Change [Minimum Data Set] MDS assessment, dated 4/8/17, documented she experienced severe cognitive</p>	F 280	<p>F 280</p> <p>Residents: Resident # 9's care plan was updated to include resident specific behaviors, amount of assistance required for ADLs, how often to change their suprapubic catheter and parameters for when to use the blue cone, who was to place it and how to monitor the skin under it. Resident # 7's care plan was updated to remove any reference to a PEG tube.</p> <p>Other Residents: All resident's behavior care plans were reviewed and updated if needed to include resident specific behaviors. All resident's ADLs care plans were reviewed and revised if required assistance was no longer accurate and to include how they receive nutrition. All residents with indwelling catheters care plans were reviewed and revised if needed to include frequency of changing. All residents utilizing a hand orthotic care plans were reviewed and</p>		

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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 280	<p>Continued From page 21</p> <p>impairment, and was totally dependent, or required extensive assistance from, staff with all cares. The MDS documented Resident #9 did not wander or resist cares.</p> <p>Resident #9's Physician Orders, dated 3/25/17, documented staff was to provide Ativan 0.25 mL every 2 hours as needed for anxiety/agitation.</p> <p>Resident #9's Anxiety Care Plan, revised 4/24/17, documented staff was to give the anti-anxiety medication to Resident #9 and "monitor side effects and effectiveness," initiated 8/24/16. The care plan identified staff were to monitor and document occurrences of "pacing, wandering, disrobing, inappropriate response to verbal communication, and violence/aggression towards staff and others," initiated on 8/24/16.</p> <p>On 5/1/17 from 12:49 pm to 3:50 pm, Resident #9 was observed sitting in her room and watching television [TV]. Staff wheeled out of her room for a short period of time for an appointment at 1:30 pm, and returned her her room at 1:40 pm. Resident #9 was tapping her hand against the bed throughout the observation. Staff interacted with Resident #9 throughout the observation and Resident #9 would smile and nod her head as staff greeted her.</p> <p>On 5/1/17 at 3:50 pm, the Licensed Social Worker [LSW] stated Resident #9 was chair, or bed, bound and required staff assistance with all cares. The LSW stated Resident #9's ability to communicate had decreased recently and she was unable to talk.</p> <p>On 5/4/17 at 1:30 pm, the Director of Nursing</p>	F 280	<p>revised if required to include when and where the hand orthotic was to be in place, who was to place and remove and how to monitor skin underneath it for any impairment.</p> <p>Systemic Changes: Care plans are reviewed quarterly and prn to ensure they are revised to include the residents' current behavioral status, level of assistance for ADLs, frequency of catheter changes, time frames for use of hand orthotics, and nutritional status. Educated RCMs to this process.</p> <p>Monitoring: DNS or designee will audit care plans on a weekly basis for accuracy and report findings to QA committee for 3 months.</p>		

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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 280	<p>Continued From page 22</p> <p>Services [DNS] stated Resident #9 experienced a decreased ability to talk and required total care. She stated the behaviors identified on the Care Plan were not consistent with Residents #9's current health status.</p> <p>b. Activities of Daily Living [ADLs] Care Plan:</p> <p>Resident #9's Significant Change MDS assessment, dated 4/8/17, documented severe cognitive impairment, contractures and/or range-of-motion impairments with both upper and lower extremities, and total dependence on staff for personal hygiene cares.</p> <p>Resident #9's ADL Care Plan, revised 4/29/16, documented an intervention that she required constant supervision with physical assistance with personal hygiene activities, initiated 6/12/15.</p> <p>On 5/1/17 at 3:50 pm, the LSW stated Resident #9 was chair, or bed, bound and required staff assistance with all cares. At 1:32 pm, Certified Nursing Assistant [CNA] #4 stated Resident #9 was dependent on staff for everything she needed.</p> <p>On 5/4/17 at 1:30 pm, the DNS stated Resident #9 experienced a decreased ability to talk and required total care.</p> <p>c. Catheter Care Plan:</p> <p>Resident #9's Significant Change MDS assessment, dated 4/8/17, documented use of a suprapubic catheter.</p> <p>Resident #9's Physician's Orders, dated 1/31/17,</p>	F 280			

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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 280	<p>Continued From page 23 documented the catheter was to be changed at an out-of-facility location.</p> <p>Resident #9's Catheter Care Plan, revised 9/21/16, did not document how often Resident #9's catheter was to be changed by the out-of-facility provider.</p> <p>d. Chronic Pain Care Plan:</p> <p>Resident #9's Significant Change MDS assessment, dated 4/8/17, documented severe cognitive impairment and contractures and/or range-of-motion impairments with both upper and lower extremities.</p> <p>Resident #9's Chronic Pain Care Plan, revised 12/29/16, documented chronic pain related to a contracted left hand that staff was to "stretch" and apply a "blue cone" to help prevent further loss of range-of-motion, initiated 9/21/16. The care plan did not document time parameters for the use of the cone; proper placement of the cone; who was to place it; and how the hand and skin under the cone was to be monitored.</p> <p>An Occupational Therapy Note, dated 2/1/17, documented facility staff was trained on how to use the blue cone and how to position the cone into Resident #9's hand.</p> <p>On 5/1/17 from 12:49 pm to 2:36 pm, Resident #9 was observed without the cone in her left hand. At 2:36 pm, Resident Care Manager [RCM] #1 was observed placing the cone into Resident #9's left hand.</p> <p>On 5/2/17 from 8:07 am to 12:40 pm, and from</p>	F 280			

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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 280	<p>Continued From page 24 1:24 pm to 2:49 pm, Resident #9 was observed without the cone in her left hand.</p> <p>On 5/4/17 at 2:21 pm, the DNS stated she did not know how often the cone was to be in Resident #9's left hand. She stated the care plan should have specified time parameters for the cone's use.</p> <p>On 5/4/17 at 6:06 pm, the DNS stated Occupational Therapy recommended Resident #9 use the "blue cone" and that staff would be educated on its use. She stated a staff in-service on Resident #9's use of the cone was completed on 1/30/17.</p> <p>On 5/4/17 at 1:30 pm, the DNS stated care plans should be updated any time there were changes with residents' needs or cares and if residents' care-planned interventions are not current then interventions should be resolved and new interventions added to the care plan.</p> <p>2. Resident #7 was admitted to the facility on 10/27/16, with multiple diagnoses which included protein-calorie malnutrition.</p> <p>The Minimum Data Set assessment, dated 2/1/17, documented Resident #7 was independent with meals after set-up.</p> <p>Resident #7's 11/14/17 Care Plan documented total dependence with eating via a percutaneous endoscopic gastostomy [PEG] tube and required set-up assistance only for oral intake.</p> <p>Nutrition delivery via PEG tube was discontinued on 3/30/17, and the tube removed on 4/14/17.</p>	F 280			

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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 280	Continued From page 25 On 5/2/17 at 8:15 am, Resident #7 was observed in bed with breakfast in her room with a sign attached to the overbed light directing staff to keep the head of the bed at 30 degrees. Resident #7 stated "The tube is out; I am just eating food now." On 5/4/17 at 2:00 pm, the Director of Nursing stated Resident #7's PEG tube had been removed and the care plan should have been updated.	F 280			
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, policy review, and record review, it was determined the facility failed to ensure residents' neurologic assessments were completed after unwitnessed falls. This was true for 1 of 3 residents (#2) reviewed for falls. Failure to complete assessments of Resident #2's neurological status placed her at risk for more than minimal harm if a change in her neurologic status was undetected. Findings include: The facility's Fall Policy and Procedure documented staff was to observe residents for "48 hours after an observed or suspected fall,	F 281	F281 Residents: Resident # 2 was assessed and has not exhibited any neurological changes. Other Residents: Reviewed the medical records of all residents who had an unwitnessed fall or a fall with a head injury in the last 14 days for completion of neurological assessments. If any were incomplete, the resident was assessed to rule out any potentially missed latent injuries and if any signs of latent injuries	6/7/17	

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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 281	<p>Continued From page 26 and will document findings in the medical record." The policy documented nursing staff "shall assess and document/report...vital signs...neurological status...all current medications especially those associated with dizziness or lethargy."</p> <p>1. Resident #2 was admitted to the facility on 6/22/16, with diagnoses which included difficulty walking, muscle wasting, major depressive disorder, and dementia.</p> <p>The quarterly Minimum Data Set [MDS] assessment, dated 3/21/17, documented Resident #2 was severely cognitively impaired and had experienced 2 or more falls without major injury prior to the previous MDS assessment.</p> <p>Resident #2's Fall Care Plan, revised 11/16/16, documented she was a high fall risk related to multiple falls, advanced dementia, and impulsivity. Interventions included:</p> <ul style="list-style-type: none"> * Staff was to encourage Resident #2 to lie down and rest in the afternoon. * Staff was to monitor Resident #2 for compliance with using her front wheeled walker or wheel chair for all ambulation. * Staff was to keep Resident #2 in their "line of sight as often as possible when she is up." * Resident #2 was to wear non-skid foot wear at all times. * Staff was to update fall risk assessments 	F 281	<p>were noted, the MD was notified.</p> <p>Systemic Changes: When a resident experiences an unwitnessed fall or a fall with a head injury, they are assessed by a licensed nurse for any injuries including a neurological assessment. They are observed for at least 48 hours post fall and their assessment, vital signs and neurological status documented. These follow up assessments are completed even when asleep. During shift to shift report, the neurological assessment flow sheets are reviewed for completion with oncoming shift nurse. Licensed nursing staff educated regarding importance of completing neurological assessments.</p> <p>Monitoring: DNS or designee will audit unwitnessed falls or falls with head injuries weekly for completion of neurological assessments and report these findings to the QA committee for 3 months.</p>		

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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 281	<p>Continued From page 27</p> <p>"quarterly, post any fall, and PRN [as needed]."</p> <p>* Staff was to provide 2-3 "offers" to toilet at night.</p> <p>a. An Incident Report, dated 3/4/17 at 1:57 pm, documented Resident #2 was found by a CNA on the ground sitting in the bathroom door way. The report documented she was wearing socks, incontinent, and had experienced an unwitnessed fall.</p> <p>Resident #2's Neurological Assessment for the 3/4/17 fall documented staff completed neurological assessments with the exception of 2 entries. The reason for one missing entry, on 3/4/17 was "Resident sleeping," and no reason was given for the other entry, on 3/5/17. The Neurological assessment was to be completed for 2 days; 3/4/17 and 3/5/17 per facility policy.</p> <p>b. An Incident Report, dated 3/14/17 at 4:36 am, documented Resident #2 was found by a CNA and a nurse at 4:10 am on her hands and knees. The nurse asked Resident #2 if she hit her head and Resident #2 stated, "I don't know." The Report documented Resident #2 was wearing non-skid socks and trying to go to the bathroom. The Report documented Resident #2 had an abrasion to her elbow and that the incident was an unwitnessed fall.</p> <p>Resident #2's Neurological Assessment for the 3/14/17 fall documented staff completed neurological assessments with the exception of 3 missing entries and 2 incomplete entries. The reason documented for the 3 missing entries on 3/15/17 was that Resident #2 was "asleep." The 2 incomplete entries on 3/15/17 did not include</p>	F 281			

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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 281	<p>Continued From page 28</p> <p>an explanation. The neurological assessment was to be completed for 2 days, 3/14/17 and 3/15/17, per facility policy.</p> <p>c. An Incident Report, dated 3/24/17 at 6:33 pm, documented Resident #2 fell in the dining room after she attempted to pick up a tissue on the floor. The Report documented after she picked up the tissue and was attempting to sit down in her wheelchair, Resident #2 missed the chair and landed on the ground. The Report documented there were no witnesses to this fall.</p> <p>Resident #2's clinical record did not contain a neurological assessment for the 3/24/17 fall.</p> <p>d. An Incident Report, dated 4/21/17 at 5:36 pm, documented Resident #2 fell in the dining room after she attempted to stand up and get herself water. The Report documented she was found on her back and denied hitting her head. The Report documented there were no witnesses for this fall.</p> <p>Staff completed neurological assessments for the 4/21/17 fall with the exception of 6 missing entries. "Eating" was the explanation given for a missing entry on 4/21/17; no explanation was provided for 5 missing entries on 4/22/17. The neurological assessment was completed for 4 days; 4/21/17 through 4/24/17 per the neurological assessment document.</p> <p>On 5/3/17 at 3:50 pm, the Director of Nursing Services stated she expected staff to complete neurological checks for at least 48 hours following an unwitnessed fall or fall with head injury. She said Resident #2 was impulsive, exit seeking, and wandered often. The DNS stated</p>	F 281			

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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 281	Continued From page 29 staff was to keep Resident #2 in their line-of-sight as much as possible.	F 281			
F 285 SS=D	<p>The facility failed to ensure neurological assessments to assess Resident #2 for injury were consistently completed following four unwitnessed falls.</p> <p>483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR</p> <p>(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:</p> <p>(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.</p> <p>(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.</p> <p>(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.</p> <p>(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:</p> <p>(i) Mental disorder as defined in paragraph (k)(3) (i) of this section, unless the State mental health</p>	F 285		6/7/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
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F 285	<p>Continued From page 30</p> <p>authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services; or</p> <p>(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.</p> <p>(2) Exceptions. For purposes of this section-</p> <p>(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.</p> <p>(ii) The State may choose not to apply the</p>	F 285			

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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 285	<p>Continued From page 31</p> <p>preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-</p> <p>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,</p> <p>(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and</p> <p>(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.</p> <p>(3) Definition. For purposes of this section-</p> <p>(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).</p> <p>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.</p> <p>(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it</p>	F 285			
			F 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 285	Continued From page 32 was determined the facility failed to ensure Pre-Admission Screening and Resident Reviews (PASRR) were complete and accurate for 1 of 15 sampled residents (Resident #8) reviewed for PASRRs. The deficient practice had the potential to cause more than minimal harm if residents required, but did not receive, specialized services for mental health needs while residing in the facility. Findings include: Resident #8 was readmitted to the facility on 2/3/17, with diagnoses which included major depression and schizoaffective and bipolar disorders. Resident #8's PASRR, dated 2/3/17, included the question, "Does the individual have any of the following Major Mental Illnesses (MMI)? Check all that apply." Depression was checked and bipolar disorder was not. On a prior PASRR, dated 8/11/16, bipolar disorder was checked and depression was not. Depression was checked on Resident #8's PASRR dated 2/3/17; bipolar disorder was not checked. On 5/2/17 at 12:30 pm, Medical Record's Personnel #1 stated the two PASRRs had inconsistent information and she stated the Director of Nursing Services [DNS] would be able to verify which diagnoses Resident #8 were current and accurate. At 3:23 pm, the DNS stated Resident #8 experienced bipolar disorder. On 5/4/17 at 2:04 pm, the DNS stated Resident #8's 2/3/17 PASRR was incorrect and would be updated with the correct diagnosis.	F 285	Resident: Resident # 8's PASRR was updated. Other Residents: Resident's PASRRs were audited for completion and accuracy and updated as needed. Systemic Changes: All resident's PASRR are reviewed prior to and upon admission for accuracy and upon readmission by social services. Social services audits all PASRRs quarterly for accuracy. Education provided to social services, admissions coordinator, medical records director and RCMs how to validate accuracy of PASRR paper work. Monitoring: DNS or designee will audit 3 PASRR's weekly for accuracy and report findings to the QA committee for 3 months.		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318		6/7/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
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F 318	<p>Continued From page 33</p> <p>(c) Mobility.</p> <p>(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents with limited range-of-motion [ROM] and contractures received necessary services to prevent further decline in ROM. This was true 1 of 7 residents (#9) reviewed for limited ROM. This deficient practice created the potential for further decline in functional range-of-motion for Resident #9. Findings include:</p> <p>Resident #9 was readmitted to the facility on 1/24/17, with diagnoses that included Multiple Sclerosis [MS-progressive neurological disorder] and convulsions.</p> <p>Resident #9's Significant Change Minimum Data Set [MDS] assessment, dated 4/8/17, documented she had severe cognitive impairment, and contractures or range-of-motion impairments with both upper and lower extremities.</p> <p>A Chronic Pain Care Plan, revised 12/29/16,</p>	F 318	<p>F 318</p> <p>Resident: Resident #9 assessed and placed on ROM program that resident can tolerate and care plan updated to reflect when to apply, for how long and who is to apply and check skin.</p> <p>Other Residents: Residents with limited ROM were reviewed to ensure they receive appropriate treatment and services to increase ROM and/or to prevent further decrease in ROM.</p> <p>Systemic Changes: When therapy recommends the use of a hand orthotic, they give clear direction as to when to apply and for how long. RCM or restorative nurse then adds intervention to the resident's care plan in order to provide clear direction to the staff. Education provided to RCMs and restorative nurse to this process and on</p>		

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F 318	<p>Continued From page 34</p> <p>documented Resident #9 experienced chronic pain related to a contracted left hand that staff was to "stretch" and apply a "blue cone" to help prevent further worsening, initiated 9/21/16.</p> <p>A Carrot [cone] Splint In-Service, dated 1/30/17, documented Resident #9 was to wear the left carrot splint during the day as she allowed. The in-service documented the narrow end of the carrot was to be located on the thumb side and included a picture illustrating its proper positioning. In addition, the in-service documented Resident #9's left hand was to be washed and dried "thoroughly" each day with soap and warm water.</p> <p>An Occupational Therapy Note, dated 2/1/17, documented facility staff was trained on how to use the blue cone (carrot) and how to position the cone in Resident #9's hand.</p> <p>Resident #9's 2/1/17 through 3/8/17 Restorative Nursing Program did not include documentation after 3/9/17. No records documenting carrot/cone usage was provided for April or May 2017.</p> <p>Resident #9's 4/25/17 Certified Nursing Assistant [CNA] Cardex documented CNAs were to perform hand hygiene and apply lotion to Resident #9's left hand before placing the cone/carrot.</p> <p>Resident #9's Physician Orders did not discontinue use of the the blue cone.</p> <p>On 5/1/17 from 12:49 pm to 2:36 pm, Resident #9 was observed without the cone in her left hand, which was contracted. At 2:36 pm,</p>	F 318	<p>identifying residents with potential need for ROM program and implementation of ROM program to either increase ROM and/or to prevent further decrease in ROM.</p> <p>Monitoring: DNS or designee will audit care plans of residents with limited ROM to ensure ROM programs are in place and then visualize those residents to ensure programs are being completed and report findings to QA committee for 3 months.</p>		

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F 318	Continued From page 35 Resident Care Manager [RCM] #1 was observed placing the cone/carrot into Resident #9's left hand. On 5/2/17 from 8:07 am to 12:40 pm, and from 1:24 pm to 2:49 pm, Resident #9 was observed without the cone/carrot in her left hand. On 5/4/17 at 6:06 pm the DNS stated Occupational Therapy recommended Resident #9 use the cone/carrot. She stated staff had been educated on the resident's use of the cone/carrot on 1/30/17.	F 318			
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 323		6/7/17	

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F 323	Continued From page 36 (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, it was determined the facility failed to ensure residents who fell were thoroughly reassessed, additional protections put in place to reduce the potential for repeated falls, and were provided supervision necessary to prevent falls. This was true for 1 of 3 residents (#2) reviewed for falls. This deficient practice created the potential for harm should Resident #2 fall and sustain bone fractures, concussions, internal injuries, or other serious injuries due to a lack of fall assessment and/or supervision. Findings include: Resident #2 was admitted to the facility on 6/22/16 with diagnoses that included difficulty walking, muscle wasting, and dementia. Resident #2's quarterly Minimum Data Set [MDS] assessment, dated 3/21/17 documented she was severely cognitively impaired and had experienced 2 or more falls without major injury prior to the previous MDS assessment. Resident #2's Fall Care Plan, revised 11/16/16, documented she was at high risk for falls due to having sustained multiple falls, having advanced dementia, and her impulsivity. Staff were to: * Encourage Resident #2 to lie down and rest in the afternoon. * Monitor Resident #2 for compliance using a front-wheeled walker or wheelchair when	F 323	F 323 Resident: Resident #2 provided with 1:1 supervision and referred to a facility with a locked unit more suited to meet her needs. Other Residents: All residents with 2 or more falls in the last 14 days reviewed to ensure that the appropriate care and services were in place to prevent falls and reflected on their care plans. Systemic Changes: The interdisciplinary team reviews all falls for determination of root cause and new interventions placed accordingly. RCMs educated regarding the importance of timely post-fall risk assessments in order to determine root cause and appropriate interventions to prevent future falls. Nursing staff educated regarding the importance of providing adequate supervision in order to prevent falls. Monitoring: DNS or designee will audit post-fall risk assessments for timeliness and additional protections put into place to reduce the potential for repeated falls weekly and report findings to QA committee for 3 months.		

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F 323	<p>Continued From page 37</p> <p>ambulating.</p> <ul style="list-style-type: none"> * Keep Resident #2 in line-of-sight as often as possible when out of bed. * Ensure Resident #2 wore non-skid foot wear at all times. * Update fall risk assessments quarterly, after any fall, and as needed. * Offer Resident #2 the opportunity to use the toilet 2-3 times at night. <p>a. An Incident Report, dated 3/4/17 at 1:57 pm, documented Resident #2 was found by a CNA sitting in her bathroom door way, incontinent and wearing socks. The report documented this was an unwitnessed fall.</p> <p>A Fall Risk Assessment, dated 3/4/17, documented Resident #2 was at high risk for falls.</p> <p>A Nurse's Note, dated 3/5/17 at 4:10 pm, documented Resident #2 was "restless...agitated," and walking in the halls without a walker.</p> <p>An Interdisciplinary Team Follow-up to the 3/4/17 fall, dated 3/5/17 at 7:59 pm, documented Resident #2 had no safety awareness, was very active, and did not remember to use her call light or ask for help. The Follow-Up documented Resident #2 fell on 3/4/17 when she attempted to self-toilet and was not wearing non-skid footwear. The Follow-Up documented non-skid socks would be added to Resident #2's care plan.</p> <p>b. An Incident Report, dated 3/14/17 at 4:36 am, documented Resident #2 was found by a CNA and nurse at 4:10 am on her hands and knees.</p>	F 323			

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F 323	<p>Continued From page 38</p> <p>The Nurse asked Resident #2 if she hit her head and Resident #2 stated, "I don't know." The Report documented Resident #2 was wearing non-skid socks while attempting to self-toilet, had sustained an abrasion to the elbow, and described the incident as an unwitnessed fall.</p> <p>The next Fall Risk Assessment, completed on 3/21/17, documented Resident #2 was a high fall risk and did not include new interventions to prevent falls.</p> <p>An Interdisciplinary Team Follow-up to the 3/14/17 fall, dated 3/23/17 at 9:00 pm, documented Resident #2 had no safety awareness, was very active, and did not use her call light or ask for help. The note documented Resident #2 attempted to self-toilet, was wearing non-skid socks, and did not use her call light. A new intervention for staff to offer toileting 2-3 times during the night was put into place.</p> <p>c. An Incident Report, dated 3/24/17 at 6:33 pm, documented Resident #2 fell in the dining room after she had pick up a tissue from the floor and was attempting to sit back down in her wheelchair. The Report documented the incident was an unwitnessed fall.</p> <p>Resident #2's clinical record did not contain a Fall Risk Assessment for the 3/24/17 fall.</p> <p>An Interdisciplinary Team Follow-up to the 3/24/17 fall, dated 3/26/17 at 1:04 pm, documented Resident #2 had no safety awareness, was very active, and did not use her call light or ask for help. The Report documented Resident #2's care plan was reviewed,</p>	F 323			

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F 323	<p>Continued From page 39</p> <p>interventions in place "appear[ed] appropriate," and that Resident #2 "could not demonstrate appropriate use of the 'Reacher.'" No new interventions were added to the care plan.</p> <p>d. An Incident Report, dated 3/25/17 at 8:56 pm, documented Resident #2 fell in her room trying to open the hallway door and sustained a skin tear to her elbow. The report documented a Licensed Practical Nurse witnessed the fall.</p> <p>Resident #2's Fall Risk Assessment, dated 3/25/17, documented she was a high fall risk due to "recent falls."</p> <p>An Interdisciplinary Team Follow-up to the 3/25/17 fall, dated 3/26/17 at 12:19 pm, documented Resident #2 had no safety awareness, was very active, and did not use her call light or ask for help. The Follow-Up documented Resident #2 fell in her room trying to "close the door to her room related to another resident across the hall yelling out." A staff member witnessed the fall but was unable to reach the resident in time to prevent the fall. Resident #2's care plan was reviewed and interventions in place "appear[ed] appropriate." The Follow-up documented the care plan was updated to include excessive noises may increase restlessness in Resident #2.</p> <p>No new interventions were added to Resident #2's care plan following the 3/25/17 fall.</p> <p>e. An Incident Report, dated 4/21/17 at 5:36 pm, documented Resident #2 fell in the dining room after attempting to get herself water. The Report documented Resident #2, who was found on her</p>	F 323			

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F 323	<p>Continued From page 40 back, denied hitting her head and that the incident was an unwitnessed fall.</p> <p>Resident #2's clinical record did not contain a Fall Risk Assessment for the 4/21/17 fall.</p> <p>An Interdisciplinary Team Follow-up to the 4/21/17, dated 5/3/17 at 10:21 am, documented Resident #2 had no safety awareness, was very active, and did not use her call light or ask for help. The Follow-Up documented Resident #2's care plan was reviewed and interventions were changed to bring the resident to the dining room just before meals were served. Resident #2 was not to be left alone in the dining room, staff were educated to keep Resident #2 in their line-of-sight as much as possible, and staff were to provide and keep fluids within her reach.</p> <p>On 5/1/17 from 12:50 pm to 1:22 pm, Resident #2's wheelchair was observed in the hallway and her front-wheeled walker was in her room. Resident #2 was observed sitting in a chair in the dining room during meal service. At 1:22 pm, CNA #5 retrieved Resident #2's wheelchair and was observed telling Licensed Practical Nurses [LPN] #2 that he/she found Resident #2 in the dining room without her walker or wheelchair.</p> <p>On 5/1/17 at 1:47 pm, Resident #2 was observed walking out of her room and down the hall without staff assistance or the front-wheeled walker. As Resident #2 approached LPN #2 at a medication cart about 10-feet from the resident's room, LPN #2 asked the Activities Assistant to retrieve Resident #2's walker and help her back to her room.</p>	F 323			

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F 323	<p>Continued From page 41</p> <p>On 5/1/17 at 3:15 pm, Resident #2 was observed sitting in a common area eating candy. Resident #2 dropped a piece of candy on the floor and attempted to reach the candy on the floor, but was unable to do so from a seated position. Resident #2 stood up from her chair and stooped over her walker to reach the candy, which she was able to grasp before sitting back in the chair. At 3:25 pm, Resident #2 dropped another piece of candy on the floor, stood up from her chair, and stooped over her walker again. CNA #2 noticed Resident #2 bending over from a standing position, assisted Resident #2 to pick up the candy, and assisted Resident #2 back to a sitting position.</p> <p>On 5/2/17 at 10:13 am, Resident #2 was observed walking without an assistive device in the hall with a CNA, as another CNA walked towards them with the resident's walker in hand.</p> <p>On 5/2/17 from 10:45 am to 11:07 am, Resident #2 was observed sitting in the common area with her eyes closed; there was no staff observed within line-of sight of the resident. At 11:07 am, Resident #2 stood up from her seat without her walker and began walking towards her room. CNA #2 came into the area after Resident #2 had taken 4 steps, assisted Resident #2 to her walker, and guided the resident to her room where she was then assisted to bed.</p> <p>On 5/3/17 at 3:50 pm, the Director of Nursing Services stated Resident #2 was "very impulsive," exhibited exit seeking behaviors, and wandered often. She stated staff was to keep Resident #2 within line-of-sight as much as possible.</p>	F 323			

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F 323	Continued From page 42	F 323			
F 327 SS=D	<p>The facility failed to perform timely post-fall risk assessments for Resident #2 to determine the cause of the fall and how to prevent future falls, and Resident #2 was observed unsupervised engaging in activities that could easily result in falls.</p> <p>483.25(g)(2) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-</p> <p>(2) Is offered sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents were provided sufficient access to and assistance with fluids. This was true for 1 of 13 (#9) residents reviewed for hydration and created the potential for harm from dehydration. Findings include:</p> <p>Resident #9 was readmitted to the facility on 1/24/17, with diagnoses that included Multiple Sclerosis [progressive neurological disease], convulsions, urinary tract infections [UTI's], and dysphagia [difficulty or discomfort in swallowing].</p> <p>A Neurological Follow-up Physician's Note, dated 2/14/17, documented Resident #9 was assessed</p>	F 327	<p>F 327</p> <p>Resident: Resident # 9 was provided with sufficient fluids. Other Residents: All residents requiring thickened liquids and/or those with functional impairments making it difficult to reach fluids or communicate fluid needs were rounded on to ensure they were being offered and assisted with sufficient fluids.</p> <p>Systemic Changes: Residents requiring thickened liquids and/or those with functional impairments making it difficult to reach fluids or communicate fluid</p>	6/7/17	

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F 327	<p>Continued From page 43 with 5 recurrent UTI's requiring hospitalization within the previous 17 months.</p> <p>Resident #9's Significant Change Minimum Data Set [MDS] assessment, dated 4/8/17, documented severe cognitive impairment; total dependence or extensive assistance required from staff for all cares, including eating and drinking; and contractures or range-of-motion impairment to both upper and lower extremities.</p> <p>Physician Orders, dated 3/20/17, documented Resident #9 was to receive a puree diet with nectar thick liquids.</p> <p>Resident #9's Hydration Care Plan, revised 5/1/16, documented the potential for fluid deficit related to her altered intake process. Staff interventions included:</p> <ul style="list-style-type: none"> * Monitor Resident #9 for signs and symptom of dehydration including dry mucous membranes, dry lips, and concentrated urine. * Encourage Resident #9 to drink nectar-thick fluids during and between meals. <p>Resident #9's Bowel Elimination Alteration Care Plan, revised 3/9/17, documented staff was to "encourage fluid intake with each care contact."</p> <p>On 5/1/17 from 12:49 pm to 3:50 pm, Resident #9 was observed sitting in her room watching television [TV]. Resident #9's mouth had a white substance in the corners, her lips were dry, and when she opened her mouth, strings of white mucous were connected to the top and bottom lips. An empty blue water bottle was on her night stand. Staff interacting with Resident #9</p>	F 327	<p>needs, receive a hydration pass between meals and a weekly hydration status check to include assessment of mucous membranes, skin turgor and BP. Nursing staff educated regarding importance of providing sufficient fluids to prevent dehydration and increased risk for residents requiring thickened liquids or if they require assistance with fluids.</p> <p>Monitoring: DNS or designee will audit hydration pass and hydration checks weekly to ensure residents are provided with sufficient fluids and the assistance they need and report findings to QA committee for 3 months.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 327	<p>Continued From page 44</p> <p>throughout the observation did not offer Resident #9 fluids during their interactions. Resident #9's catheter bag contained dark brownish-yellow urine.</p> <p>On 5/1/17 at 3:50 pm, the Licensed Social Worker (LSW) stated Resident #9 was chair- or bed bound, required staff assistance with all cares, and her ability to communicate had recently declined. The LSW stated staff had to anticipate Resident #9's needs.</p> <p>On 5/2/17 from 9:27 am to 12:00 pm, Resident #9 was observed sitting in her room listening to music. An empty blue water bottle was observed on the nightstand. Various staff members interacting with the resident throughout the observation did not offer Resident #9 fluids during their interactions. Resident #9's catheter bag was observed with dark brownish-yellow urine.</p> <p>On 5/2/17 at 12:40 pm, Resident Care Manager [RCM] #3 was observed assisting Resident #9 with her lunch. RCM #3 guided Resident #9's right hand to her cup and assisted her with placing the straw to her mouth at various times throughout the observation.</p> <p>On 5/2/17 from 1:24 pm to 2:49 pm, Resident #9 was observed in her bed. There were no fluids within her reach and no staff were observed offering her fluids. Resident #9's catheter bag was observed with dark brownish-yellow urine.</p> <p>On 5/4/17 at 2:21 pm, the Director of Nursing Services [DNS] stated staff should offer Resident #9 fluids per the care plan with each "care</p>	F 327			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 327	Continued From page 45 contact." On 5/4/17 at 3:24 pm, Hospitality Aide #1 was observed making rounds with a hydration cart. Hospitality Aide #1 entered Resident #9's room to obtain Resident #9's drinking cup and saw it was not there. Hospitality Aide #1 left the room and returned with a cup, which he/she then filled with nectar thick orange juice and placed on the bedside table. The bedside table was located on Resident #9's left side and out of her reach. Hospitality Aide #1 then radioed a Certified Nursing Assistant [CNA] and stated he/she had left fluids in Resident #9's room. No CNA's were observed entering the room to assist Resident #9 with her fluids. On 5/4/17 at 3:50 pm, the DNS stated Resident #9 could not use her left hand due to contractures and she required staff assistance with drinking. On 5/4/17 at 3:58 pm, Resident #9 was in bed and the cup remained on the bedside table to the left of her where she could not access it. At that time, CNA #2 stated Resident #9 could not use her left hand or consume fluids without staff assistance.	F 327			
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or	F 329		6/7/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 329	<p>Continued From page 46</p> <p>(2) For excessive duration; or</p> <p>(3) Without adequate monitoring; or</p> <p>(4) Without adequate indications for its use; or</p> <p>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--</p> <p>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure:</p> <p>* Residents' medication orders included specific target behaviors identified for monitoring</p>	F 329	<p>F 329</p> <p>Residents: Resident # 8's psychotropic medications were reviewed and order received for GDR of Ability from 5mg to 2.5mg. Resident # 2's diagnosis for</p>	

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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 329	<p>Continued From page 47</p> <ul style="list-style-type: none"> * Non-pharmacological interventions were initiated prior to administration of psychoactive medications * Physicians' medication orders included specific indications for use * Medications were monitored for effectiveness * Gradual Dose Reductions (GDR) of psychotropic medications were attempted <p>This was true for 9 of 11 residents (#1-#9) reviewed for psychoactive medication use. The deficient practice had the potential for more than minimal harm should medications not have their desired effect, lead to adverse consequences, or if residents received excessive dosages over prolonged periods of time. Findings include:</p> <p>The facility's Psychotropic Management Guideline, dated October 2015, documented that residents receiving psychotropic medication would:</p> <ul style="list-style-type: none"> * Have a supporting diagnosis and target behavior/s for use * Be monitored daily for possible side-effects and effectiveness of medications. <p>This policy was not followed. Examples include:</p> <ol style="list-style-type: none"> 1. Resident #8 was re-admitted to the facility on 2/3/17 with diagnoses that included major depression, schizoaffective disorder, and bipolar disorder. <ol style="list-style-type: none"> a. Resident #8's 11/23/16 quarterly Minimum Data Set [MDS] assessment documented no cognitive impairment and no signs of depression. Resident #8's two previous admission MDS 	F 329	<p>Ativan was clarified as anxiety and care plan updated to reflect target behaviors. Resident # 9's Significant Change MDS assessment dated 4/8/17 was modified with completion of the mood section. A behavior monitor for resident # 9 was put in place to monitor for signs and symptoms of depression, the behavior monitor for anxiety was modified to reflect resident-specific behaviors related to anxiety and the behavior monitor for bipolar disorder was modified to include resident-specific behaviors related to bipolar disorder. Resident #9's care plan was revised to include resident specific signs and symptoms of depression, anxiety and bipolar disorder as well as target behaviors to monitor for and non-pharmacological interventions to try prior to administering Ativan. Resident # 9's diagnosis for lamictal was clarified as seizures and MD contacted for either a GDR of Lexapro or documentation of why it would be clinically contraindicated to reduce. A behavior monitor for residents # 1 and 3 were put in place to monitor resident-specific target signs and symptoms of depression. Resident # 4's diagnosis for Cymbalta was clarified as chronic pain and behavior monitor initiated for signs of depression. Resident # 5's care plan updated with resident-specific target behaviors for antipsychotic medication use. Obtained new consent for resident #5's Abilify indicating it is for major depression. Resident #5's behavior monitor was updated to reflect target behaviors.</p>		

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F 329	<p>Continued From page 48</p> <p>assessments, dated 6/20/16 and 8/23/16, each documented minimal signs of depression.</p> <p>Resident #8's Admission Physician's Orders, dated 8/16/16, documented staff were to provide Lexapro [antidepressant] 10 milligrams [mg] in the morning for depression and Abilify [antipsychotic] 5 mg in the morning for major depressive disorder.</p> <p>Resident #8's Anti-Depressant Care Plan, dated 8/16/16, documented staff was to "monitor side effects and effectiveness" of the medications, and monitor, document, and report to the physician "ongoing" signs and symptoms of depression.</p> <p>Nurses Notes', dated 11/16/16 through 12/21/16, did not document whether Resident #8 exhibited signs and symptoms of depression.</p> <p>On 5/3/17 at 3:23 pm, the Director of Nursing Services [DNS] stated the facility did not monitor for signs of depression on a routine basis and nursing staff were instructed to document in the progress notes any signs and symptoms of depression a resident may experience. The DNS stated Resident #8's depression presented as anger and tearfulness, which was treated with Abilify and Lexapro. She stated Resident #8's clinical record would be reviewed for increased signs and symptoms of depression prior to an increase in Lexapro.</p> <p>A Physician Progress Note, dated 12/21/16, documented Resident #8 had "a terrible day...patient was quite teary during this exam. Staff note that she has been more teary as the winter has started. At this time, we will increase</p>	F 329	<p>Psychiatrist contacted for clarification of diagnoses for psychoactive medications. Resident # 6's care plan was updated to indicate target behaviors for antidepressant use. A behavior monitor for resident # 6 was put in place to monitor for signs and symptoms of depression. Resident # 7's care plan was updated to indicate resident-specific target behaviors for antipsychotic and antidepressant use.</p> <p>Other Residents: All residents receiving psychotropic medications were reviewed to ensure adequate monitoring in place for target behaviors and effectiveness, care plans were reviewed for individualized target behaviors and interventions and revised if needed, GDRs completed or documentation in place to explain why GDR was contraindicated and justification documented for any increase in dosages.</p> <p>Systemic Changes: On admission, residents receiving psychotropic medications are reviewed for appropriate diagnoses, target behaviors, behavior monitors and interventions for any behaviors observed. If a new psychotropic medication order is received, documentation is reviewed to ensure the addition or increase in dosage is justified and if not, then nursing will contact the MD to collaborate. All residents receiving psychotropic medications are reviewed on a quarterly basis through psychotropic med review and CP review for possible GDR,</p>		

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F 329	<p>Continued From page 49 her Lexapro to 20 mg and follow up as needed."</p> <p>A 12/21/16 physician's order documented Resident #8 was to receive Lexapro 20 mg in the morning for depression.</p> <p>Resident #8's 2/23/17 quarterly MDS assessment documented no cognitive impairment and minimal signs of depression.</p> <p>Behavior Monitoring logs, dated 3/1/17 through 5/2/17, documented Resident #8's "behavior" was "non-compliance with fluid restriction." The Behavior Monitoring log did not include documentation related to Resident #9's depression or behaviors associated with the use of Lexapro.</p> <p>* Resident #8's March 2017 Behavior Monitor Log documented 15 episodes of "non-compliance with fluid restriction behavior."</p> <p>* Resident #8's April 2017 Behavior Monitor Log documented no episodes of "non-compliance with fluid restriction behavior."</p> <p>* Resident #8's Behavior Monitor Log for 5/1/17 and 5/2/17 documented she did not experience any episodes of "non-compliance with fluid restriction behavior."</p> <p>Resident #8's clinical record did not contain documentation of staff monitoring for signs and symptoms of depression prior to the increase in Lexapro or that the medication's effectiveness was monitored.</p> <p>On 5/4/17 at 2:05 pm, the DNS stated she could</p>	F 329	<p>appropriate diagnoses and target behaviors. RCMs and social services educated that all residents receiving psychotropic medications need resident-specific target behaviors identified for each medication use indicated in their care plan and behavior monitor, and also educated on regulated GDR requirements.</p> <p>Monitoring: DNS or designee will audit care plans, behavior monitors, physician orders and psychotropic medication reviews weekly for compliance with psychotropic medication use and report findings to QA committee for 3 months.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 329	<p>Continued From page 50</p> <p>not find documentation that Resident #8 experienced increased signs and symptoms of depression to support the need for the increase in Lexapro. The DNS stated she could not find documentation for the effectiveness of the medication.</p> <p>On 5/4/17 at 3:26 pm, Resident #8 stated she enjoyed being in the facility and tried to follow her fluid restriction, which she knew she needed to follow to return home.</p> <p>b. Resident #8's Psychotropic Medication Review, dated 2/20/17, documented Lexapro 10 mg was started on 8/17/16 and increased to 20 mg on 12/21/16. The Review did not document a GDR had been attempted in the facility as of 2/20/17. The Review documented Abilify 5 mg was started on 8/16/16, and did not document a GDR had been attempted in the facility as of 2/20/17.</p> <p>A "Note to the Attending Physician from Pharmacy," dated 4/20/17, documented Resident #8 had received Abilify 5 mg and Lexapro 20 mg daily for major depression since August 2016. The pharmacist recommended a GDR for the Abilify to 2.5 mg daily. The Physician responded to the pharmacist's recommendation on 5/2/17, and documented, "No. Pt. [Patient] stable." The physician's response did not include a clinical rationale for declining the pharmacist's GDR recommendation.</p> <p>2. Resident #2 was admitted to the facility on 6/22/16 with diagnoses that included major depressive disorder and dementia.</p>	F 329			

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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 329	<p>Continued From page 51</p> <p>Resident #2's quarterly MDS assessment, dated 3/21/17, documented severe cognitive impairment and mild depression.</p> <p>A Nurse's Note, dated 3/5/17, documented Resident #2 was restless, agitated, and walking in the halls without a walker. The note documented a nurse called the physician for new orders of Ativan [anti-anxiety] 0.5 mg every 6 hours as needed.</p> <p>A 3/5/17 Physician's Order documented Resident #2 was to receive Ativan 0.5 mg every 6 hours as needed for agitation.</p> <p>The March 2017 Medication Administration Record (MAR) documented Resident #9 received Ativan 0.5 mg on 3/7/17, 3/8/17, 3/9/17, 3/11/17, 3/12/17, 3/14/17, and 3/15/17. There was no documentation of behaviors prompting administration of the Ativan or that nonpharmacological interventions were attempted prior to the resident receiving the medication.</p> <p>Resident #2's behavior monitoring was initiated on 3/23/17, 18 days after the medication was ordered. The first behavior monitoring documentation related to Ativan was recorded on the evening shift of 3/24/17.</p> <p>Resident #2's Anti-Anxiety Care Plan, dated 3/20/17, documented staff was to "monitor side effects and effectiveness" of the Ativan, but did not specify which "anxiety behaviors" staff was to monitor. Resident #2 had not been diagnosed with anxiety.</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 329	<p>Continued From page 52</p> <p>Behavior Monitors for 3/22/17 through 3/31/17, and for April 2017, documented Resident #2's "anxiety behaviors" as "pacing and nervous."</p> <p>A narcotic sign out log from 3/8/17 through 4/30/17 documented staff administered 2 doses of Ativan to Resident #2 on 3/18/17 and 3/25/17. The clinical record did not include staff monitoring of behaviors or effectiveness associated with these two administrations.</p> <p>The April 2017 MAR documented Resident #2 was administered doses of Ativan on 4/16/17, 4/28/17, and 4/29/17. The clinical record did not include staff monitoring of behaviors or effectiveness associated with these administrations.</p> <p>On 5/4/17 at 2:05 pm, the DNS stated Resident #2's anxiety presented as exit seeking, wandering, and fearfulness. She stated staff was instructed to give anti-anxiety medication as needed when Resident #2's own behaviors were distressing to her or placed her or others at risk of harm. She stated staff was to attempt other nonpharmacological interventions before administering PRN anxiety medications and to chart observed resident behaviors into the resident's electronic health record.</p> <p>3. Resident #9 was re-admitted to the facility on 1/24/17 with diagnoses that included Multiple Sclerosis, convulsions, bipolar disorder, anxiety, and major depression.</p> <p>a. Resident #9's Significant Change MDS assessment, dated 4/8/17, documented severe cognitive impairment and total dependence or</p>	F 329			

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F 329	<p>Continued From page 53</p> <p>extensive assistance required from staff for all cares, including locomotion; behaviors of wandering and rejection of cares were not exhibited. The Mood Section of the MDS was not completed.</p> <p>Physician Orders, dated 1/24/17, documented Resident #9 was to receive Lexapro 10 mg twice daily for bipolar disorder and major depression, and Lamictal [anticonvulsant] 150 mg twice daily for bipolar disorder, anxiety, and major depression.</p> <p>A Depression Care Plan, revised 4/27/17, documented staff were to "monitor side effects and effectiveness" of the Lexapro and Lamictal, initiated 8/24/16. Staff were also to monitor, document, and report "ongoing" signs and symptoms of depression to the physician, initiated on 8/24/16.</p> <p>Resident #9's clinical record did not contain documentation of persistent signs and symptoms of depression, there was no behavior monitoring for depression, and a GDR had not been attempted related to the resident's medications to treat depression.</p> <p>b. Anti-psychotic:</p> <p>Physician Orders, dated 1/24/17, documented Resident #9 was to receive Seroquel 300 mg at bedtime for bipolar disorder.</p> <p>May 2017 Physician Orders did not identify resident-specific behaviors related to a diagnosis of bipolar disorder or include direction for staff to monitor Resident #9's behaviors related to the</p>	F 329		

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F 329	<p>Continued From page 54 use of the antipsychotic medication.</p> <p>A Behavior Management Care Plan, revised 4/27/17, documented Resident #9 received Seroquel for behaviors and that staff were to "monitor side effects and effectiveness," as well as "behaviors," initiated 8/24/16. The care plan did not identify resident-specific behaviors staff was to monitor.</p> <p>c. Anti-Anxiety:</p> <p>A Physician's Order, dated 1/24/17, documented Resident #9 was to receive Ativan 0.5 milliliters [mL] every 2 hours as needed for anxiety/agitation. This order was discontinued 3/28/17.</p> <p>A Physician's Order, dated 3/25/17, documented Resident #9 was to receive Ativan 0.25 mL every 2 hours as needed for anxiety/agitation.</p> <p>Resident #9's clinical record did not contain documentation the facility was monitoring anxiety-related behaviors from 1/24/17 through 3/31/17.</p> <p>The March 2017 MAR documented Resident #9 was administered Ativan on 3/2/17, 3/2/17, and on 3/8/17 for "agitation."</p> <p>Behavior Monitoring logs for 3/2/17 and 3/8/17 were not completed and there was no documentation detailing whether nonpharmacological interventions had been attempted prior to Resident #9 receiving Ativan.</p> <p>Resident #9's 4/11/17 eMAR Note documented</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 55 staff administered Ativan for "resident reported anxiety and appears agitated."</p> <p>Resident #9's Behavior Monitoring log for 4/17/17 through 4/30/17 documented her "behavior" was "anxiety." The Behavior Monitoring log did not document resident-specific behaviors related to anxiety.</p> <p>Resident #9's clinical record documented behavior monitoring was not initiated until 83 days after Ativan was initially ordered. The first documentation that Resident #9's anxiety was monitored occurred on the evening shift of 4/17/17.</p> <p>An Anxiety Care Plan, revised 4/24/17, documented staff were to "monitor side effects and effectiveness" related to the Ativan, initiated 8/24/16. The care plan directed staff to monitor and record occurrences of "pacing, wandering, disrobing, inappropriate response to verbal communication and violence/aggression towards staff and others," initiated on 8/24/16.</p> <p>Resident #9's clinical record did not include documentation that staff attempted nonpharmacological interventions prior to administration of Ativan.</p> <p>On 5/1/17 from 12:49 pm to 3:50 pm, Resident #9 was observed sitting in her room watching television. Resident #9 was taken by wheelchair from her room for a 1:30 pm appointment and returned at 1:40 pm. Resident #9 was tapping her hand against the bed throughout the observation.</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 329	<p>Continued From page 56</p> <p>On 5/1/17 at 3:50 pm, the LSW stated Resident #9 was chair, or bed, bound and required staff assistance with all cares. The LSW stated Resident #9's ability to communicate had decreased recently and she did not talk often. The LSW stated she was aware Resident #9 had a history of yelling at staff and wandering.</p> <p>On 5/4/17 at 1:30 pm, the DNS stated Resident #9 was unable to talk and could not pace or wander. She stated the target behaviors identified on the Anxiety Care Plan were not current.</p> <p>4. Resident #1 was admitted to the facility on 1/8/15, with multiple diagnoses including anxiety and depression.</p> <p>Resident #1's quarterly MDS assessment, dated 4/19/17, documented Resident #1 experienced mild depression with no behaviors exhibited.</p> <p>The recapitulated May 2017 Physician Order Report documented Resident #1 was to receive Fluoxetine HCL [Prozac] 20 mg daily for depressive disorder, initiated 7/31/16.</p> <p>Resident #1's current care plan, with a revision date of 4/17/17, documented, "Resident will be free from adverse reactions related to antidepressant therapy through the review date of 7/26/17." Interventions included:</p> <p>* Staff were to monitor, document, and report to the physician and Registered Nurse on-going signs and symptoms of depression unaltered by antidepressant medications.</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 329	<p>Continued From page 57</p> <p>* Staff were to monitor side effects and effectiveness of the antidepressant, monitor for unsteady balance, and the pharmacist was to review the drug regime every month.</p> <p>The care plan did not include resident-specific signs and symptoms of depression for staff to monitor and report to the physician or Registered Nurse.</p> <p>A Psychiatric Progress Note, dated 2/21/17, documented Resident #1 continued to experience depression as evidenced by tearfulness, refusing to eat, anger, and anxiety symptoms. The Note documented these symptoms were exacerbated if the dose was gradually reduced and clinically contraindicated at this time.</p> <p>The May 2017 MAR documented Resident #1 received Prozac 20 mg daily in the morning, initiated 7/31/16. The clinical record did not include documentation of resident-specific target signs and symptoms of depression Resident #1 was exhibiting to evaluate the medication's effectiveness.</p> <p>On 5/1/17 at 1:05 pm, Resident #1 was observed in bed with the privacy curtain pulled when a nurse knocked on the door, entered the room, and offered Resident #1 assistance out of bed for lunch. Resident #1 shook his/her head from side-to-side and closed his/her eyes.</p> <p>On 5/1/17 at 2:15 pm, Resident #1 was observed in bed watching television. Resident #1 said he/she liked to stay in bed with the privacy curtain closed to be alone.</p>	F 329			

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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 329	<p>Continued From page 58</p> <p>On 5/2/17 at 3:30 pm, the DNS said the facility did not monitor behaviors or the effectiveness of antidepressants. The RCNA [Regional Clinical Nurse Assistant] said nurses were expected to document in the nurse's notes if Resident #1 had a change in behavior.</p> <p>On 5/3/17 at 11:30 am, the LSW said staff did not monitor behaviors or the effectiveness of antidepressants, but stated she thought monitoring would have been beneficial.</p> <p>5. Resident #3 was admitted to the facility on 8/24/16 then readmitted to the facility on 3/24/17, with multiple diagnoses, including cellulitis, diabetic foot ulcers, and depression.</p> <p>Resident #3's quarterly MDS assessment, dated 3/3/17, documented Resident #3 experienced mild depression with no behaviors exhibited.</p> <p>An NP [Nurse Practitioner] Progress Note, dated 4/19/17, documented Resident #3 was more depressed and at times wanted to give up and other times wanted to keep fighting. The NP documented an assessment and plan with Resident #3 for palliative care, hospice, or increasing Zoloft, an antidepressant, to help with her mood and feelings of depression. Resident #3 decided to have the Zoloft increased and the NP was to reevaluate in one-to-two months.</p> <p>A Physician's Order, dated 4/19/17, increased the Zoloft from 50 mg daily to 100 mg daily for 7 days, initiated 4/20/17, and increased the Zoloft again to 150 mg daily beginning 4/27/17 for major depression.</p>	F 329			

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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 329	<p>Continued From page 59</p> <p>The current care plan, revised 1/5/17, documented, "The resident will be free from discomfort or adverse reactions related to antidepressant therapy and...will show decreased episodes of s/sx [signs and symptoms] of depression through the review date of 6/6/17." Interventions included:</p> <ul style="list-style-type: none"> * Staff were to monitor behaviors to assist in assuring the lowest possible therapeutic dose. * Staff were to monitor, document, or report to the physician as needed ongoing signs and symptoms of depression unaltered by antidepressant medications. * The pharmacist was to review the drug regime quarterly. <p>A Nurse's Note, dated 4/20/17, documented Resident #3 started the increase of the Zoloft to 100 mg today.</p> <p>A Nurse's Note, dated 4/23/17, documented Resident #3 had no change in mood with the increase of the Zoloft.</p> <p>A Nurse's Note, dated 4/25/17, documented Resident #3 was smiling a little more with the recent increase of Zoloft.</p> <p>A Nurse's Note, dated 4/26/17, documented Resident #3 was more talkative and exhibited no increase in depression.</p> <p>A Nurse's Note, dated 4/27/17, documented Resident #3 was a little more talkative, but did</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 329	<p>Continued From page 60</p> <p>not otherwise exhibit much change in behavior with the increase of Zoloft.</p> <p>The April 2017 MAR documented on 4/27/17 that Resident #3's Zoloft was increased to 150 mg daily for major depression.</p> <p>On 5/1/17 at 11:15 am, Resident #3 was observed in bed sleeping. The bed was facing the hallway with the privacy curtain pulled.</p> <p>On 5/1/17 at 2:45 pm, Resident #3 was observed in bed, with the privacy curtain pulled, visiting with a family member. Resident #3 said, with a positive tone of voice, that she/he was not getting out of bed that day.</p> <p>On 5/2/17 at 8:15 am, Resident #3 was observed in bed sleeping. CNA said Resident #3 would use the call light when she/he was ready to eat breakfast.</p> <p>On 5/2/17 at 9:00 am, Resident #3 was observed in bed eating breakfast. Resident #3 said, with a flat affect, that she/he was not getting out of bed that day.</p> <p>On 5/2/17 at 11:30 am, Resident #3 was observed in bed while the Tx RCM [Treatment Resident Care Manager] provided wound care. Resident #3 said, with a flat affect, she/he was not getting out of bed that day and requested to have the privacy curtain pulled and the lights turned off in the room.</p> <p>A Nurse's Note, dated 5/2/17, documented Resident #3 had no change in demeanor with the change in antidepressant therapy.</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 329	<p>Continued From page 61</p> <p>On 5/3/17 at 12:45 pm, Resident #3 was observed in her/his wheelchair watching television. Resident #3 said she/he had a doctor's appointment and was going back to bed after lunch.</p> <p>On 5/3/17 at 11:30 am, the LSW said she gathered information for the psychotropic meeting through staff and resident interviews, review nurse's notes, and behavior monitoring flow sheets. The LSW was unable to provide behavior monitoring flow sheets or other documentation to verify the effectiveness of the increase in Zoloff to 150 mg daily, but said she would visit Resident #3 later in the week.</p> <p>6. Resident #4 was readmitted to the facility on 2/3/16, with multiple diagnoses including depression and pain.</p> <p>The quarterly MDS assessment, dated 4/5/17, documented Resident #4 experienced minimal depression with no behaviors.</p> <p>The Physician Order Summary Report, dated 5/4/17, documented Resident #4 received Duloxetine HCL [Cymbalta] 60 mg daily for chronic pain and major depression.</p> <p>Resident #4's current care plan, revised 10/20/15, documented, "Patient will show decreased episodes of s/sx of depression and will be free from discomfort or adverse reactions related to antidepressant therapy through the review date of 6/8/17." Interventions included:</p> <p>* Staff were to monitor behaviors to assist in</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 329	<p>Continued From page 62 assuring the lowest possible therapeutic dose.</p> <p>* Staff were to monitor, document, and report behaviors to the physician or nurse for ongoing signs and symptoms of depression unaltered by antidepressant medications.</p> <p>* Staff were to monitor for side effects and effectiveness of the antidepressant ordered by the physician.</p> <p>The care plan did not include resident-specific signs and symptoms of depression for staff to monitor and report to the physician or nurse.</p> <p>Resident #4's Behavior Monitoring Record, initiated on the night shift of 5/3/17, did not include resident-specific target behaviors.</p> <p>There was no documentation in Resident #4's clinical record that a GDR for the Cymbalta had been attempted. Resident #4's Cymbalta was initiated 2/4/16 for chronic pain and major depression.</p> <p>On 5/2/17 at 3:30 pm, the DNS, RCNA, and LSW said the facility did not monitor behaviors or the effectiveness of antidepressants. The RCNA said nurses chart in the nurse's notes if a resident exhibits a change in behavior.</p> <p>On 5/4/17 at 5:00 pm, the facility was unable to provide additional documentation of an attempted GDR for Resident #4's Cymbalta.</p> <p>7. Resident #5 was admitted to the facility on 8/13/14, and readmitted on 4/26/17, with multiple diagnoses, including major depressive disorder</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
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F 329	<p>Continued From page 63 with psychotic features.</p> <p>Physician Orders for May 2017 documented Resident #5 received Abilify [antipsychotic] 15 mg at bedtime, Sertraline [antidepressant] 150 mg in the morning, and Trazodone [antidepressant] 100 mg at bedtime.</p> <p>The MDS assessment, dated 2/22/17, documented Resident #5 was cognitively intact with minimal depression.</p> <p>A Care Plan, dated 12/2/14 and revised on 4/5/17, directed staff to monitor behaviors to assist in assuring the lowest possible antidepressant therapeutic dose, as well as for withdrawal, decreased activity attendance, decreased appetite, and verbalizations of feeling down.</p> <p>A Care Plan, dated 4/5/17, documented Resident #5 directed staff to monitor/document side effects and effectiveness of the Abilify, but did not provide individualized target behaviors for which the antipsychotic medication was used.</p> <p>The April 2017 MAR documented Resident #5 received Abilify, Sertraline, and Trazodone for those days she was in the facility, from 4/1/17 through 4/14/17 and 4/20/17 through 4/30/17. Staff documented the presence or absence of side effects for the psychoactive medications.</p> <p>A Psychotropic Medication Review, completed on 2/21/17, documented Resident #5 received Abilify and Sertraline for major depression, and Trazodone for insomnia. The documentation did not list or identify target behaviors that were</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 329	<p>Continued From page 64 monitored for these medications.</p> <p>A "Consent for Use of Psychotropic Medications" form, dated 4/20/17, documented Abilify was prescribed for bipolar disorder.</p> <p>An Initial Psychiatric Evaluation completed on 12/13/16, documented Resident #5's major depression was resistive to treatment, and the Abilify and Trazodone were necessary as management with only Sertraline was insufficient.</p> <p>A Behavior Monitoring flow sheet, initiated on 5/3/17, documented behaviors as "depression/bipolar," but did not identify target behaviors.</p> <p>On 5/2/17 at 3:30 pm, the DNS, RCNA, and LSW said the facility did not monitor behaviors or the effectiveness of antidepressants. The RCNA said nurses' chart in the nurse's notes if a resident receiving an antidepressant exhibits a change in behavior.</p> <p>8. Resident #6 was admitted to the facility on 2/21/17, with multiple diagnoses including depression.</p> <p>Physician Orders, dated 2/21/17, documented Resident #6 was to receive Lexapro [antidepressant] 20 mg each morning for depression.</p> <p>The 4/6/17 MDS assessment documented Resident #6 was cognitively intact with minimal depression.</p> <p>A Care Plan, dated 4/5/17, directed staff to report</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 329	<p>Continued From page 65</p> <p>symptoms of depression to Social Services and to monitor medication side effects and effectiveness. The care plan did not provide individualized target behaviors for which the antidepressant medication was used.</p> <p>On 5/2/17 at 3:30 pm, the DNS, RCNA, and LSW said the facility did not monitor behaviors or the effectiveness of antidepressants. The RCNA said nurses' chart in the nurse's notes if a resident receiving an antidepressant exhibits a change in behavior.</p> <p>9. Resident #7 was admitted to the facility on 11/11/16, with multiple diagnoses that included major depressive disorder.</p> <p>Physician Orders, dated 11/11/16, documented Resident #7 was to receive both Aripiprazole [antipsychotic] 5 mg and Celexa [antidepressant] 20 mg each morning for major depressive disorder.</p> <p>A 2/18/17 MDS documented Resident #7 was cognitively intact with active diagnoses of anxiety and depression, exhibited no signs or symptoms of depression, and rejected cares for 1 to 3 days at the time of the assessment.</p> <p>A Care Plan, dated 11/19/16 and revised 1/11/17, documented Resident #7 received antipsychotic medication [Aripiprazole] related to behavior management. The Care Plan documented staff were monitor/document for side effects and effectiveness and provided a list of potential side effects; but not target behaviors for which the antipsychotic medication was ordered.</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 329	<p>Continued From page 66</p> <p>A Care Plan, dated 11/14/16 and revised 1/11/17, documented Resident #7 received antidepressant medication [Celexa] related to depression and directed staff to monitor/document/report to the physician ongoing signs and symptoms of depression unaltered by antidepressant medications. The intervention listed 25 potential behaviors, but did not provide individualized target behaviors for which the antidepressant medication was ordered.</p> <p>The April 2017 MAR documented Aripiprazole and Celexa were provided to Resident #7 daily. Staff documented each shift the presence or absence of side effects for the psychoactive medications.</p> <p>A Psychotropic Medication Review completed on 4/17/17, documented Resident #7 received antipsychotic and antidepressant medications for the diagnosis of major depression. The Psychotropic Medication Review form documented Resident #7 had not exhibited psychotic or depression related symptoms or behaviors during the previous month and did not list or identify target behaviors that staff were to monitor.</p> <p>A Behavior Monitoring flow sheet, initiated on 5/3/17, provided target behaviors, triggers, interventions, and outcome effectiveness.</p> <p>On 5/3/17 at 4:00 pm, Resident #7 stated she was looking forward to going home and that her family was supportive and taking turns to visit her "almost every day."</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
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F 371	<p>Continued From page 68</p> <p>ensure measures were in place to prevent possible cross-contamination of dirty to clean areas in the kitchen. This was true for 12 of 13 (#1-#4 and #6-#13) sampled residents residing in the facility and 59 of 60 other residents who consumed food prepared by the facility. This had the potential for harm if residents contracted food-borne illnesses or diseases. Findings include:</p> <p>Residents #1-#4 and #6-#13 ate food prepared in the facility's kitchen.</p> <p>The facility's Preventing Foodborne Illness Policy - Employee Hygiene and Sanitation Practices, dated December 2008, documented hand washing was to be performed at these times:</p> <ul style="list-style-type: none"> * After handling soiled equipment and utensils. * To prevent cross contamination when changing tasks <p>On 5/3/17 at 9:29 am, Dietary Aide #1 was observed collecting soiled dishes from the dining room which she then placed into the dishwashers. There was no barrier between Dietary Aide #1's shirt and the soiled dishware and she was not wearing gloves. After Dietary Aide #1 finished running a load of soiled dishes through the dishwasher she submerged her hands into a sanitizer bucket for approximately 1 second and immediately proceeded to put away clean dishes. Dietary Aide #1 repeated this same process between dirty and clean dishes with the next load.</p> <p>On 5/3/17 at 4:30 pm, the Administrator stated an in-serviced was conducted that day with the</p>	F 371	<p>Resident: Residents #1-4 and 6-13 were affected by this. None of these residents showed any ill effects afterward.</p> <p>Other Residents: This has the potential to affect all residents who consume fluids and/or nutrition provided by the facility. At the time the cross contamination during dishwashing was observed, those dishes were re-washed and sanitized.</p> <p>Systemic Changes: All dietary staff were educated regarding the importance of proper handwashing prior to touching clean dishware and utensils.</p> <p>Monitoring: The Dietary manager or designee will monitor dishwashing procedures two meals a day for 4 weeks, then one meal per day for 2 months to determine staff is washing their hands with soap, water, and friction after touching dirty dishes and before putting away clean dishes. Any issues will be immediately corrected. The results of these audits will be reported to the QA committee for 3 months.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
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F 371	Continued From page 69 kitchen staff on proper hand hygiene techniques while performing dishware washing.	F 371			
F 526 SS=D	On 5/4/17 at 5:35 pm, the Registered Dietitian stated employees should wash their hands with soap, water, and friction after touching dirty dishes and before putting away clean dishes. She stated using the hand sanitizer bucket was not a suitable hand hygiene technique. 483.70(o)(1)-(4) Hospice (o) Hospice services. (1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. (2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and	F 526		6/7/17	

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F 526	<p>Continued From page 70 to the timeliness of the services.</p> <p>(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:</p> <p>(A) The services the hospice will provide.</p> <p>(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.</p> <p>(C) The services the LTC facility will continue to provide based on each resident's plan of care.</p> <p>(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.</p> <p>(E) A provision that the LTC facility immediately notifies the hospice about the following:</p> <p>(1) A significant change in the resident's physical, mental, social, or emotional status.</p> <p>(2) Clinical complications that suggest a need to alter the plan of care.</p> <p>(3) A need to transfer the resident from the facility for any condition.</p> <p>(4) The resident's death.</p>	F 526			

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F 526	Continued From page 71 (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must	F 526			

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F 526	<p>Continued From page 72</p> <p>report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.</p> <p>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.</p> <p>(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.</p> <p>The designated interdisciplinary team member is responsible for the following:</p> <p>(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.</p> <p>(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality</p>	F 526			

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F 526	<p>Continued From page 73 of care for the patient and family.</p> <p>(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.</p> <p>(iv) Obtaining the following information from the hospice:</p> <p>(A) The most recent hospice plan of care specific to each patient.</p> <p>(B) Hospice election form.</p> <p>(C) Physician certification and recertification of the terminal illness specific to each patient.</p> <p>(D) Names and contact information for hospice personnel involved in hospice care of each patient.</p> <p>(E) Instructions on how to access the hospice's 24-hour on-call system.</p> <p>(F) Hospice medication information specific to each patient.</p> <p>(G) Hospice physician and attending physician (if any) orders specific to each patient.</p> <p>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.</p>	F 526			

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F 526	<p>Continued From page 74</p> <p>(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.20. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure coordination of care, including a delineation of duties, between the hospice provider and the facility. This was true for 2 of 2 residents (#7 & #9) reviewed for hospice care. This failed practice created the potential for Resident #7 and Resident #9 to receive inadequate care from the facility and/or hospice agency if the care and services to be provided by each were not clearly described and documented in their respective records. Findings include:</p> <p>1. Resident #7 was admitted to the facility on 11/11/16 with multiple diagnoses, including coronary artery disease, Type II diabetes, and a non-healing surgical wound to the back.</p> <p>Resident #7's Physician Order Summary Report for May 2017 documented a physician's order for hospice care on 4/21/17.</p> <p>Resident #7's care plan was updated on 4/28/17 for end-of-life care related to a diagnosis of failure to thrive. Interventions directed staff to collaborate with the hospice team for care, pain and symptom management, and coordinate</p>	F 526	<p>F526</p> <p>Residents: Residents #s 7 and 9 care plans were updated to reflect the delineation of care between the facility and the hospice providers.</p> <p>Other Residents: All residents receiving hospice services care plans were reviewed and updated to reflect the delineation of care between the facility and the hospice providers.</p> <p>Systemic Changes: When a resident admits on hospice services, or elects hospice services while in facility, a delineation of care between the facility and the hospice provider is obtained at that time. Education was provided to RCMs and social services regarding the importance of updating plans of care to reflect the delineation of care between the facility and the hospice provider.</p> <p>Monitoring: DNS or designee will audit care plans of residents receiving hospice services weekly to ensure they reflect the</p>		

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F 526	<p>Continued From page 75</p> <p>aspects of the resident's care with hospice and the physician. The care plan did not delineate duties between the facility and hospice provider.</p> <p>On 5/4/17 at 2:20 pm, the Director of Nursing stated she was not familiar with the delineation of duties for residents receiving hospice-provided care.</p> <p>On 5/4/17 at 6:06 pm, the Director of Nursing provided a facsimile Delineation of Services-Responsibilities form, dated 5/4/17 and unsigned by the facility or the hospice agency.</p> <p>2. Resident #9 was re-admitted to the facility on 1/24/17 with diagnoses that included Multiple Sclerosis [progressive neurological disease], convulsions, urinary tract infections, and dysphagia [difficulty or discomfort in swallowing].</p> <p>Resident #9's Significant Change MDS assessment, dated 4/8/17, documented she was severely cognitively impaired, totally dependent on or required extensive assistance from staff with all cares, and had contractures or range-of-motion impairments to both upper and lower extremities.</p> <p>Physician Orders, dated 3/30/17, documented Resident #9 was to receive hospice services.</p> <p>Resident #9's End-of-Life Care Plan, revised 4/10/17, documented hospice-provided care was related to a diagnosis of end stage Multiple Sclerosis. Interventions included:</p> <p>* Facility staff was to collaborate with the hospice team for "pain and symptom management."</p>	F 526	delineation of care between the facility and the hospice provider and report these findings to the QA committee for 3 months.		

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

PRINTED: 06/08/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2017
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F 526	<p>Continued From page 76</p> <p>* Facility staff was to "coordinate aspects of resident's care with hospice and [facility physician]."</p> <p>The care plan did not provide delineation of duties between facility staff and hospice staff.</p> <p>On 5/4/17 at 2:20 pm, the Director of Nursing stated she was not familiar with the delineation of duties for residents on hospice.</p> <p>On 5/4/17 at 6:06 pm, the Director of Nursing provided a facsimile Delineation of Services-Responsibilities form, dated 5/4/17 and unsigned by the facility or the hospice agency.</p>	F 526			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001250	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/04/2017
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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - B	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the state re-licensure survey conducted at the facility on May 1, 2017 to May 4, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Edith Cecil, RN Dennis Burlingame, RN Teresa Kobza, RDN, LD</p> <p>Abbreviations:</p> <p>DNS = Director of Nursing Services</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on review of Quality Assurance Performance Improvement meeting minutes and staff interview, it was determined the facility failed to ensure the Maintenance and Housekeeping managers participated in the facility's Infection Control Meetings at least quarterly. This failure created the potential for negative outcomes for residents, visitors, and staff in the facility related to the prevention of infections and disease. Findings included:</p> <p>On 5/4/17 at 5:00 pm, the Infection Control Program was reviewed with the DNS [Director of</p>	C 664	<p>C 664</p> <p>Infection Control Committee to include: medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services rep, and maintenance services rep. Must meet no less than quarterly with minutes showing members, business addressed and signed and dated by the chairperson. Must review quarterly report of infections.</p>	6/7/17

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/26/17
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Bureau of Facility Standards

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C 664	<p>Continued From page 1</p> <p>Nursing Services]. The DNS said the facility held its Quality Assurance Performance Improvement meetings on a monthly basis and infection control was a component of those meetings.</p> <p>The DNS provided attendance records, dated 1/19/17, 2/16/17, 3/16/17, and 4/20/17, that documented the Maintenance or Housekeeping Manager failed to attend the Infection Control Meetings.</p> <p>On 5/4/17 at 5:00 pm, the DNS was unable to provide additional documentation for the Maintenance or the Housekeeping Managers' attendance. The DNS said the facility will ensure both managers attend monthly Infection Control meetings.</p>	C 664	<p>Residents: No specific residents identified</p> <p>Other Residents: This has the potential to affect all residents in the facility.</p> <p>Systemic Changes: The Maintenance Director and Housekeeping Manager will attend the facility's Infection Control Meetings at least quarterly.</p> <p>Monitoring: The Administrator or designee will monitor each Infection Control Meeting's attendees to ensure the Maintenance Director and Housekeeping Manager attend the meeting at least quarterly for 6 months.</p>	
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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
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Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

May 19, 2017

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

Provider #: 135077

Dear Mr. Schneider:

On **May 4, 2017**, an unannounced on-site complaint survey was conducted at Avamere Transitional Care & Rehab - Boise. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007489

ALLEGATION #1:

The Reporting Party said an identified resident was discharged home without a discharge plan and no services were arranged.

FINDINGS #1:

The allegation was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted May 1, 2017 through May 4, 2017.

The clinical records of the identified resident and two other residents were reviewed for discharge planning and the provision of post-discharge services.

Brent Schneider, Administrator
May 19, 2017
Page 2 of 2

Interviews were conducted with the Licensed Social Worker, Director of Nursing, and two Resident Care Managers. The interviews included questions about the discharge process, including arranging services and equipment needed for the resident post-discharge home.

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

The clinical record of the identified resident documented the facility and resident reviewed the discharge packet instructions, including a medication list, follow-up appointments, equipment needed at home, and the home health agency that would provide in-home services.

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

CONCLUSIONS:

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,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

David Scott, R.N., Supervisor
Long Term Care

DS/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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July 18, 2017

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

Provider #: 135077

Dear Mr. Cartney:

On **May 4, 2017**, an unannounced on-site complaint survey was conducted at Avamere Transitional Care & Rehab - Boise. The complaint was investigated during a Recertification and Complaint Investigation Survey conducted May 1, 2017 to May 4, 2017.

Immediately after entering the facility on the first day of the survey, the survey team conducted a general tour of residents' rooms and common areas. Throughout the survey, eleven individual residents and all residents in general were observed for quality of care, signs of distress, and quality of life issues. In addition, facility staff were observed as they provided care, interacted with residents, responded to call light and provided residents with medications and any other requests.

The clinical records of the identified residents and eleven other residents were reviewed for quality of life, quality of care, physician services, medication management. Specifically, pressure ulcer and wound management, discharge planning, and physician rounding was reviewed. The facility's grievance files and Incident and Accident reports were reviewed.

Interviews were conducted with multiple individual residents. Several direct care staff, including nurses and nursing aides, were also interviewed, as well as the Director of Nursing Services, Social Worker, Wound Care Nurse, and Resident Care Managers. The interviews included questions about quality of life and quality of care issues.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007503

ALLEGATION #1:

The facility does not have a sufficient number of staff to care for residents.

FINDINGS #1:

Based on interviews with residents and family members, and review of clinical records, there were no concerns with staff ability to provide the necessary cares and services for residents' needs.

The survey process included a group interview with nine residents who did not identify issues with insufficient staffing. The facility's staffing levels over a three-week period were also reviewed and determined to meet state requirements.

Based on observation, interviews, and record review, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Facility licensed nursing personnel leave medications at an identified resident's bedside when the resident is not in the room.

FINDINGS #2:

The identified resident stated medications were not left in his/her room when he/she was not present.

Eight residents were observed throughout the survey receiving scheduled and as-needed medications as ordered by the physician. Three nurses were observed on different shifts providing thirty-four different medications. The medications were delivered per physician orders, at their scheduled times, and to residents in which the licensed personnel observed the resident consume the medications.

Based on observations, interviews, and record reviews, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility did not provide quality oral care, pressure ulcer care, and catheter care for an identified resident.

FINDINGS #3:

Residents interviewed did not voice concerns about their wound care, oral care or catheter care. The identified resident, when interviewed, also did not voice any concerns about these issues.

The identified resident was observed without a catheter and wearing pressure-reducing boots on his/her feet.

The identified resident's clinical records documented the identified resident was not currently using a catheter and was able to manage his/her own cares. The clinical records documented wound care was completed per physician orders and the boots were in place.

Based on observations, interviews, and record reviews, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility failed to provide adequate supervision for an identified resident.

FINDINGS #4:

Three individual residents were reviewed for falls and adequate supervision.

Based on observation, record review, and staff interview there were concerns identified with inadequate supervision.

The identified resident was observed walking in the halls without assistive devices and or staff supervision.

The clinical record documented the identified resident experienced multiple unwitnessed falls in which the care plan was not updated and or evaluations were not completed.

Based on observations, interviews and record reviews the allegation was substantiated and cited at F323. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

Rich Cartney, Administrator
July 18, 2017
Page 4 of 4

Call lights were not answered in a timely manner.

FINDINGS #5:

Thirteen individual residents and all other residents were observed using call lights throughout the survey.

Four residents interviewed voiced concerns that call lights were not answered in a timely manner.

Observations were conducted and call light response times were noted to sometimes take twenty to thirty minutes.

Based on observation, interview, and record review, deficient practice was identified and the allegation was substantiated and cited at F246. Please refer to federal 2567 report for details.

CONCLUSIONS:

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,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

David Scott, R.N., Supervisor
Long Term Care

DS/lj