



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RUSS BARRON – Director

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BUREAU OF FACILITY STANDARDS
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July 12, 2018

Joe Rudd Jr, Administrator
Life Care Center Of Boise
808 North Curtis Road
Boise, ID 83706-1306

Provider #: 135038

Dear Mr. Rudd Jr:

On **June 28, 2018**, a survey was conducted at Life Care Center Of 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.

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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 22, 2018**. Failure to submit an acceptable PoC by **July 22, 2018**, may result in the imposition of penalties by **August 14, 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 **August 2, 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 26, 2018**. A change in the seriousness of the deficiencies on **August 12, 2018**, may

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result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 28, 2018** includes the following:

Denial of payment for new admissions effective **September 28, 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 28, 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 28, 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:

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

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

- BFS Letters (06/30/11)

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

This request must be received by **July 22, 2018**. If your request for informal dispute resolution is received after **July 22, 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/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during an on-site complaint survey conducted at Life Care Center of Boise from June 25, 2018 to June 28, 2018. The surveyors conducting the survey were: Teresa Kobza, RDN, LD, Team Coordinator Susan Devereaux, RN Abbreviations: CDM = Certified Dietary Manager CNA = Certified Nursing Assistant DNS = Director of Nursing H&P = History and Physical I&A = Incident and Accident IDT = Interdisciplinary Team MDS = Minimum Data Set mg = milligrams RN = Registered Nurse 1:1 = One to One	F 000			
F 571 SS=D	Limitations on Charges to Personal Funds CFR(s): 483.10(f)(11)(i)-(iii) §483.10(f)(11) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15 of this chapter, which limits participation	F 571		8/2/18	

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

TITLE

(X6) DATE

Electronically Signed

07/22/2018

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.

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F 571	Continued From page 1 in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.) (i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities must not charge a resident for the following categories of items and services: (A) Nursing services as required at §483.35. (B) Food and Nutrition services as required at §483.60. (C) An activities program as required at §483.24(c). (D) Room/bed maintenance services. (E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry. (F) Medically-related social services as required at §483.40(d). (G) Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan. (ii) Items and services that may be charged to residents' funds. Paragraphs (f)(11)(ii)(A) through (L) of this section are general categories and	F 571			

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F 571	Continued From page 2 examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident's care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid: (A) Telephone, including a cellular phone. (B) Television/radio, personal computer or other electronic device for personal use. (C) Personal comfort items, including smoking materials, notions and novelties, and confections. (D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. (E) Personal clothing. (F) Personal reading matter. (F) Gifts purchased on behalf of a resident. (H) Flowers and plants. (I) Cost to participate in social events and entertainment outside the scope of the activities program, provided under §483.24(c). (J) Non-covered special care services such as privately hired nurses or aides. (K) Private room, except when therapeutically required (for example, isolation for infection control). (L) Except as provided in (e)(11)(ii)(L)(1) and (2) of this section, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by §483.60. (1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist, as these are included per §483.60.	F 571			

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F 571	<p>Continued From page 3</p> <p>(2) In accordance with §483.60(c) through (f), when preparing foods and meals, a facility must take into consideration residents' needs and preferences and the overall cultural and religious make-up of the facility's population.</p> <p>(iii) Requests for items and services.</p> <p>(A) The facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident.</p> <p>(B) The facility must not require a resident to request any item or service as a condition of admission or continued stay.</p> <p>(C) The facility must inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, review of a sitter service invoice, and record review, it was determined the facility failed to ensure residents were not charged for services required to meet the supervision needs of residents. This was true for 1 of 5 residents (#8) reviewed who required increased supervision due to falls. The deficient practice created the potential for Resident #8 to experience ongoing falls due to a lack of supervision, should he not be able to pay for a 1:1 sitter. Findings include:</p> <p>Resident #8 was admitted to the facility on 3/7/17, with diagnoses which included cerebral vascular accident (stroke), dementia, and convulsions. Resident #8 passed away on 3/10/17 at the facility.</p> <p>Resident #8's Hospital H&P documented</p>	F 571	<p>This Plan of Correction required under Federal and State Regulations and statutes applicable to long-term care providers. This Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.</p> <p>Additional Abbreviations: Daily = Monday through Friday (with</p>		

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F 571	<p>Continued From page 4</p> <p>Resident #8 was admitted to the hospital after he experienced a ground level fall and acute seizures.</p> <p>Resident #8's Fall Risk Assessment dated 3/7/17, documented he was at high risk for falls. Interventions included pain assessments, review of resident's space, family and resident education, bowel and bladder education, and review of his medication.</p> <p>Resident #8's Nursing Notes and Hospice Notes documented the following:</p> <p>* 3/8/17 at 10:12 AM - A nursing progress note documented Resident #8 was found on the floor after his roommate was calling out for assistance. Resident #8's roommate stated Resident #8 stood up from his bed, tried to walk, lost his balance, fell, struck his head on the floor and then on the front of his wheelchair.</p> <p>*3/8/17 at 2:00 PM - Resident #8's Hospice RN documented Resident #8 experienced 2 falls since admission to the facility.</p> <p>* 3/9/17 at 9:04 AM - Resident #8 had multiple 'almost' falls and was impulsive. The note documented the facility IDT met and discussed initiating a 1:1 sitter for Resident #8. The note documented Resident #8's family was called and 3 sitter services were referred to the family.</p> <p>An I&A dated, 3/8/17, documented Resident #8 experienced the unwitnessed fall on 3/8/17 at 9:45 AM. The facility recommended, and action was taken to provide, a 1:1 sitter for Resident #8 related to his impulsively and severe dementia.</p>	F 571	<p>regard to audits) DX = Diagnosis UM = Unit Manager SDC = Staff Development Coordinator QA = Quality Assurance DNS = Director of Nursing Services IDT = Interdisciplinary Team</p> <p>F 571</p> <p>Corrective Action: 1. Resident #8 Discharged from facility on 3/10/2017 2. Resident #8's family reimbursed for the cost of the companion care service provided during the resident's stay.</p> <p>Identification: All residents that may require companion care services are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes: 1. Residents that may be deemed to require companion care service, by the facility, will receive that service as part of the covered items. 2. Facility staff received inservice education regarding items considered covered during the course of a resident's Medicare or Medicaid stay in the facility.</p> <p>Monitor: 1. DNS or Designee to audit documentation related to placing a resident on companion care services to</p>		

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F 571	Continued From page 5 Resident #8's care plan was updated on 3/8/17 to include "sitter for safety PRN (as needed.)" The 1:1 Sitter Care Giver Service Invoice, dated 3/8/17 - 3/10/17, billed to Resident #8, documented he received 52.15 hours of companion care amounting to \$992.75. The invoice identified the "Payer" and "Client" as Resident #8. The invoice was sent to Resident #8's family to pay on his behalf. Resident #8 was required to pay for a 1:1 sitter which was determined necessary by the facility to protect his safety. On 6/27/17 at 3:01 PM, the DNS said Resident #8 required a 1:1 sitter because of his increased impulsiveness and falls. The DNS stated Resident #8's family paid for the 1:1 and she was unsure why. The DNS stated the facility usually provided this service and the caregiver service the family chose was one of the companies the facility worked with and usually paid for.	F 571	ensure that if deemed necessary, by the facility, the charges are considered covered items. 2.Audits to be conducted at the following frequencies: Weekly for eight (8) weeks Monthly for three (3) months 3.Findings to be reviewed by Administrator and reported to QA Committee		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 583		8/2/18	

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F 583	<p>Continued From page 6</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.</p> <p>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.</p> <p>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, review of maintenance logs, and resident and staff interview, it was determined the facility failed to ensure a resident's privacy was maintained during personal care. This true for 1 of 3 residents (#3) observed during the provision of personal care. The failure created the potential for Resident #3 to be embarrassed if her body was exposed to others unnecessarily. Findings include:</p> <p>Resident #3 was admitted to the facility on 6/16/17 with diagnoses which included difficulty walking and muscle weakness.</p> <p>A quarterly MDS assessment, dated 3/22/18,</p>	F 583	<p>F 583</p> <p>Corrective Action: Blinds in Resident Room #302 / Resident #3's room have been replaced.</p> <p>Identification: All residents are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: 1. Inservice education provided to facility staff regarding identifying and reporting areas in the resident's physical environment that need repair to the facility</p>		

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F 583	<p>Continued From page 7</p> <p>documented Resident #3 was cognitively intact and required extensive assistance of two staff members for toileting and was always incontinent.</p> <p>The Maintenance/Housekeeping Request Log documented problems and concerns regarding Resident #3's blinds needing repair as follows:</p> <ul style="list-style-type: none"> * 10/8/17 - Blinds were broken in Resident #3's room. * 10/9/17 - Blinds were not working in Resident #3's room. * 11/10/17 - Needed new blinds in Resident #3's room. * 3/4/18 - Blinds would not close in Resident #3's room. * 5/8/18 - Blinds would not twist open in Resident #3's room. * 5/25/18 - Blinds would not twist closed in Resident #3's room. * 5/26/18 - Blinds were sticking when attempts to slide them open in Resident #3's room. <p>On 6/25/18 at 3:47 PM, CNA #1 and CNA #2 were assisting Resident #3 with changing her incontinence briefs. Resident #3's bed was located next to a window which faced a parking lot and a street with houses lining it. Resident #3's blinds were vertical upright blinds that would rotate closed for privacy. CNA #2 pulled the blinds closed and when he attempted to rotate the blinds for privacy the blinds would not rotate closed. CNA #2 stated to Resident #3, "They just replaced your blinds, didn't they?" Resident #3 said to CNA #2 her blinds had not been fixed or repaired. CNA #2 stated he remembered placing maintenance requests for Resident #3's broken</p>	F 583	<p>Maintenance and Housekeeping departments.</p> <p>2. Inservice education provided to nursing staff regarding maintaining resident privacy.</p> <p>3. Inservice education provided to Housekeeping and Maintenance staff regarding facility policy and procedure related to maintaining the resident's environment.</p> <p>Monitor:</p> <p>1. Administrator or Designee to conduct audit of Maintenance / Housekeeping Concern Log and area of concern noted to ensure compliance.</p> <p>2. Audits to be conducted at the following frequencies:</p> <ul style="list-style-type: none"> Daily (Monday – Friday) for two (2) weeks. Weekly for four (4) weeks Monthly for three (3) months. <p>2. Audits to be reported to QA Committee</p>		

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F 583	Continued From page 8 blinds before. On 6/27/17 at 8:48 AM, the Maintenance Director stated staff should be able to close residents' blinds when they were assisting residents during incontinence care. The Maintenance Director stated it was a dignity issue when residents were exposed. The Maintenance Director stated he was aware of Resident #3's blinds needing repair and he had ordered new blinds for the room. He said the vendor delivery was a three week wait after the bidding and approval processes were completed. The Maintenance Director stated there should have been a corrective action to protect Resident #3's privacy until her blinds were ordered, delivered, and installed.	F 583			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 610		8/2/18	

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
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F 610	<p>Continued From page 9</p> <p>by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure a resident's fall was thoroughly investigated. This was true for 1 of 5 (#8) residents reviewed for falls and created the potential for harm due to a lack of an investigation to rule out abuse or neglect. Findings include:</p> <p>Resident #8 was admitted to the facility on 3/7/17, with diagnoses which included cerebral vascular accident (stroke), dementia, and convulsions. Resident #8 passed away on 3/10/17 at the facility.</p> <p>Resident #8's Hospital H&P documented Resident #8 was admitted to the hospital after he experienced a ground level fall and acute seizures.</p> <p>Resident #8's Fall Risk Assessment dated 3/7/17, documented he was at high risk for falls. Interventions included pain assessments, review of resident's space, family and resident education, bowel and bladder education, and review of his medication.</p> <p>Resident #8's Hospice Notes documented he experienced 2 unwitnessed falls between 3/7/17 and 3/10/17.</p> <p>Resident #8's Hospice Nurse's Note, dated 3/8/17, documented he was newly admitted to the facility and fell in the evening of 3/7/17 and again in the morning of 3/8/17. The note documented Resident #8 had multiple bandages on his left wrist, forearm, and elbow.</p>	F 610	<p>F 610</p> <p>Corrective Action: Resident #8 Discharged from the facility on 3/10/2017.</p> <p>Identification: All residents that experience a fall in the facility are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: 1. Inservice Education provided to facility staff regarding facility policy and procedure for the reporting and the investigation of falls by a resident, and the implementation of interventions for resident's safety. 2. Education provided to hospice providers regarding facility policy and procedure for the reporting of resident incidents. Specifically, the communication required between hospice providers and the DNS or Designee regarding reporting of any fall a resident may experience while they are providing services.</p> <p>Monitor: 1. DNS or Designee to audit Nursing Notes, Incident Reports, Hospice Notes, and 24 Hour Log for falls and compliance to Incident Reporting and Investigation policy and procedure. 2. Audits to be conducted at the following frequencies: Weekly for eight (8) weeks</p>		

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F 610	Continued From page 10 On 6/27/18 at 3:45 PM, the DNS stated she was unaware Resident #8 fell more than once in the facility and would look for another I&A and fall investigation for the 3/7/17 fall. On 6/28/18 at 8:50 AM, the DNS stated she was unable to find an I&A and fall investigation for a 3/7/17 fall.	F 610	Monthly for three (3) months. 3. Audits to be reported to QA Committee		
F 637 SS=D	Comprehensive Assessment After Significant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure 1 of 1 resident reviewed who experienced a significant change in condition had a Significant Change in Status Assessment (SCSA) completed within 14 days of her election of hospice services. This failure placed Resident #1 at risk of inappropriate care, or lack of needed services, due to insufficient coordination between the facility and the hospice provider. Findings include: Resident #1's Face Sheet documented her	F 637	F 637 Corrective Action: Resident #1 discharged from the facility on 7-9-2018. Identification: All residents that experience a "Significant Change" are identified as potentially being affected by this deficiency. Systemic Changes:	8/2/18	

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F 637	<p>Continued From page 11</p> <p>original admission to the facility was 6/22/15, and she was readmitted on 4/27/18, with medical diagnoses that included acute and chronic respiratory failure, convulsions, secondary malignant neoplasm of the brain, and congestive heart failure.</p> <p>Resident #1's record included a physician's order dated 4/27/18, which stated she was admitted to the facility for hospice services.</p> <p>Resident #1's Care Plan section related to her terminal illness showed a problem onset date of 4/27/18 which stated Resident #1 was currently receiving hospice care, and included contact information for the hospice physician and the names of other hospice personnel serving the resident.</p> <p>Resident #1's SCSA MDS assessment was dated 6/11/18, 45 days after she was readmitted to the facility on 4/27/18 with orders for hospice services.</p> <p>On 6/27/18 at 3:10 PM, MDS Coordinator #2 stated a SCSA should be done within 14 days after a significant change in condition. MDS Coordinator #2 said a SCSA should have been done within 14 days of Resident #1's admission to hospice, or by 05/11/18.</p> <p>The October 2017 Resident Assessment Instrument Manual, page 2-23, states "A SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home...A SCSA</p>	F 637	<p>Inservice education provided to facility MDS staff regarding RAI guidelines concerning timelines for completion of assessments, specifically Significant Change Assessments.</p> <p>Monitor:</p> <ol style="list-style-type: none"> DNS or Designee to audit resident Care Plans of residents that experience a significant change to ensure compliance with assessment completion. Audits to be conducted at the following frequencies: <ul style="list-style-type: none"> Weekly for four (4) weeks Monthly for three (3) months. Audits to be reported to QA Committee 		

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F 637	Continued From page 12 must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place."	F 637			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and	F 657		8/2/18	
			F 657		

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F 657	<p>Continued From page 13</p> <p>record review, it was determined the facility failed to ensure 1 of 14 residents (Resident #1) whose care plans were reviewed, had a quarterly interdisciplinary care plan reviews that included participation of the the physician and the resident and the resident's family members, as applicable. This deficient practice had the potential to result in lack of care, or inappropriate care and services provided to residents. Findings include:</p> <p>Resident #1's Face Sheet documented her original admission to the facility was 6/22/15, and she was readmitted on 4/27/18, with medical diagnoses that included acute and chronic respiratory failure, convulsions, secondary malignant neoplasm of the brain, and congestive heart failure.</p> <p>Resident #1's record included a physician's order dated 4/27/18, which stated she was admitted to the facility for hospice services.</p> <p>The MDS assessment screen in the facility's electronic health record (EHR) showed the last completed MDS assessment for Resident #1 was 3/13/18. There was a significant change of status MDS assessment, dated 6/11/18, that was "In Progress" as of the 6/28/18 print date of the screen shot.</p> <p>Resident #1's Care Plan Conference Record sheets were reviewed. They documented care conferences for Resident #1 on 7/28/16 and 10/5/16, and had a handwritten note dated 12/21/17, stating "Daughters called & canceled CPC (care plan conference)."</p> <p>On 6/27/18 at 5:00 PM, MDS Coordinator #1</p>	F 657	<p>Corrective Action: Resident #1 discharged from the facility on 7-9-2018.</p> <p>Identification: All residents are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: Inservice education provided to facility IDT regarding timelines for completion of Care Plan Reviews and Quarterly Interdisciplinary Care Plan Review that includes the participation of physician, the resident, and the resident's family member if applicable per RAI requirements</p> <p>Monitor: 1. DNS or Designee to audit resident Resident Care Plans for compliance. 2. Audits to be conducted at the following frequencies: Weekly for four (4) weeks Monthly for three (3) months. 3. Audits to be reported to QA Committee</p>		

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F 657	<p>Continued From page 14</p> <p>stated social services scheduled the care plan conference meetings.</p> <p>On 6/27/18 at 5:38 PM, the resident support services staff member (RSS). She stated the resident's daughter canceled the care plan conference 12/21/17 and the resident did not want to have a conference without the daughter. When asked if there had been a care plan conference held since October 2016, the RSS stated "I guess not, the daughter was supposed to let us know when she got to town."</p> <p>On 06/28/18, at 10:45 AM, MDS Coordinator #1 stated care plans were to be reviewed and updated quarterly and nurses updated the care plans on the floor. MDS Coordinator #1 stated "If we have a care plan conference, I go to those, otherwise, I talk to the unit manager, the nurse, nurse aides, and social services; the resident if they can provide any input, and families if I can catch them in here." When asked when Resident #1's care plan was last updated, MDS Coordinator #1 looked it up and stated it "expires 06/19/18 - so it was updated 3 months ago." She went on to clarify the care plan was updated by speaking with staff individually, not including the resident's physician, and there was no care plan conference meeting.</p> <p>The facility's undated Resident Care Conferences policy included "The Resident Care Conference occurs within 21 days of admission and quarterly thereafter (as defined in OBRA Guideline [OBRA - Federal Nursing Home Reform Act, the provisions of the Act are contained in Omnibus Budget Reconciliation Act])."</p>	F 657			

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F 684 SS=D	<p>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:</p> <p>Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure professional standards of practice were followed for 2 of 13 residents (#3 and #8) reviewed for standards of practice. Resident #3's positioning schedule was not followed. Resident #8's seizure suppository was delayed in transcribing physician's orders. These failed practices had the potential to adversely affect or harm residents whose care and services were not delivered according to accepted standards of clinical practices. Findings include:</p> <p>1. Resident #8 was admitted to the facility on 3/7/17, with diagnoses which included cerebral vascular accident, dementia, and convulsions. Resident #8 passed away on 3/10/17 at the facility.</p> <p>The care plan area addressing Resident #8's palliative care, dated 3/7/17, documented Resident #8 had end stage Alzheimer's disease and end stage cerebrovascular disease. Interventions included hospice services.</p>	F 684	<p>F 684</p> <p>Corrective Action: 1. Resident #3 discharged from the facility on 3-10-2017. 2. Resident #3 is alert and oriented, and able to make her own decisions. Positioning Schedule ("Up and Down") has been removed as resident able to choose when she wants to get up and down.</p> <p>Identification: All residents are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: 1. Licensed Nurse staff educated to facility policy and procedure related to processing Physician Orders timely. 2. Licensed Nurse staff educated to facility policy and procedure related to following of the Resident Care Plan and Care Directives to ensure each resident receives care in accordance with</p>	8/2/18	

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F 684	<p>Continued From page 16</p> <p>A Hospice Physician's Order, dated 3/8/17, documented Resident #8 was to receive a 10 mg suppository of Diazepam for seizures as needed. The order was faxed to the facility on 3/9/17 at 12:09 PM.</p> <p>A facility Physician's Order, dated 3/10/17 at 2:00 PM, documented Resident #8 was to receive a 10 mg suppository of Diazepam for seizures, as needed. The order of the Hospice Physician was transcribed to the facility's physician orders 26 hours after the order was received by the facility.</p> <p>On 6/27/17 at 4:33 PM, the DNS stated she did not know the reason the order was not transcribed when the order was received on 3/9/17.</p> <p>2. Resident #3 was admitted to the facility on 6/16/17, with diagnoses which included difficulty walking and muscle weakness.</p> <p>A quarterly MDS assessment, dated 3/22/18, documented Resident #3 was cognitively intact and required extensive assistance of two staff members for transfers.</p> <p>The care plan area addressing Resident #3's mood and behavior, dated 6/16/17, documented Resident #3 could refuse to get out of bed or refuse care. The interventions included adhering to the plan of care and reminding Resident #3 of the importance of getting out of bed.</p> <p>Resident #3's undated Up Down Schedule documented she was to be in bed for breakfast unless she requested to be in her wheelchair. Resident #3 was to be assisted in her wheelchair</p>	F 684	<p>professional standards of practice.</p> <p>Monitor:</p> <ol style="list-style-type: none"> DNS or Designee to audit Physician Orders to ensure compliance. Audits to be conducted at the following frequencies: Daily for eight (8) weeks. Weekly for three (3) months. DNS or Designee to audit Resident Care Plans and Care Directives to ensure compliance with treatment and care. Audits to be conducted at the following frequencies: Weekly for eight (8) weeks Monthly for three (3) months. Audits to be reported to QA Committee 		

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F 684	Continued From page 17 "around" 11:00 AM for lunch and assisted back in bed between 2:00 or 3:00 PM. The schedule documented Resident #3 was to be assisted back into her wheelchair "around" 5:00 PM for dinner and assisted back to bed between 7:00 and 8:00 PM. On 6/25/18 at 9:42 AM, Resident #3 stated the facility requested she stay up in her wheelchair for 1 meal a day. Resident #3 stated the meal time staff assisted her into her wheelchair varied depending on when staff decided to get her up. On 6/26/18 at 10:17 through 12:34 PM, Resident #3 was observed in bed. On 6/26/18 at 2:18 PM, RN #1 stated Resident #3 schedule for getting out of bed was in the front of Resident #3's MAR and RN #1 stated the staff should be following it. RN #1 stated the schedule was there to remind staff to assist Resident #3 out of bed. RN #1 stated Resident #3's family came up with the schedule of assisting Resident #3 out of bed twice a day. RN #1 stated he was unsure if the schedule was discussed with Resident #3 or not. RN #1 was not aware Resident #3 positioning scheduled was not being followed.	F 684			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent	F 689		8/2/18	

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F 689	<p>Continued From page 18 accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, staff interview, and review of I&A reports, it was determined the facility failed to ensure resident falls were documented and investigated and interventions to prevent future falls were initiated. prevention interventions were implemented following a fall. This was true for 1 of 5 residents reviewed for falls (#8) and had the potential for harm if the resident sustained fractures, concussions, or other serious injuries from a fall. Findings include:</p> <p>Resident #8 was admitted to the facility on 3/7/17, with diagnoses which included cerebral vascular accident (stroke), dementia, and convulsions. Resident #8 passed away on 3/10/17 at the facility.</p> <p>Resident #8's Hospital H&P documented Resident #8 was admitted to the hospital after he experienced a ground level fall and acute seizures.</p> <p>Resident #8's Fall Risk Assessment dated 3/7/17, documented he was at high risk for falls. Interventions included pain assessments, review of the resident's space, family and resident education, bowel and bladder education, and review of his medication.</p> <p>The care plan area addressing Resident #8's risk for falls, dated 3/7/17, documented interventions of educating the resident and family on safety, 1-2 staff members to assist Resident #8 with transfers, 1 staff member to assist Resident #8</p>	F 689	<p>F 689</p> <p>Corrective Action: Resident #8 discharged from the facility on 3-10-2017.</p> <p>Identification: All residents are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: 1. Inservice education provided to facility staff regarding facility policy and procedure for the reporting of and the investigation of falls by a resident. 2. Inservice education to be provided to hospice providers regarding facility policy and procedure for the reporting of resident incidents. Specifically, education was provided regarding the communication required between hospice providers and the DNS or Designee regarding reporting of any fall a resident may experience while they are providing services.</p> <p>Monitor: 1. DNS or Designee to audit Physician Orders to ensure compliance. Audits to be conducted at the following frequencies: Daily for eight (8) weeks. Weekly for three (3) months. 2. DNS or Designee to audit Resident Care Plans and Care Directives to ensure</p>		

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F 689	<p>Continued From page 19</p> <p>with ambulation, 1-2 staff to assist with toileting, low bed, non-skid material to wheelchair, staff to monitor and encourage use the proper foot wear, and provide assistive devices for bed mobility, transfers, or ambulation, and to specify what the assistive devices were. Specific assistive devices were not documented in the care plan.</p> <p>Resident #8's Nursing Notes and Hospice Notes documented he experienced 2 unwitnessed falls between 3/7/17 and 3/10/17, as follows:</p> <p>* 3/8/17 at 10:12 AM - A nursing progress note documented Resident #8 was found on the floor after his roommate was calling out for assistance. Resident #8's roommate stated Resident #8 stood up from his bed, tried to walk, lost his balance, fell, struck his head on the floor and then on the front of his wheelchair.</p> <p>An I&A report dated, 3/8/17, documented Resident #8 experienced the unwitnessed fall on 3/8/17 at 9:45 AM. The facility recommended, and action was taken to provide, a 1:1 sitter for Resident #8 related to his impulsively and severe dementia. The I&A report also documented one of the immediate actions taken to provide safety to Resident #8 was a mat at bedside.</p> <p>Resident #8's 3/8/17 - 3/10/17 Neurological Assessments were to be completed following the 3/8/17 fall. The assessments were to assess for neurological status changes. The monitoring on 3/8/17 at 4:30 PM through 3/9/17 evening shift documented a change in status of drowsiness in Resident #8.</p> <p>* 3/8/17 at 2:00 PM - Resident #8's Hospice</p>	F 689	<p>compliance with treatment and care. Audits to be conducted at the following frequencies:</p> <p>Weekly for eight (8) weeks. Monthly for three (3) months. 3. Audits to be reported to QA Committee</p>		

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F 689	<p>Continued From page 20</p> <p>Nurse's Note documented Resident #8 experienced 2 falls since admission to the facility.</p> <p>* 3/8/17 - Resident #8's Hospice Nurse's Note documented he was newly admitted to the facility and fell in the evening of 3/7/17 and again in the morning of 3/8/17. The note documented Resident #8 had multiple bandages on his left wrist, forearm, and elbow.</p> <p>Resident #8's clinical records did not include an I&A report or fall investigation related to the 3/7/17 fall.</p> <p>* 3/9/17 at 9:04 AM - A nursing progress note documented Resident #8 had multiple 'almost' falls and was impulsive. The note documented the facility's IDT met and discussed initiating a 1:1 sitter for Resident #8. The note documented Resident #8's family was called and 3 sitter services were referred to the family.</p> <p>On 6/27/17 at 3:01 PM, the DNS stated she was unaware Resident #8 fell more than once in the facility and would look for an I&A report and fall investigation for the 3/7/17 fall. The DNS stated the facility implemented a 1:1 sitter because of his increased impulsiveness and his fall on 3/8/17. The DNS stated she did not implement fall mats to Resident #8's bedside due to his ability to walk. The DNS stated if Resident #8 had fall mats implemented she feared the mats would create falls. The DNS stated when a resident fell the facility the IDT team met to determine the cause of the fall and discover the timeline. The DNS stated if a resident fell often in a short period of time the staff would implement interventions that increased supervision and 1:1</p>	F 689			

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F 689	Continued From page 21 supervision was one of those interventions. On 6/28/18 at 8:50 AM, the DNS stated she was unable to find an I&A report and fall investigation related to Resident #8's 3/7/17 fall. Resident #8 experienced a fall on 3/7/18 and the facility did not initiate an investigation to determine the cause of the fall and what additional interventions were needed to prevent futher falls.	F 689			
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, food test tray evaluation, and staff interviews, it was determined the facility failed to ensure food served to residents was palatable. This impacted 5 of 7 residents interviewed for food palatability (#1, #2, #3, #5, and #15), and had the potential to effect the 57 other residents who dined in the facility. This failed practice had the potential to	F 804	F 804 Corrective Action: 1. "House-wide" survey completed regarding food palatability, temperature, and general satisfaction with food in the facility. 2. Delivery process modified in an effort	8/2/18	

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F 804	<p>Continued From page 22</p> <p>negatively impact residents' nutritional status and psychosocial well-being. Findings include:</p> <p>On 6/25/18 at 9:22 AM, Resident #2 stated the food was not good. Resident #2 stated the chicken could be undercooked or overcook at times. Resident #2 stated the food was not hot by the time the meal made it down to her room.</p> <p>On 6/25/18 at 9:42 AM, Resident #3 stated the food was ok and it could be better.</p> <p>On 6/25/18 at 9:53 AM, Resident #15 said the chicken was "cardboard" and his food was usually cold. Resident #15 stated the food tasted like hospital food.</p> <p>On 6/25/18 at 8:59 AM Resident #5's breakfast tray was removed from her room by staff. The breakfast tray was observed with a partially eaten biscuit and 2 hard boiled eggs. Resident #5 was offered other food items and she declined them. At 2:19 PM, Resident #5 stated she lost her appetite at breakfast this morning because the biscuit was undercooked. Resident #5 stated she could not eat her eggs because of this. Resident #5 stated the food was not good and her meals arrived "luke warm."</p> <p>On 6/27/18 at 8:26 AM, Resident #1 stated the food was not very good.</p> <p>On 6/27/18 at 12:18 PM, a lunch meal test tray was evaluated by two surveyors with the CDM. The Turkey Pot Pie had a temperature of 151 degrees Fahrenheit and the CDM said the dough was undercooked and doughy. The surveyors evaluated the pot pie and found it to be doughy</p>	F 804	<p>to improve temperature and palatability of meals delivered to residents.</p> <p>3. CDM to continue to attend Resident Council and Menu Meetings with residents.</p> <p>Identification: All residents are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: 1. Facility staff educated regarding facility policy and procedure, and CMS regulations, regarding food procurement, storage, preparation, and delivery. 2. Facility Dietary Staff educated regarding facility policy and procedure related to above. Additionally, education was provided regarding the taking temperatures as required and documentation of those temperatures as required.</p> <p>Monitor: 1. Dietary Manager or Designee to conduct audits on temperature documentation, and on test trays with regard to palatability and temperature. Audits to be conducted at the following frequencies: Three (3) times \ week for eight (8) weeks. Monthly for three (3) months. 2. Audits to be reported to QA Committee.</p>		

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F 804	Continued From page 23 and undercooked, as well.	F 804			
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure food was handled properly and maintained according to safe practices. This was true when the facility failed to ensure refrigerated foods were dated and covered, and Potentially Hazardous Food (PHF) cold food temperatures were assessed prior to service, and/or were stored at appropriate temperatures to prevent the growth of potential disease-causing pathogens. These failed practices placed 10 of 10 sample residents residing in the facility (#1-#7 and #11-#13) and	F 812	F 812 Corrective Action: 1. "House-wide" survey completed regarding food palatability, temperature, and general satisfaction with food in the facility. 2. Delivery process modified in an effort to improve temperature and palatability of meals delivered to residents. 3. CDM to continue to attend Resident Council and Menu Meetings with	8/2/18	

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F 812	<p>Continued From page 24</p> <p>the other 54 residents who resided in, and dined in the facility, at risk of adverse health outcomes. Findings include:</p> <p>The 2017 FDA Food Code, Chapter 3, Part 3-5, Limitation of Growth of Organisms of Public Health Concern, subpart 3-501.12 Time/Temperature Control for Safety Food, Slacking, documented, "(A) Under refrigeration that maintains the food temperature at 5 C (41 F [Fahrenheit]) or less..."</p> <p>On 6/27/18 at 12:18 PM, a lunch meal test tray was evaluated and the foods were within appropriate temperatures except for the milk 55 degrees F and the chocolate cream pie 64.8 degrees F. The CDM stated the milk and the pie should be below 41 degrees as PHF and she stated she would ensure the temperature logs prior to service showed less than 41 degrees.</p> <p>On 6/27/18 at 12:20 PM, the Food Temperature Logs were acquired for review from the dietary staff. The log did not include temperature assessments for the milk or the chocolate cream pie.</p> <p>On 6/27/18 at 12:21 PM, the CDM spoke with Cook #1, Cook #2 and Cook #3 to figure out the process of acquiring the cold food prior to service. Cook #3 stated they did not assess the temperatures of the milk or the chocolate cream pie prior to service. Cook #1 stated they removed all the pies from the refrigerators at once prior to tray line. Cook #2 stated the milks were removed from the refrigerator and placed into the freezer for a while then placed into a bin of ice and waiting for tray line.</p>	F 812	<p>residents.</p> <p>Identification: All residents are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: 1. Facility staff educated regarding facility policy and procedure, and CMS regulations regarding food procurement, storage, preparation, and delivery. 2. Facility Dietary Staff educated regarding facility policy and procedure related to above. Additionally, education was provided regarding the taking temperatures as required and documentation of those temperatures as required.</p> <p>Monitor: 1. Dietary Manager or Designee to conduct audits on temperature documentation, and on test trays with regard to palatability and temperature. Audits to be conducted at the following frequencies: Three (3) times a week for eight (8) weeks. Monthly for three (3) months. 2. Audits to be reported to QA Committee.</p>		

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F 921 SS=E	<p>Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)</p> <p>§483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, review of maintenance logs, and staff and resident interview, it was determined the facility failed to maintain a safe and functional environment for residents. This was true for 6 of 14 (#2, #3, #11, #12, #13, and #14) sampled residents and 3 random (#16, #17, and #18) residents. This deficient practice placed residents at risk for harm due to the potential for falls and risk for harm if environmental needs where not fixed in a timely manner. Findings include:</p> <p>1. Resident #2 and Resident #3 were roommates. Resident #2 was admitted to the facility on 3/24/17, with diagnoses which included difficulty walking and muscle weakness. A quarterly MDS assessment, dated 6/8/18, documented Resident #2 was cognitively intact and was independent with cares.</p> <p>Resident #3 was admitted to the facility on 6/16/17, with diagnoses which included difficulty walking and muscle weakness. A quarterly MDS assessment, dated 3/22/18, documented Resident #3 was cognitively intact and required extensive assistance of two staff members for transfers.</p> <p>a. The Maintenance/Housekeeping Request Log documented problems and concerns regarding</p>	F 921	<p>F 921 Corrective Action: 1. Each of the issues noted in the 2567 have been resolved. 2. With regard to the "dirt in the hallway" during the sewer line repair, it should be added that the Administrator also explained to the Surveyor that the dirt was off to the side in the common area, out of the area used for moving through the hallway. It was also explained to the Surveyor that there was plastic under and completely covering the dirt. It was further explained to the Surveyor that due to the cold temperatures, the decision was made to leave the dirt inside rather than subject the residents in the area to the cold outside temperatures and wind.</p> <p>Identification: All residents are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: 1. Inservice education provided to facility staff regarding identifying and reporting areas in the resident's physical environment that need repair. Reporting to be done through the use of facility Maintenance/Housekeeping Request Log.</p>	8/2/18	

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F 921	<p>Continued From page 26</p> <p>the bathroom toilet in the room Resident #2 and Resident #3 shared, as follows:</p> <p>* 9/29/17 - Toilet ran for 4 hours straight and then stopped.</p> <p>* 10/11/17 - Toilet constant flush will not stop, "2nd request."</p> <p>* 11/24/17 - Toilet was leaking at the base.</p> <p>A Plumbing Invoice, dated 12/19/17, documented the toilet in the room Resident #2 and Resident #3 shared was backed up and a camera was used to locate a towel and a cable end in the pipes. The invoice documented the pipes needed to be replaced.</p> <p>Two Plumbing Proposals, dated 12/21/17, documented the cost of the repairs for the pipes and the toilet.</p> <p>A Plumbing Work Order, dated 12/22/17, documented the toilet was replaced with a new toilet.</p> <p>A Plumbing Work Order, dated 1/3/18-1/5/18, 12 days after the toilet was replaced, documented the pipe was replaced.</p> <p>On 6/25/18 at 9:22 AM, Resident #2 stated the toilet in her room stopped working a few months ago and she had to use the bathroom in a vacant room next door for a few weeks. Resident #2 stated the facility offered her the option of moving to the other room, however, she did not want to leave her roommate because she worried about her roommate's welfare if she left. Resident #2 stated after a while it was embarrassing when she had to go to the room next door to use the</p>	F 921	<p>2. Inservice education provided to Housekeeping and Maintenance staff regarding facility policy and procedure related to maintaining the resident's environment and documentation of the resolution of issues placed in the facility Maintenance/Housekeeping Request Log.</p> <p>Monitor:</p> <ol style="list-style-type: none"> 1. Administrator or Designee to conduct audit of Maintenance / Housekeeping Concern Log and area of concern noted to ensure compliance. 2. Audits to be conducted at the following frequencies: Daily (Monday – Friday) for two (2) weeks. Weekly for four (4) weeks Monthly for three (3) months. 3. Audits to be reported to QA Committee 		

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F 921	<p>Continued From page 27</p> <p>restroom because people knew what she was doing.</p> <p>On 6/25/18 at 9:42 AM, Resident #3 stated the facility did not offer her the option of changing rooms when the toilet in her room broke. Resident #3 stated she was incontinent and did not use the toilet, so she did not think the facility thought to ask her.</p> <p>On 6/27/18 at 8:48 AM, the Maintenance Director stated the toilet pipe in the room Resident #2 and Resident #3 shared, stopped working and Resident #2 had to use the bathroom in the room next-door. The Maintenance Director stated he was not the director at that time and he was not aware of when the toilet first acted up.</p> <p>On 6/27/18 at 9:46 AM, the Resident Support Services staff person (RSS) stated she spoke with Resident #2 and asked her about moving rooms when the toilet stopped working. The RSS stated Resident #2 did not want to change rooms because she did not want to leave her roommate. The RSS stated she was unsure how long the toilet was broken. The RSS stated she did not offer to move Resident #3 because Resident #3 was incontinent and did not use the bathroom. The RSS stated Resident #2 would not move rooms without Resident #3 and the RSS offered to move her to a room next door. The RSS stated both beds were open and both residents could have been moved.</p> <p>On 6/27/18 at 11:14 AM, the Previous Maintenance Director stated the toilet stopped working intermittently from 11/24/17 until 12/19/17. The Previous Maintenance Director</p>	F 921			

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F 921	<p>Continued From page 28</p> <p>stated Resident #2 used the bathroom next-door intermittently during this time. The Previous Maintenance Director stated when the camera was used on 12/19/17 to diagnosis the issue Resident #2 had to use the bathroom next-door completely until the toilet and the pipes were fixed. The Previous Maintenance Director stated the process for bids to be completed took "awhile." The Previous Maintenance Director said he was unsure why the work was not completed after the bidding was completing on 12/21/17.</p> <p>On 6/28/18 at 12:52 PM, the Executive Director stated there was dirt in the hallway and the residents had to wheel their way through the area. The Executive Director stated the bidding was placed on 12/21/17 and he received confirmation on 12/28/17 from corporate of which bidding company to use.</p> <p>b. The Maintenance/Housekeeping Request Log documented problems and concerns regarding the blinds in the room Resident #2 and Resident #3 shared that needed correction as follows:</p> <ul style="list-style-type: none"> * 10/8/17 - Blinds were broken in Resident #3's room. * 10/9/17 - Blinds were not working in Resident #3's room. * 11/10/17 - Needed new blinds in Resident #3's room. * 3/4/18 - Blinds would not close in Resident #3's room. * 5/8/18 - Blinds would not twist open in Resident #3's room. * 5/25/18 - Blinds would not twist closed in Resident #3's room. * 5/26/18 - Blinds were sticking when attempts to 	F 921			

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F 921	<p>Continued From page 29</p> <p>slide them open in Resident #3's room.</p> <p>On 6/25/18 at 3:47 PM, CNA #1 and CNA #2 were assisting Resident #3 with changing her incontinence briefs. Resident #3's bed was located next to a window which faced a parking lot and a street with houses lining it. Resident #3's blinds were vertical upright blinds that would rotate closed for privacy. CNA #2 pulled the blinds closed and when he attempted to rotate the blinds for privacy the blinds would not rotate closed. CNA #2 stated to Resident #3, "They just replaced your blinds, didn't they?" Resident #3 said to CNA #2 her blinds had not been fixed or repaired. CNA #2 stated he remembered placing maintenance requests for Resident #3's broken blinds before.</p> <p>On 6/27/17 at 8:48 AM, the Maintenance Director stated staff should be able to close residents' blinds when they were assisting residents during incontinence care. The Maintenance Director stated it was a dignity issue when residents were exposed. The Maintenance Director stated he was aware of Resident #3's blinds needing repaired and he had ordered new blinds for the room. He said the vendor delivery was a three week wait after the bidding and approval processes were completed. The Maintenance Director stated there should have been a corrective action to protect Resident #3's privacy until her blinds were ordered, delivered, and installed.</p> <p>2. Resident #14 was readmitted to the facility on 2/13/17, with diagnoses which included epilepsy and muscle weakness.</p>	F 921			

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F 921	<p>Continued From page 30</p> <p>a. An I&A report dated, 4/19/18, documented Resident #14 experienced a witnessed fall on 4/19/18 at 11:45 AM. The facility recommended and action was taken to provide a rug at bedside.</p> <p>On 6/28/18 at 11:15 AM, Resident #14's room was observed with a rug between the two beds, not near Resident #14's bed. The rug was loose and slid when stepped upon.</p> <p>On 6/28/18 at 11:40 AM, the Maintenance Director stated the rug was in the middle of the room and was worn out. The Maintenance Director stated all staff members should be assessing the rugs for functionality, and stated he did not ensure the rugs were functional.</p> <p>b. The Maintenance/Housekeeping Request Log documented problems and concerns regarding Resident #14's toilet that needed correction as follows:</p> <p>* 5/24/18 - Please fix toilet in Resident #14's room. There was no follow-up written down for the toilet.</p> <p>* 6/20/18 - Toilet won't flush in Resident #14's room.</p> <p>On 6/28/18 at 11:40 AM, the Maintenance Director stated the toilet was fixed and the lack of documented follow up after the 5/24/18 report, did not indicate the toilet was not fixed after problems were first identified on 5/24/18.</p> <p>3. The Maintenance/Housekeeping Request Log included maintenance needs for Residents #11, #12, #13, #16, #17, and #18 that were not documented as resolved as follows:</p>	F 921			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 921	<p>Continued From page 31</p> <ul style="list-style-type: none"> * 1/3/18 - 6 missing blind panels in Resident #18's room. * 1/10/18 - Blinds broken and missing in Resident #18's room. * 3/27/18 - Hole in wall at head of bed in Resident #12's bed. * 3/28/18 - Massive damage to wall at head of bed in Resident #12's room. * 5/17/18 - Resident #11's foot peg on the left-side was broken. * 5/29/18 - Resident #17's television volume was staticy. * 5/30/18 - Resident #13 needed a new mattress. * 5/31/18 - Resident #16 required headphones for her television. <p>On 6/28/18 at 11:40 AM, the Maintenance Director stated the logs did not show if the items above were corrected. The Maintenance Director stated Resident #12's wall did not have holes in it and the wall had missing paint that he had not gotten around to painting yet. The Maintenance Director stated Resident #16 did not require headphones. He stated she just wanted the headphones because someone else had them and he never provided her with them. The Maintenance Director stated he was able to speak with her about the headphones. The Maintenance Director stated he was not sure if Resident #13 received a new mattress. The Maintenance Director stated housekeeping would provide the new mattress. The Maintenance Director stated he was sure Resident #11's foot peg was corrected and the log was not updated. The Maintenance Director stated he was not aware that Resident #17's television was not working. The Maintenance Director stated blinds</p>	F 921			

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

PRINTED: 07/27/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 921	Continued From page 32 take 3 weeks to order and receive and staff put requests for blinds multiple times on the list. The facility lack an effective system for tracking the identification and prompt resolution of maintenance concerns.	F 921			



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
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PHONE: (208) 334-6626
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June 4, 2019

Joe Rudd Jr, Administrator
Life Care Center of Boise
808 North Curtis Road
Boise, ID 83706-1306

Provider #: 135038

Dear Mr. Rudd Jr:

On **June 25, 2018** through **June 28, 2018**, an unannounced on-site complaint survey was conducted at Life Care Center of Boise. The complaint allegations, findings and conclusions are as follows:

Complaint#ID00007477

ALLEGATION #1:

Residents were not fully informed of the cost of living in the facility prior to admission to the facility.

FINDINGS #1 :

During the investigation care and services were observed being provided to 3 residents and 7 resident's records were reviewed. Three of the 7 residents' records reviewed were those of residents who no longer resided at the facility. Multiple interviews were conducted with residents, family members, and staff, regarding the admission process. Facility grievances and Resident Council minutes were reviewed.

Each of the residents' records reviewed included appropriate admission paperwork, including the cost of services, provided to the resident/family prior to admission to the facility.

Joe Rudd Jr, Administrator
June 4, 2019
Page 2 of 9

Grievances and Resident Council meeting minutes, from February 2017 to June 2018, were reviewed and did not document concerns with the admission process or notification of costs.

Several residents and family members were interviewed and stated they had no concerns with the admission process.

Several staff members interviewed described the admissions process and demonstrated how costs were allocated to residents.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Residents were placed with incompatible roommates.

FINDINGS #2 :

During the investigation 7 resident's records were reviewed. Three of the 7 residents' records reviewed were those of residents who no longer resided at the facility. Multiple interviews were conducted with residents and family members regarding roommates and the roommate selection process. Multiple staff members were interviewed regarding roommate selection and what to do if concerns arose. Facility grievances and Resident Council minutes were reviewed.

None of the residents' records reviewed included documentation of concerns with their roommates making excess noise or issues with their televisions being loud.

Grievances and Resident Council meeting minutes, from February 2017 to June 2018, were reviewed and did not document concerns with roommates being loud or incompatible with each other.

Several residents stated they had no concerns with their roommates noise levels.

Several nurses were interviewed regarding roommate compatibility and did not recall issues or complaints of televisions being loud or excess noise.

Based on the investigative findings, the allegation could not be substantiated due to lack of sufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Psychotropic medications residents took for years at home were changed when the residents were admitted to the facility, resulting in behavioral issues, not previously seen in other living environments. The discontinued medications were not replaced with another medication needed to manage the behavioral issues.

FINDINGS #3:

During the investigation 5 residents were observed receiving medications and a total of 7 residents' records were reviewed for medication management. Three of the residents whose records reviewed no longer resided in the facility. Multiple interviews were conducted with residents and family members. The residents and family members did not voice concerns about medications or the use of them. Multiple staff members were interviewed and observed providing medications to residents. Facility grievances and Resident Council minutes were reviewed. The grievances and minutes did not include documentation of concerns related to medication management.

Three of the 7 residents' records were reviewed for accuracy of admission orders related to psychoactive medications. The psychoactive medications for each of the 3 residents were administered as ordered by the admitting physician.

The record of one resident, admitted March 2017, documented he had an order for Lorazepam (anti-anxiety medication) as needed. The nursing progress notes and the medication record did not include documentation the resident had issues with severe anxiety.

Several nurses were observed administering medications and each resident received the correct medications as ordered. Several facility staff stated Lorazepam was provided per physician orders for anxiety. Facility staff stated the facility would not medicate someone to prevent them from getting out of bed, as it would be considered a chemical restraint.

Based on the investigative findings, the allegation could not be substantiated due to lack of sufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Residents who were known to be at high risk for falls did not receive the services and supervision necessary to prevent falls.

FINDINGS #4:

During the investigation multiple interviews were conducted with residents and family members. The residents and family members did not share concerns regarding supervision or protection from falls. Multiple staff members were interviewed regarding supervision and falls. The records of 5 residents were reviewed for accidents and supervision. Three of the 5 residents whose records were reviewed resided in the facility. The care and services of the 3 residents residing in the facility were observed throughout the survey and their records were reviewed. The 3 residents were noted to receive services and supervision to protect them from falls. Two of the 5 residents reviewed no longer resided in the facility. One of the 2 residents' records included documentation of supervision and services necessary to protect the resident from falls.

The second resident whose record was reviewed did not receive the supervision necessary to protect him from repeated falls. The resident's record documented he was admitted to the facility on 3/7/17, with diagnoses which included cerebral vascular accident (stroke), dementia, and convulsions. The resident passed away on 3/10/17 at the facility.

The resident's Hospital History and Physical examination documented he was admitted to the hospital after he experienced a ground level fall and acute seizures.

The resident's Fall Risk Assessment dated 3/7/17, documented he was at high risk for falls. Interventions included pain assessments, review of the resident's space, family and resident education, bowel and bladder education, and review of his medication.

The care plan area addressing the resident's risk for falls, dated 3/7/17, documented interventions of educating the resident and family on safety, 1-2 staff members to assist him with transfers, 1 staff member to assist him with ambulation, 1-2 staff to assist with toileting, low bed, non-skid material to wheelchair, staff to monitor and encourage the use of proper foot wear, and to provide assistive devices for bed mobility, transfers, or ambulation, and to specify what the assistive devices were. Specific assistive devices were not documented in the care plan.

The resident's Nursing Notes and Hospice Notes documented he experienced 2 unwitnessed falls between 3/7/17 and 3/10/17, as follows:

- 3/8/17 at 10:12 AM - A nursing progress note documented the resident was found on the floor after his roommate was calling out for assistance. The resident's roommate stated the resident stood up from his bed, tried to walk, lost his balance, fell, struck his head on the floor and then on the front of his wheelchair.

An Incident and Accident (I&A) report dated, 3/8/17, documented the resident experienced the unwitnessed fall on 3/8/17 at 9:45 AM. The facility recommended, and action was taken to provide, a one-to-one (1:1) sitter for him. A fall mat at his bedside was also recommended.

The resident's 3/8/17 - 3/10/17 Neurological Assessments were to be completed following the 3/8/17 fall. The assessments were to assess for neurological status changes. The monitoring on 3/8/17 at 4:30 PM through 3/9/17 evening shift documented a change in status of drowsiness in the resident.

- 3/8/17 at 2:00 PM - The Hospice Nurse's Note documented the resident experienced 2 falls since admission to the facility.
- 3/8/17 - The Hospice Nurse's Note documented the resident was newly admitted to the facility and fell the evening of 3/7/17 and again in the morning of 3/8/17. The note documented the resident had multiple bandages on his left wrist, forearm, and elbow.

The resident's clinical record did not include an I&A report or fall investigation related to the 3/7/17 fall.

- 3/9/17 at 9:04 AM - A nursing progress note documented the resident had multiple 'almost' falls and was impulsive. The note documented the facility's Interdisciplinary Team (IDT) met and discussed initiating a 1:1 (one-to-one) sitter for him. The note documented the resident's family was called and 3 sitter services were referred to the family.

On 6/27/17 at 3:01 PM, the Director of Nursing Services (DNS) stated she was unaware the resident fell more than once in the facility and would look for an I&A report and fall investigation for the 3/7/17 fall. The DNS stated the facility implemented a 1:1 sitter because of his increased impulsiveness and his fall on 3/8/17. The DNS stated she did not implement fall mats to the resident's bedside due to his ability to walk. The DNS stated if the resident had fall mats implemented she feared the mats would create falls. The DNS stated when a resident fell the facility's Interdisciplinary Team met to determine the cause of the fall and discover the timeline. The DNS stated if a resident fell often in a short period of time the staff would implement interventions that increased supervision and 1:1 supervision was one of those interventions.

Joe Rudd Jr, Administrator
June 4, 2019
Page 6 of 9

On 6/28/18 at 8:50 AM, the DNS stated she was unable to find an I&A report and fall investigation related to the resident's 3/7/17 fall.

The resident experienced a fall on 3/7/18 and the facility did not initiate an investigation to determine the cause of the fall and what additional interventions were needed to prevent further falls.

Based on the results of the investigation, the allegation was substantiated. Deficiencies were cited at F610 as it relates to the failure of the facility to investigate the cause of falls and initiate further preventative actions, and F689 as it relates to the failure of the facility to ensure residents were supervised, and services provided, to prevent falls.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

Residents/residents' families were responsible for paying the cost of 1:1 caregivers the facility determined were necessary to protect residents' from falls.

FINDINGS #5:

During the investigation multiple interviews were conducted with residents and family members. Multiple staff members were interviewed regarding supervision and falls. The records of 5 residents were reviewed for accidents and supervision, including 1:1 supervision. Four of the 5 residents reviewed received the supervision necessary to protect them from falls and the facility paid for the caregivers.

One resident's record noted the resident was charged for 1:1 caregiver services determined necessary by the facility to protect him from falls. The record of the resident, who was admitted to the facility in March 2017, documented he experienced multiple falls while at the facility. A nursing progress note documented the resident had multiple 'almost' falls and was impulsive. The note documented the facility's IDT met and discussed initiating a 1:1 sitter for the resident and he required a 1:1 caregiver for safety. The note documented his family was called and 3 sitter services were referred to the family. The resident's record contained an invoice for the caregiver service billed to the resident and documented the invoice was sent to his family to be paid on his behalf.

The DNS said the resident required a 1:1 caregiver because of his increased impulsiveness and falls. The DNS stated the family paid for the 1:1 and she was unsure why. The DNS stated the facility usually provided this service and the caregiver service the family chose was one of the companies the facility worked with and usually paid for.

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F571 as it relates to the failure of the facility to ensure 1:1 caregivers, needed to protect the safety of residents, were paid for by the facility.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #6:

Residents' medication orders were not transcribed timely from a hospice provider.

FINDINGS #6:

During the investigation 7 residents' records were reviewed for medication management. Three of the residents' whose records were reviewed no longer resided in the facility. Multiple interviews were conducted with residents and family members. The residents and family members did not voice concerns regarding medication management. Multiple staff members were interviewed.

Six of the 7 residents' records reviewed reflected timely and correct physician orders.

One resident's record did not include documentation of timely transcription of physician orders. The resident was admitted to the facility in March 2017. The resident's record documented his hospice provider ordered a suppository of Diazepam for seizures as needed. The order was faxed to the facility on 3/9/17 at 12:09 PM. The facility's physician's order, dated 3/10/17 at 2:00 PM, documented he was to receive a 10 mg suppository of Diazepam for seizures, as needed. The order of the Hospice Physician was transcribed to the facility's physician orders 26 hours after the order was received by the facility.

The DNS stated she did not know the reason the order was not transcribed when the order was received on 3/9/17.

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F684 as it relates to the failure of the facility to ensure standards of practice were followed for medication management.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #7:

Residents' call bells/lights were not responded to in a timely manner.

FINDINGS #7:

During the investigation observations were conducted for call lights response times, Resident Council meeting minutes were reviewed, facility grievances were reviewed, and staff, residents, and family members were interviewed.

During observations of call light response times no concerns were identified. The call lights were answered within minutes and residents' needs were taken care of before call lights were turned off.

Resident Council Meeting minutes and Grievances from January 2018 to June 2018, documented call light response times were not a current issue. The Grievances from January 2017 to April 2017, documented call light response times were a concern and the facility had corrected the issue.

Several residents and two family members said call lights were answered in a timely manner and residents' needs were met, including in an emergent situation. Multiple certified nursing assistants and nurses said call lights were answered timely and residents' needs were met. The DNS and the Administrator said call light response times were not a current issue.

Based on the investigative findings, the allegation was substantiated. Deficiencies were not cited, however, as the facility had corrected the issue and call light response times were not identified as a issue at the time of the survey.

CONCLUSIONS:

Substantiated. No 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.

Joe Rudd Jr, Administrator
June 4, 2019
Page 9 of 9

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,



Sylvia Creswell, LSW
Long Term Care Program

SC/lj



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
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June 4, 2019

Joe Rudd, Jr., Administrator
Life Care Center of Boise
808 North Curtis Road
Boise, ID 83706-1306

Provider #: 135038

Dear Mr. Rudd Jr:

On **June 25, 2018** through **June 28, 2018**, an unannounced on-site complaint survey was conducted at Life Care Center of Boise. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007589

ALLEGATION #1:

The facility does not answer call lights timely during the evening shift 7:00 PM - 9:30 PM, residents have to wait for 45 minutes - 1 hour for call bells to be answered.

FINDINGS #1:

Observations of call light response times were completed on each date of the survey. Multiple interviews were conducted with residents from each staffed area of the facility, family members and staff members. Fourteen residents were included in the investigation's sampled residents.

The investigation revealed staff answered all call lights during the investigation observation periods on all the different staffed areas in under ten minutes. Interviews with current residents revealed call light answer times had been a problem in the past; however, the majority of the residents interviewed felt call light response times were currently reasonable.

Joe Rudd Jr, Administrator
June 4, 2019
Page 2 of 3

Review of the facility concern forms revealed a number of residents and/or family members submitted forms in the past year. The Director of Nursing stated there was a period of time when staffing was lower than normal, but that agency staff was now being used to supplement facility staff.

Due to investigative findings, the allegation was unsubstantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Facility failed to ensure residents had access to call lights to be able to call for assistance.

FINDINGS #2:

The allegation of the facility failing to keep call lights within reach of the residents could not be substantiated. There was insufficient evidence to establish that the facility acted inappropriately in response to the subject of the allegation and no deficiencies were written.

Two surveyors conducted an onsite complaint investigation at the facility on 06/25/18 through 06/28/18. Observations of call light placement were completed on each date of the survey. Multiple interviews were conducted with residents from each staffed area of the facility, family members and staff members. Fourteen residents were included in the investigation's sampled residents.

The investigation revealed call lights were placed within resident reach during the investigation observation periods on all the different staffed sections of the facility. Interviews with current residents revealed call light placement was not an issue. Review of the facility concern forms revealed no concerns forms about call lights in the past year.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility failed to ensure residents were treated with dignity.

Joe Rudd Jr, Administrator
June 4, 2019
Page 3 of 3

FINDINGS #3:

Two surveyors conducted an onsite complaint investigation at the facility on 06/25/18 through 06/28/18. Observations of resident treatment by staff were completed on each date of the survey in all areas of the facility where residents were located. Multiple interviews were conducted with residents from each staffed area of the facility, family members and staff members. Fourteen residents were included in the investigation's sampled residents.

The investigation did reveal incidences of resident being left in a state of undress in their rooms with blinds open during incontinence cares.

Due to investigative findings, the allegation was substantiated and cited at F 583, Personal Privacy/Confidentiality.

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 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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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June 12, 2019

William Jacobsen
808 N. Curtis Rd.
Boise, ID 83706

Dear Mr. Jacobsen:

On **June 25, 2018** through **June 28, 2018**, an unannounced on-site complaint survey was conducted at Life Care Center of Boise.

On behalf of the Bureau of Facility Standards, we extend our sincerest apologies for the delay in the response to your concerns regarding the care provided by Life Care Center of Boise. We understand the importance of these concerns and take these matters very seriously. It is unfortunate we had a delay in our investigation and response to you. For that we deeply apologize.

Thank you for bringing your concerns to our attention and it is our hope these concerns were resolved.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007743

ALLEGATION #1:

Facility failed to ensure nursing staff administered correct medications as ordered by the physician.

FINDINGS #1:

Multiple interviews were conducted throughout the facility with residents, family members, and staff members; medication administration was observed; and resident charts were reviewed. Fourteen residents were reviewed during the complaint investigation.

Current residents' insulin administration were observed to be administered according to the physicians' orders. During interviews with current diabetic residents there were no concerns with the type and/or timing of insulin administration.

One diabetic resident's record was reviewed and documentation included orders for Lantus and sliding scale regular insulin. The orders also included the resident could direct/choose the dose to be administered.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Facility failed to ensure call lights were answered in a timely manner.

FINDINGS #2:

The allegation of the facility failing to respond to call lights was unsubstantiated.

Observations of call light response times were completed on each date of the survey. Multiple interviews were conducted with residents from each staffed area of the facility, family members and staff members. Fourteen residents were reviewed during the investigation.

Staff were observed answering all call lights during the investigation on all the different staffed areas in under ten minutes. Current residents interviewed said call light answer times had been a problem in the past; however, the majority of the residents felt call light response times were currently reasonable. Review of the facility concern forms documented a number of residents and/or family members submitted forms in the past year. The Director of Nursing stated there was a period of time when staffing was lower than normal, but agency staff was now being used to supplement facility staff.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Facility failed to ensure resident food was palatable.

FINDINGS #3:

Observations were completed of meal tray service, and a sample tray was tested. Multiple interviews were conducted with residents, family members, and staff members. Fourteen residents were reviewed during the complaint investigation.

William Jacobsen
June 12, 2019
Page 3 of 3

A test tray was sampled (last tray to come off the tray cart) and hot food was still at a palatable temperature, however, the cold food products were above palatable temperatures. The main dish and dessert foods were not served in a palatable form. Interviews with the current residents stated the majority opinion the food was alright. Even though the allegation could not be substantiated for the food the complainant received, the allegation was substantiated for the food being currently served during the investigation survey. The facility failed to respond appropriately to the subject of the allegation and deficiencies were written.

Due to investigative findings, the allegation was substantiated and the facility was cited with deficient practice F804 Nutritive value/palatable food/preferred temperature.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, the facility was required to submit a Plan of Correction in writing to this office. In the facility's Plan of Correction, they stated the actions taken to correct each deficiency and a date it would be completed. A copy of the survey results may be obtained, after the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards has released it for public disclosure, through the Internet at www.facilitystandards.idaho.gov, posted under survey results, or through a Public Records Request. The contact information for making a Public Records Request is at www.healthandwelfare.idaho.gov/AboutUs/PublicRecordsRequest, or you may call (208) 334-5564, or the fax number is (208) 334-6558. The Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards will continue to monitor the progress of the facility.

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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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June 11, 2019

Joe Rudd Jr, Administrator
Life Care Center of Boise
808 North Curtis Road
Boise, ID 83706-1306

Provider #: 135038

Dear Mr. Rudd Jr:

On **June 25, 2018** through **June 28, 2018**, an unannounced on-site complaint survey was conducted at Life Care Center of Boise. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007822

ALLEGATION #1:

Facility failed to ensure proper assistance was provided to residents when transferring from bed.

FINDINGS #1:

Multiple interviews were conducted throughout the facility with residents, family members, and staff members. Fourteen residents were reviewed during the complaint investigation.

During observations during the investigation, one resident was out of bed daily and was cognitively intact to be able to choose if she wanted to get out of bed, and to communicate she had been out of bed. A review of one resident's care plan and nursing progress notes did not include the Resident's Representative's desire to have the resident out of bed on a daily basis. The care plan reviewed showed the care plan conference was overdue and not updated with current preferences.

Due to investigative findings, the facility was cited with deficient practice F684 for not following a planned program for a resident to be up and out of bed.

CONCLUSIONS:

Joe Rudd Jr, Administrator
June 11, 2019
Page 2

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

Facility failed to ensure call lights were answered in a timely manner.

FINDINGS #2:

Observations of call light response times were completed on each date of the survey. Multiple interviews were conducted with residents from each staffed area of the facility, family members and staff members. Fourteen residents were included on the investigation sample.

During observations during the investigation, staff answered all call lights on all the different staffed areas in under ten minutes. In interviews with residents, they said call light answer times had been a problem in the past; however, the majority of the residents felt call light response times were currently reasonable. Review of the facility concern forms documented a number of residents and/or family members submitted forms in the past year. The Director of Nursing stated there was a period of time when staffing was lower than normal, but that agency staff was now being used to supplement facility staff.

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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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June 20, 2019

Joe Rudd Jr, Administrator
Life Care Center of Boise
808 North Curtis Road,
Boise, ID 83706-1306

Provider #: 135038

Dear Mr. Rudd Jr:

On **June 28, 2018**, an unannounced on-site complaint survey was conducted at Life Care Center of Boise. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007715

ALLEGATION #1

A resident was not offered to move out of his/her room when the sewer backed up into their room. The facility allowed residents to wheel through the dirty corridor while the sewer was being fixed.

FINDINGS #1

An unannounced onsite complaint survey was conducted on 6/25/18 to 6/28/18. During the investigation observations were conducted for environmental issues, Resident Council Meeting minutes and facility grievances were reviewed, six resident records were reviewed, maintenance logs were reviewed, and residents and staff were interviewed regarding environmental concerns.

The Maintenance/Housekeeping Log documented problems and concerns regarding the bathroom toilet in one of the rooms shared by two residents on 9/27/17, 10/11/17, and 11/24/17.

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A Plumbing Invoice, dated 12/19/17, documented the toilet in the room was backed up and a camera was used to locate a towel and a cable end in the pipes. The invoice documented the pipes needed to be replaced.

A Plumbing Work Order, dated 1/3/18-1/5/18, documented the pipe was replaced.

A resident stated the toilet in his/her room stopped working a few months ago and he/she had to use the bathroom in a vacant room next door for a few weeks. The resident stated the facility offered them the option of moving to the other room; however, they did not want to leave their roommate because they were worried about the roommate's welfare. The resident stated they wheeled themselves through the dirt while it was initially being repaired and the facility moved them to another room later.

Another resident stated the facility did not offer them the option of changing rooms when the toilet in their room broke. The resident stated they were incontinent and did not use the toilet, so the resident did not think the facility thought to ask them about it.

The Maintenance Director, Resident Support Services personnel, and nursing personnel remembered the incident when the toilet broke and residents had to use other bathrooms and/or stayed in their rooms while it was being fixed. The staff stated they offered to relocate one of the residents and not the other because of different continence levels.

The Executive Director stated there was dirt in the hallway when the construction work first began and residents had to wheel their way through the area. The Executive Director stated all residents were moved to different areas of the building when the concrete work began.

CONCLUSIONS:

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F921 as it related to the failure of the facility to ensure the physical environment was maintained and when issues were identified residents moved to a clean area.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Thank you for the courtesies and assistance extended to us during our visit. 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.

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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,

A handwritten signature in black ink, appearing to read "Laura Thompson". The signature is written in a cursive style and is positioned above the typed name.

LAURA THOMPSON, RN, Supervisor
Long Term Care Program

LT/slj