



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS BARRON – Director

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

July 5, 2018

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

Provider #: 135077

Dear Mr. Smith:

On **June 15, 2018**, 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.

Josh Smith, Administrator
July 5, 2018
Page 2 of 4

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 15, 2018**. Failure to submit an acceptable PoC by **July 15, 2018**, may result in the imposition of penalties by **August 7, 2018**.

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 **July 20, 2018 (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 **September 15, 2018**. A change in the seriousness of the deficiencies on **July 30, 2018**, may result in a change in the remedy.

Josh Smith, Administrator
July 5, 2018
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **September 15, 2018** includes the following:

Denial of payment for new admissions effective **September 15, 2018**. [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 **December 15, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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 **September 13, 2018** 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>

Josh Smith, Administrator
July 5, 2018
Page 4 of 4

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

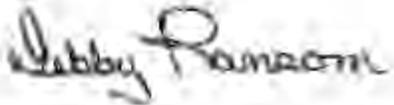
- BFS Letters (06/30/11)

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

This request must be received by **July 15, 2018**. If your request for informal dispute resolution is received after **July 15, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

dr/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/15/2018
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------------------

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 an on-site complaint survey conducted at Avamere Transitional Care and Rehabilitation from June 14, 2018 to June 15, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Teresa Kobza, RDN, LD, Team Coordinator Susan Devereaux, RN</p> <p>Acronyms used in the report include:</p> <p>DNS - Director of Nursing Service mg - milligram</p> <p>F 684 SS=E Quality of Care CFR(s): 483.25</p> <p>§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, review of medication error reports, and staff interview, it was determined the facility failed to ensure nursing staff administered the correct medications to the residents as well as the correct dosage for that medication to 4 of 8 residents (#1, #2, #3, and #4) whose medications were reviewed. This had the potential to place residents at risk for harm related to adverse</p>	F 000	<p>F 684</p> <p>1a. Resident #1, staff education provided to all licensed nursing staff regarding medication administration with passing posttest on file. All licensed nursing staff will pass medication administration competencies. DNS or designee will continue to monitor medication errors through risk management and medication error binder. Will continue to utilize</p>	7/16/18
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 07/10/2018
-----------------------------------------------------------------------------------------------------------	-------	--------------------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/15/2018
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 684	<p>Continued From page 1 medication effects. Findings include:</p> <p>1. The facility's Medication Error reports for the previous 4 months included documentation Resident #1 had 3 medication errors reported.</p> <p>a. Resident #1's record included an order, dated 4/19/18, for methadone 145 mg each morning except on Wednesdays and methadone 40 mg every afternoon.</p> <p>A Medication Error report, dated 3/31/18 at 10:37 AM, stated Resident #1 received 145 mg of Methadone (an opiate pain medication) instead of the ordered dose of 40 mg.</p> <p>A subsequent Medication Error report for Resident #1, dated 6/11/18 at 5:04 PM, stated Resident #1 went to the medication cart for her afternoon medications and after receiving her medication stated "Oh no, it's not right, it's too strong." The report documented the LN (licensed nurse) then looked at the medication bag and realized she had given Resident #1 her morning dose of methadone which was 145 mg and not her afternoon dose, which should have been 40 mg of methadone. The report documented Resident #1 stated to the LN she should check her medicine before taking it.</p> <p>b. A Medication Error report for Resident #1, dated 5/11/18 at 3:30 PM, stated orders for Norco 10/325 mg (an opiate pain medication) were mistakenly entered into Resident #1's medical record and she received 1 dose of the pain medication before the error was recognized by facility staff. The report stated the error was due to Resident #1 and another resident, for whom</p>	F 684	<p>medication error worksheet. Will continue to utilize medication error worksheet disciplinary action recommendations using point system. Will began to use different colored zip lock bag for evening dose of Methadone. Staff education on proper order entry to all licensed nurses provided.</p> <p>1b. For resident #2, staff education provided to all licensed nurses regarding medication administration with passing posttest on file. All licensed nurses will pass medication administration competencies. DNS or designee will continue to monitor medication errors through risk management and medication error binder. Will continue to utilize medication error worksheet. Will continue to utilize medication error disciplinary action recommendations using point system. Narcotic handling policy education provided to all licensed nurses which includes taking discontinued and discharged medication off the cart in a timely manner per policy.</p> <p>1c. For resident #3, staff education provided to all licensed nurses regarding medication administration with passing posttest on file. All licensed nurses will pass medication administration competencies. DNS or designee will continue to monitor medication errors through risk management and medication error binder. Will continue to utilize medication error worksheet. Will continue to utilize medication error worksheet</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 C 06/15/2018
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 684	<p>Continued From page 2</p> <p>the order was written, sharing the same last name. The report further stated staff were educated on the practice of being aware of name alerts and double checking orders properly.</p> <p>On 6/15/18 at 11:35 AM, the DNS stated it was not appropriate for residents to verify their medications. The DNS also said Resident #1's methadone dose was administered incorrectly multiple times.</p> <p>2. The facility's policy titled Discontinued Medications, revised April 2007, stated "Policy Statement: Staff shall destroy discontinued medications or shall return them to the dispensing pharmacy in accordance with facility policy. Discontinued medications must be destroyed or returned to the issuing pharmacy in accordance with established policies." This policy was not followed.</p> <p>The facility's Medication Error reports for the previous 4 months included documentation Resident #2 had 1 Medication Error report dated 06/5/18 at 9:48 PM. The report stated Resident #2 received 30 mg of Oxycodone (narcotic) IR (Immediate Release) instead of 20 mg of Oxycodone.</p> <p>The Order Summary Report for Resident #2 documented the Oxycodone IR 30 mg was discontinued on 6/2/18, 3 days prior to being administered to Resident #2 in error.</p> <p>During an interview on 6/15/18 at 3:00 PM, the Administrator confirmed the Oxycodone IR, which was a discontinued medication, should have been removed from the nurses' medication</p>	F 684	<p>disciplinary action recommendations using point system. Education provided to all licensed nurses regarding pre-preparing medications.</p> <p>1d. For resident #4, staff education provided to all licensed nurses regarding medication administration with passing posttest on file. All licensed nurses will pass medication administration competencies. DNS or designee will continue to monitor medication errors through risk management and medication error binder. Will continue to utilize medication error worksheet. Will continue to utilize medication error worksheet disciplinary action recommendations using point system. New Narcotic polices formed including taking discontinued and discharged medications off the cart in a timely manner per policy.</p> <p>2. All residents had the potential to be affected by the deficient practice. Staff education provided to all licensed nurses regarding medication administration with passing posttest on file. All licensed nurses will pass medication administration competencies. DNS or designee will continue to monitor medication errors through risk management and medication error binder. Will continue to utilize medication error worksheet. Will continue to utilize medication error worksheet disciplinary action recommendations using point system. New Narcotic polies formed including taking discontinued and</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 C 06/15/2018
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 684	<p>Continued From page 3</p> <p>cart immediately when the medication was discontinued.</p> <p>3. The facility's Medication Error report for the previous 4 months included documentation Resident #3 had 1 Medication Error report, dated 6/02/18 at 4:00 PM. The report stated "Incident Description: Nursing Description - Came back to med (medication) cart after another incident, picked up medication for resident and gave meds that had been cupped for resident. In addition to another medication that was not his."</p> <p>On the third page of the report, there was a follow-up note, dated 6/6/18, which stated "On the evening of 6/2/18 LN on the hall was getting medications for two different residents and ended up giving both medications to (Resident #3). At this same time, there was a resident fall outside at the smoking area that the LN was called for. When she returned to the hall she realized that she had given (Resident #3) both (residents') meds. (Resident #3) received 500 mg of APAP (acetaminophen), 300 mg Gabapentin (a medication for nerve pain), and 5 mg of Oxycodone."</p> <p>Resident #3's Order Summary Report included orders for acetaminophen 650 mg every 4 hours as needed for pain and Gabapentin 300 mg in the morning and 600 mg at bedtime for neuropathic foot pain. There was not an order for Oxycodone.</p> <p>During an interview on 6/15/18 beginning at 3:03 PM, the DNS stated it was his expectation the licensed nurses prepare medications for one resident at a time.</p>	F 684	<p>discharged medications off the cart in a timely manner per policy. Education provided to all licensed nurses regarding pre-preparing medication.</p> <p>3. Medication administration education provided to all licensed nurses and will be provided upon hire an annually. Medication competencies to be done with all licensed nurses and upon hire. Narcotic handling polies reviewed and education given to all licensed nurses.</p> <p>4. Medication administration, Narcotic handling policy and order entry education provided to all licensed nurses with posttest by DNS or designee. Passing posttest will be required for all licensed nurses. Passing post test will be audited against current nurse staffing roster to be completed no later than 7/16/2018. All staff that have not completed education with passing posttest will not be allowed to work until completed. Education to be provided upon hire the annually thereafter. To ensure that all new hires have received this education, facility will audit all new nursing staff Quarterly during QAPI for no less than one year.</p> <p>Medication competencies will be given to all licensed nurses by 7/16/2018. Random audits will be performed by DNS or designee daily x5, weekly x4, monthly x3 and the quarterly thereafter no less than one year.</p> <p>DNS or designee will continue to monitor</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 C 06/15/2018
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 684	<p>Continued From page 4</p> <p>4. The facility's policy titled Administering Oral Medications, revised October 2010, instructed staff to:</p> <ul style="list-style-type: none"> * Select the drug from the unit dose drawer or stock supply. * Check the label on the medication and confirm the medication name and dose with the Medication Administration Record. * Check the expiration date on the medication. Return any expired medications to the pharmacy. * Check the medication dose. Re-check to confirm the proper dose. <p>The facility's Medication Error report for the previous 4 months included documentation Resident #4 had 1 Medication Error report dated 3/4/18 at 2:50 PM. The report stated Resident #4 was administered Oxycodone 15 mg instead of Oxycodone 5 mg, as ordered. The report stated Resident #4 noted the color of the pill had changed and asked the nurse why.</p> <p>The Medication Error Report did not include documentation of follow up actions taken to prevent future errors.</p> <p>Resident #4's Order Summary Report did not include an order for Oxycodone 15 mg.</p> <p>On 6/15/18 at 12:34 PM, the DNS stated he did not complete Resident #4's Medication Error report. The DNS stated the previous DNS did not complete a follow up note and from a conversation with the previous DNS he believed Resident #4 received another resident's medications and the facility still had not identified</p>	F 684	<p>Medication Errors through risk management and medication error binder and results will be reviewed by QAPI committee. Each medication error will be investigate through current medication error policy and will continue indefinitely.</p>		

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

PRINTED: 07/19/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/15/2018
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 684	Continued From page 5 where the medication came from.	F 684			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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

June 12, 2019

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

Provider #: 135077

Dear Mr. Smith:

On **June 14, 2018** and **June 15, 2018**, an unannounced on-site complaint survey was conducted at Avamere Transitional Care & Rehab - Boise. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007792

ALLEGATION #1:

Medications are not administered appropriately and accurately, insulin is being given when blood glucose values are within normal limits, medications are not readily available from the pharmacy, and the wrong resident's medications are being given to residents.

FINDINGS #1:

Observations were conducted throughout the facility and interviews were conducted with residents, family and staff members. A total of eight residents were reviewed, and four specifically reviewed for medications.

Resident records reviewed for medications did not include documentation medications were administered inappropriately or contrary to physician's orders. During review of the facility's stock of medications, there were medications available to use in the event the physician ordered a medication and the pharmacy had not delivered it.

Josh Smith, Administrator
June 12, 2019
Page 2 of 3

Review of a resident's record who was receiving insulin confirmed the resident's blood glucose was obtained, and either treated with insulin according to physician orders or held if the blood glucose was within acceptable parameters.

Review of residents' records did not include documentation regarding incorrect medications were given to residents.

However, medication reports reviewed for the previous 4 months did include documentation incorrect medication doses were administered to residents on several occasions, and one incorrect medication was transcribed into a resident's record and the resident received one dose of the incorrect medication.

Due to investigative findings, the facility was cited with deficient practice for inaccurate medication administration, and cited at F 684, Quality of Care.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility did not provide a walker for resident use.

FINDINGS #2:

Observations were conducted throughout the facility, resident records were reviewed, and interviews were conducted with residents.

During interviews three residents stated the facility provided a walker. During interviews two other residents stated they had a personal walker.

One resident's initial physician's orders did not indicate the use of a walker for the resident. However, the physician did order a physical therapy evaluation. The physical therapy evaluation documented a recommendation for the resident to use a front wheeled walker, although one was not provided to the resident.

The allegation was substantiated but not cited. However, the facility was cited for failure to provide appropriate restorative services to maintain mobility and range of motion in a November 2018 survey.

Josh Smith, Administrator
June 12, 2019
Page 3 of 3

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #3:

Call lights were not answered up to 48 minutes and there was fecal odors in the facility.

FINDINGS #3:

Observations were made during the survey at various times of both days in the facility. Call lights were observed to be answered in a timely manner and no odors were present in the hallways. Five residents and one family member were interviewed. They did not voice concerns with call lights. Review of the last six months of resident council minutes and the facility's grievances did not document concerns with call lights or odors in the facility.

Due to investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj