IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

December 17, 2018

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

Provider #: 135077

Dear Mr. Smith:

On **November 30, 2018**, a survey was conducted at Avamere Transitional Care & Rehab - Boise by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 27, 2018**. Failure to submit an acceptable PoC by **December 27, 2018**, may result in the imposition of penalties by **January 19, 2019**.

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 <u>in column (X5)</u>.

  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 **January 4, 2019 (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 **February 28, 2019**. A change in the seriousness of the deficiencies on **January 14, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 1, 2019** includes the following:

Denial of payment for new admissions effective **March 1, 2019**. [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 **May 30, 2019**, 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 **March 1, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

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

This request must be received by **December 27, 2018**. If your request for informal dispute resolution is received after **December 27, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,

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

dr/lj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from November 26, 2018 through November 30, 2018. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Cecilia Stockdill, RN Sharon Whitehead, RN, BSN Laura Thompson, RN, BSN Belinda Day, RN, BSN Survey Abbreviations: @ = at ADL = Activities of Daily Living CNA = Certified Nursing Assistant DM = Diabetes Mellitis DNS = Director of Nursing Services LPN = Licensed Practical Nurse MDS = Minimum Data Set assessment RN = Registered Nurse RNA = Restorative Nursing Assistant ROM = Range of Motion			
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and	F 561		1/4/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/24/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 1 waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, resident family interview, and staff interview, it was determined the facility failed to ensure a resident's bathing preferences were honored. This was true for 1 of 3 residents (#3) reviewed for choices. This deficient practice had the potential for Resident #3 to experience a decreased sense of wellbeing, lack of self-worth, and frustration when his preference for tub baths was not accomodated. Findings include: The facility's accommodation of needs policy, dated October 2009, directed staff to accommodate individual preferences to maintain dignity and well being. Resident #3 was admitted to the facility on	F 561	1. One resident (#3)was affected by the deficient practice. This residents care plan reviewed and revised as appropriate. 2.All residents had the potential to be affected by the deficient practice. Facility Care Plan Questionnaire will be utilized for all residents and Care Plans will be revised as appropriate. 3. Care Plan Questionnaire will be added to Facility Admission packet and utilized for all residents upon admission. 4. Facility will conduct audits on random sample of Care Plans daily x5 in first five seven days, then weekly x4, then monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 2 5/10/18 with multiple diagnoses, including stroke, left-sided hemiplegia and hemiparesis (paralysis and weakness), and reduced mobility. Resident #3 nurse's progress notes, dated 5/11/18, documented his family member requested tub baths and that CNAs were to be informed of this preference. Resident #3's current care plan directed staff to bathe him with the assistance of 2 staff persons. The care plan did not document how to bathe him. Resident #3's ADL flow sheets from 5/10/18 through 11/28/18 documented he received a tub bath on 9/6/18, which was 1 out of 82 opportunities. On 11/26/18 at 4:10 PM, Resident #3's family member said it would be nice if he received a tub bath once in a while. The family member said he enjoyed a bath but staff did not have time to give him a tub bath. On 11/29/18 at 8:34 AM, CNA #7 said Resident #3 received showers and had never been told he liked a tub bath. On 11/29/18 at 3:26 PM CNA #8 said due to his paralysis, Resident #3 would slide down in the tub. On 11/29/18 at 3:31 PM, the MDS Coordinator demonstrated the use of the facility's bath tub. He said the tub could be tilted back so someone with limited mobility or paralysis could use it. He said Resident #3's bathing preferences should have	F 561	x3, to be conducted by DNS or designee. Results of these audits will be brought to monthly QAPI committee x3 months, and Quarterly x2 quarters until substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 3 been clarified in care plan and communicated to staff.	F 561		
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. §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. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (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. (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.	F 583		1/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and resident and staff interview, it was determined the facility failed to ensure a resident's privacy in their room. This was true for 1 of 15 residents (#60) reviewed for privacy when a resident's room had private health information hanging on the wall in view of any person who entered the room. This deficient practice had the potential for psychosocial harm if the resident felt embarrassed with the placement of the sign. Findings include: The facility's quality of life policy, dated October 2009, directed staff not to post signs in a resident's room which indicated the resident's clinical status or care needs. Resident #60 was admitted to the facility on 10/2/18, with multiple diagnoses including heart failure. An incident report, dated 11/9/18, documented Resident #60 fell out of bed on 11/2/18 and sustained a bruise to her head. Resident #60's current care plan documented a revised intervention on 11/7/18 to keep the bed in the lowest position. On 11/26/18 at 2:43 PM, 11/27/18 at 8:05 AM, and 11/28/18 at 9:08 AM, Resident #60's wall above her bed had a sign posted that documented, "Bed in lowest position @ all times." On 11/26/18 at 2:43 PM, Resident #60 said after	F 583	1. One resident (#60) was affected by the deficient practice. PHI was removed from residents room upon discovery of PHI. 2. All residents had the potential to be affected bu the deficient practice. Facility completed full building audit of residents room and all PHI removed as appropriate. 3.In-services provided to all nursing staff (C.N.A and LN's)regarding posting of PHI in resident rooms/ care areas. 4. Resident-in-Room audit to be completed by DNS or designee daily x5 in first seven days, then weekly x4, then monthly x3 to be conducted by DNS or designee. Results of these audits will be brought to monthly QAPI committee x3 months, and Quarterly QA x2 quarters until substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 5 her fall, the sign had appeared without her consent or input. On 11/28/18 at 9:10 AM, RN #1 said the sign in Resident #60's room alerted staff to keep the bed in the low position. On 11/28/18 at 2:19 PM, the Staff Development Coordinator observed the sign on the wall and said it should not be there.	F 583		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		1/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 6 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and resident, resident family, and staff interviews, it was determined the facility failed to provide sufficient laundry service for clean linen, towels, and resident clothing for 3 of 15 (#3, #40, and #50) residents reviewed for a clean, comfortable, and homelike environment. This created the potential for diminished quality of life for all residents in the facility if they did not have access to clean laundry. Findings include: On 11/26/18 at 4:10 PM, Resident #3's family member said the facility was slow getting his clothes washed and returned in an appropriate time. On 11/27/18 at 11:34 AM, during the resident group interview, Resident #40 and Resident #50 said there was always a delay with the laundry, including not having enough towels and bed linens. On 11/30/18 at 10:10 AM, the laundry room was	F 584	1. 3 residents (#3, #40 and #50)were affected by the deficient practice. Facility has ordered additional linens to ensure appropriate par levels for use in facility. Facility will monitor laundry services to ensure that clothing is delivered back to residents with 48. 2. All residents had the potential to be affected by the deficient practice. Facility has ordered additional linens to ensure appropriate par levels for use in facility. Facility will monitor laundry services to ensure that clothing is delivered back to residents within 48 hours. 3.Staff will be in serviced about taking to appropriate number and type of linens when preforming tasks. 4. Par levels audits will be conducted by Housekeeping/ Laundry manger or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 7 observed to have a clothing rack, approximately 5-6 feet long with tightly packed clothing. Housekeeper #1, who staffed the laundry room, said the rack contained clothing that did not have identifiers and the laundry staff was unable to determine who the clothing belonged to. Housekeeper #1 said the clothing likely belonged to residents who had discharged and the resident or family did not pick up the clothing, or the labels had come off of current residents' clothing. On 11/30/18 at 11:20 AM, CNA #6 said there was not enough linens in the facility and she often would have to go find towels or linens in one of the other two hallways in the facility. She said there were times when a resident did not receive a bath or shower because she could not find clean towels. CNA #6 said she also had noticed an increased incidence of residents complaining about not getting their clothing back from the laundry. On 11/30/18 at 11:36 AM, there were no towels in the linen closet on Hallway 100 and approximately 4 sets of bed linens. Hallway 200 had 2 linen closets to provide linens and towels for 22 occupied rooms. The first closet had no linens or towels. The second closet had no towels, a few sheets and the shelves were mostly bare. Hallway 300 did not have a linen closet. CNA #6 said towels and linens for Hallway 300 were accessed directly from the laundry room, which was located on Hallway 300. On 11/30/18 at 11:43 AM, when the surveyor entered the laundry room and asked Housekeeper #1 if she could provide a stack of towels for residents, she pointed to two towels	F 584	designee daily x5 in first seven days, then weekly x4 and monthly x3. Administrator will review the audits in parallel with the audit schedule and ensure that linen is being ordered as needed. Results of these audits will be brought to monthly QAPI committee x3 months, and Quarterly QA x2 quarters until substantial compliance is met. Facility will also utilize Abaqis customer satisfaction survey and Resident council minutes to monitor continuing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 8 she had available and said she was working on folding more. When asked about towels being available in the facility, Housekeeper #1 said she had delivered a supply early in the morning to Hallway 100, but had not yet delivered towels for the day to Hallway 200.	F 584		
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 by: Based on record review and staff interview, it was determined the facility failed to ensure an investigation was conducted for a written grievance regarding possible drug diversion for 1 of 3 residents (Resident #50) who received narcotic medications and whose records were reviewed. This failure had the potential for harm if residents' narcotic pain medications were diverted by staff and they did not receive their	F 610	1. One resident (#50) had the potential to be affected by the deficient practice. Residents chart reviewed to ensure that no additional concerns noted by Medical Providers. Facility conducted investigation regarding the unsubstantiated complaint from Medical Provider and took action as appropriate.	1/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 9 prescribed medications to control their pain. Findings include: Resident #50 was admitted to the facility on 7/23/16, with diagnoses which included chronic pain and neuropathy (nerve damage which causes numbness and pain). Resident #50's October 2018 physician orders included Oxycodone 20 mg 1 tablet every 4 hours as needed for pain, up to 5 tablets a day. A consultation report from Resident #50's pain management physician, dated 10/15/18, stated "Recurrent mismanagement of opioid pain meds [medications] @ Avamere and I will no longer provide pain management treatment for patients @ Avamere." There was no documentation in Resident #50's record this concern was acknowledged or investigated by Administration. The next prescription for Resident #50's Oxycodone was written and signed by a nurse practitioner on 11/8/18. On 11/29/18 at 3:00 PM, the DNS and Regional Nurse Consultant stated narcotic medications were contained in locked drawers on the medication cart and a narcotic book was kept on each cart to monitor administration and counts. The DNS stated narcotic medications were counted at the end of each shift by 2 nurses and signed by both nurses. The DNS stated he was not aware of the pain management physician's concern with mismanagement of narcotic medications or that it was documented in a note in Resident #50's record.	F 610	2. Any resident who receives pain management series from an outside provider has the potential to be affected by the deficient practice. These residents charts will be reviewed for any documentation which would constitute a concern or grievance and investigations will be conducted for any identified issues. 3.Licensed nurses will receive in services regarding reviewing of MD progress notes/ comments and the proper reporting procedure of any issues to RCM or DNS. RCMs will review all notes back from MD's as needed for further follow up. Any issues identified will be investigated by RCM/ DNS. 4. DNS or designee will audit 5 MD progress notes per week for any issues requiring follow up, and issues identified will be investigated immediately. Audits will be conducted daily x5 for first seven days, then weekly x4 and monthly x3. results of these audits will be brought to monthly QAPI committee x3 months, and Quarterly x2 quarters until substantial compliance has been met.	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622		1/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 10 §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 11 or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 12 ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the record included documentation the physician was notified and discussed the risks of the resident leaving against medical advice for 1 of 3 residents (Resident #64) whose closed records were reviewed. This had the potential for the resident to experience harm if their condition worsened as a result of leaving against medical advice. Findings include: Resident #64 was admitted to the facility on 9/1/18, with a right heel pressure ulcer, osteomyelitis (infection of the bone), vascular disease with stent placement in right leg, DM Type II, and chronic pain. An admission note, dated 9/1/18 at 7:03 AM, documented Resident #64 was admitted to the facility from a local hospital. Resident #64 had a PICC line and required the assistance of 1 person when he was transferred from the transport gurney into his bed. A PICC line is a peripherally inserted central catheter used for administration of medications and to obtain blood for laboratory tests. A subsequent nursing note, dated 9/1/18 at 11:08 AM, documented Resident #64 was complaining	F 622	1. One resident (#64) had the potential to be affected by the deficient practice. Tis resident is no longer at the facility. 2. Any resident who leaves the facility AMA has the potential to be affected by the deficient practice. Any resident who leaves AMA will be reviewed by DNS or designee to ensure that all proper steps and documentation is completed. 3. Licensed Nursing staff will be in serviced on AMA documentation, to include detailed explanation of risks and benefits and MD notification. An AMA checklist will be developed and implemented to ensure that all necessary steps are taken in the event of an AMA discharge, and use of check list will be included in AMA in-service. 4. All AMA discharges will be reviewed by DNS or designee the next day or as soon as is practicable to ensure completion of all necessary tasks and documentation. ALL AMA discharges will be reviewed quarterly at QAPI committee for 1 year in addition to initial review of AMA documentation to ensure continued	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 13 of the food, being cold, and the facility's smoking rules and he wanted to leave the facility and go home. The nurse documented she informed Resident #64 "...of the risks of leaving AMA [against medical advice] with PICC, ABX [antibiotics], therapies, wound care etc [sic] and that I don't have a SW [social worker] till Tues to assist wit [sic] home health." The nurse did not include documentation of what the risks were for Resident #64 related to his diagnoses and condition. There was no documentation of interventions regarding his complaints about the food or being cold. A nursing note, dated 9/1/18 at 9:43 PM, documented Resident #64 stated he wanted to leave AMA if he cannot have an electric blanket. The nurse documented she informed him why he could not have one. The nurse documented the DON was made aware of the situation and was going to come talk with Resident #64. At 10:18 PM on 9/1/18, a nursing note documented Resident #64 left AMA. The note documented "...resident was educated about risks vs benefits of staying about worsening infection..." There was no documentation Resident #64's physician was notified he left AMA. There was no documentation how Resident #64 left the facility, where he went, who he left with, or his physical status or condition. An AMA form, dated 9/1/18 at 9:37 PM, documented Resident #64 was informed of the risks involved with leaving which included worsening infection and falls. A handwritten note on the form stated Resident #64 refused to sign the form. The form was signed by 2 staff	F 622	compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 14 members. On 11/30/18 at 10:50 AM, the DON stated he had come to the facility to speak with Resident #64 but he had already left. He stated the attending physician was made aware of Resident #64 leaving AMA but confirmed this was not documented in the record. He stated he signed the AMA form along with an LPN. The DON stated he "coached" the LPN on what to say to Resident #64 regarding the risks of leaving the facility. He stated Resident #64 was picked up by a friend who took him to his home. The DON confirmed this was not documented.	F 622		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident and staff interviews, it was determined the facility failed to ensure oral care and bathing were provided consistent with residents' needs. This was true for 2 of 4 residents (Resident #38 and #213) who were reviewed for ADL care. This failure created the potential for residents to experience tooth decay and/or skin breakdown and a negative effect to their psychosocial well-being when teeth were not brushed and/or bathing was not provided. Findings include: The facility's Nursing Services policy, dated October 2010 directed staff to assist residents	F 677	1. Two residents (#38 and #213) were affected by the deficient practice. These residents care plans were reviewed and updated as appropriate to ensure their needs were being reflected on both the Care Plan and POC (Point of Care) system to ensure tasks appearing appropriately for C.N.A staff. Orders updated to reflect oral care every morning and evening. Bathing documentation reviewed and resident #213 brought into compliance with bathing schedule. 2. All dependent residents had the potential to be affected by the deficient	1/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 15 with brushing their teeth based on their needs. The policy directed staff to bath residents to promote cleanliness. Resident Council minutes, dated 9/17/18 and 10/22/18, documented concerns of residents not receiving their showers consistently. 1. Resident #38 was readmitted to the facility on 7/31/17 with multiple diagnoses, including incomplete quadriplegia and muscle wasting and atrophy. A quarterly MDS assessment, dated 10/18/18, documented Resident #38 required extensive assistance with personal hygiene and had limited ROM (Range of Motion) impairments in both upper extremities. Resident #38's current care plan directed staff to assist him with brushing his teeth in the morning and evening. Resident 38's ADL flowsheet for October 2018, documented he received assistance with brushing his teeth 26 out of 31 opportunities on evening shift. There was no documentation for oral care on the morning shift. Resident 38's ADL flowsheet for November 2018 documented he received assistance with brushing his teeth 25 out of 30 opportunities on evening shift. There was no documentation for oral care on the morning shift. On 11/26/18 at 2:49 PM, Resident #38 had visible white debris on his upper and lower teeth. He said staff did not brush his teeth enough.	F 677	practice. Facility determined which residents are dependent and reviewed their documentation for bathing and oral care. Orders and care plans updated as appropriate upon completion of review. Review to be conducted by DNS or designee. 3. Direct care staff provided in service on Bathing Refusal policy with re-approach and Nurse approach expectations, along with documentation of refusal and reason for refusal along with documentation of risk and benefits for refusal of the care. Direct Care Staff provided in service on Oral care for dependent residents. 4. Facility will conduct audits of dependent residents Oral Care and Bathing ADL documentation daily x5 of first seven days, then weekly x4 and monthly x3. Results of these audits will be brought to monthly QAPI committee x3 months, and Quarterly x2 quarters until substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 16 On 11/28/18 at 11:58 AM, Resident #38 was in bed and had red colored food debris on his upper teeth and lip. At 12:08 PM, CNA #5, who had just left the room after providing incontinence care, came back into the room with a clean washcloth and wiped the food debris off Resident #38's lip. CNA #5 did not brush his teeth or wipe off the food debris in his mouth. On 11/29/18 at 11:13 AM, CNA #5 said she had not noticed the food debris in Resident #38's mouth on the previous day. CNA #5 said she tried to brush his teeth before breakfast and if he had food debris, she would use a sponge swab to clean out his teeth. On 11/29/18 at 10:45 AM, CNA #6 said she tried to brush Resident 38's teeth once a day between breakfast and lunch. CNA #6 said she had not had time to clean his teeth that day, and some days he went without getting his teeth brushed. On 11/30/18 at 1:50 PM, RCM #1 said according to the care plan, Resident #38 was to have his teeth brushed twice a day. RCM #1 said his ADL documentation showed his teeth were only brushed in the evenings. RCM #1 said Resident #38's teeth were not brushed in the evenings on a few occasions. 2. Resident #213 was admitted to the facility on 11/24/17 with multiple diagnoses, including difficulty in walking and morbid obesity. A quarterly MDS assessment, dated 8/22/18, documented Resident #213 had limited ROM impairments in both lower extremities and required extensive assistance from one person	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 17 for bathing. Resident #213's current care plan directed staff to provide one person assistance for bathing. Resident #213's ADL flowsheet for September 2018 documented he received a bed bath on 9/3/18, 9/20/18, 9/24/18, and 9/27/18. The ADL record documented he refused his bed bath on 9/10/18. There was no documentation of the reason why he refused or if staff had followed up with him regarding his 9/10/18 refusal. He did not receive a bath for 16 days between 9/3/18 and 9/20/18. Resident #213's ADL flowsheet for October 2018 documented he received a bed bath on 10/7/18, 10/11/18, 10/14/18, and 10/21/18. The ADL record documented he refused his bed bath on 10/4/18 and 10/6/18. There was no documentation of the reason why he refused or if staff had followed up with him regarding his 10/4/18 or 10/6/18 refusals. He did not receive a bath for 9 days between 9/27/18 and 10/7/18 and for 6 days between 10/14/18 and 10/21/18. Resident #213's ADL flowsheet for November 2018 documented he received a bed bath on 11/8/18, 11/18/18, and 11/22/18. The ADL record documented he refused his bed bath on 11/4/18, 11/11/18, and 11/25/18. There was no documentation of the reason why he refused or if staff had followed up with the resident regarding his refusals on 11/4/18, 11/11/18, and 11/25/18. He did not receive a bath for 17 days between 10/21/18 and 11/8/18 and for 9 days between 11/8/18 and 11/18.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 18 On 11/26/18 at 3:55 PM, Resident #213 said staff was not providing bed baths twice a week and he would sometimes not get a bath for two to three weeks in a row. On 11/29/18 at 10:48 AM, CNA #6 said Resident #213 sometimes refused showers. CNA #6 said if he did that, she reported it to the nurse for the nurse to reapproach him. On 11/29/18 at 4:54 PM, LPN #4 said Resident #213 rarely refused his bed baths. LPN #4 said if he refused then the CNA would alert the nurse and the nurse would chart in progress notes and then the nurse would reapproach the resident about bathing. On 11/30/18 at 1:50 PM, RCM #1 said Resident #213 preferred a bed bath twice a week. She said there were several days the resident did not get a bath and should have. RCM #1 said there were several refusals and the nurse should have documented what the staff did after the refusals. On 11/30/18 at 4:45 PM, Resident #213 said he did not refuse his baths because he really enjoyed them.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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	F 684		1/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 19 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and review of facility policy and procedures, the facility failed to: 1) ensure staff implemented pressure ulcer prevention measures as ordered by the physician and as directed in the care plan. This was true for one of three residents (Resident #7) reviewed for pressure ulcers. 2) ensure timely urostomy care was provided for one of one resident (Resident #49) reviewed for ostomies. These failed practices placed Resident #7 at risk of developing pressure ulcers and Resident #49 at risk of severe pain due to delayed ostomy care and incorrect ostomy care due to lack of staff training. Findings include: The facility's policy and procedure for Prevention of Pressure Ulcers, revised 10/2010, documented the following: * General Preventive Measures for a person in bed: Change position at least every two hours or more frequently if needed. * Risk Factor - Friction and Shear: Contractures need to be addressed and managed to prevent skin integrity disruption. * Skin to skin contact needs to be avoided by placement of pillows, folded sheets or clothing. * Risk Factor - Immobility: Use pillows or wedges to keep bony prominences such as knees or ankles from touching each other. 1. Resident #7 was admitted to the facility on 3/11/14 with diagnoses that included a history of unspecified head injury and quadriplegia (the	F 684	1. Two residents (#7 and #49) were impacted by the deficient practice. Resident #7 had review of care plan and orders and updated as appropriate. In services provided to care staff related to specific care needs related to pressure ulcer prevention of resident #7 to ensure needs being met. Resident #49 care plan and ostomy orders reviewed and revised as medically appropriate and to reflect the preferences off resident #49. 2. Any resident with pressure ulcer prevention interventions or with an ostomy had the potential to be affected by the deficient practice. These residents identified and care plans/ orders reviewed and updated as medically appropriate and to reflect residents preferences. 3. In services will be provided to all LN"s and C.N.As in relation to pressure prevention interventions, how to access the Kardex and review frequency expectations and ostomy care. Ostomy competencies will be conducted on all LNs and ostomy care will be added to the orientation process of LNs. 4. TAR will be audited for compliance with ostomy care. Random sample of residents with pressure ulcer prevention interventions utilizing the dependent resident audit form will be conducted to monitor for compliance. These audits will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 20 severely limited ability, or inability, to voluntarily move all four extremities). Resident #7's quarterly MDS assessment, dated 11/1/18, documented the following: * She had severe cognitive impairment. * She required total assistance of two or more persons for bed mobility and all other activities of daily living. * There were no pressure ulcers, but she was at risk for their development. * Resident #7's Skin and Ulcer Treatments included a pressure reducing device for her chair and bed, a "turning/repositioning program," and the "applications of ointments/medications other than to feet." Resident #7's active care plan documented a revision on 9/6/18, which stated she was at risk for skin impairment due to dependent for all mobility, tracheostomy and equipment related to tracheostomy care and incontinence. The care plan also document an open area Resident #7's right buttock noted on 9/4/18. The interventions for treatment included the following: * Float heels on pillows when in bed, revised on: 6/6/17. * Offloading boots to both lower extremities at all times as Resident #7 tolerated and to readjust the boots with every care encounter, revised on: 5/30/18. * Palm protector to left hand at all times, remove for hygiene daily and replace. Report any skin issues to the nurse, revised on: 6/6/17."	F 684	be conducted daily x5 in first seven days, then weekly x4 and monthly x3 by DNS or designee. Results of these audits will be brought to monthly QAPI committee x3 months, and Quarterly x2 quarters until substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 21 * Palm protector to right hand during the night due to using right hand during awake hours to reach out and touch. Date Initiated: 6/6/17. * Place pillow between knees when in bed. Date Initiated: 12/11/15. * Pressure reducing mattress and wheelchair cushion per physician's order. Date Initiated: 3/13/14. * Reposition every 2 hours, avoid skin on skin contact, use pillows as necessary. Date Initiated: 4/28/15. Resident #7's November 2018 physician orders documented the following orders related to Resident #7's skin status: * Skin monitor: Monitor the skin on Resident #7's right buttock open area every day on the day shift, ordered on 9/6/18. * Weekly Skin Audits to be completed and document "N" for no skin issues and "Y" for new skin issues, assess whether Resident #7's wheelchair cushion is in good condition by documenting (Y) yes or (N) no, notify the wound team for replacement cushion. These tasks were to be completed on the day shift every Friday and were ordered on 10/3/17. On 11/26/18 at 11:34 AM, Resident #7 was in bed on her back partially covered by a sheet, and her neck, shoulders, head, both arms and hands, and both legs from the knees down were visible. Resident #7 had large padded boots on both	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 22 feet; however, no pillows or other positioning devices were in place between the resident's knees or elsewhere in the bed, and her left hand, which was contracted into a fist, did not have a palm protector in use. On 11/26/18 at 3:54 PM, Resident #7 was in bed on her back partially covered by a sheet; however, her neck, shoulders, and head, and both arms and hands were visible. She did not have a palm protector in her left hand. On 11/28/18 at 2:11 PM, Resident #7 was in bed on her back. A sheet covered her from mid-chest to just below her knees, but both arms and hands rested on top of the sheet. Her contracted left hand had no palm protector in place. There was no pillow between her knees. During continuous line-of-sight observation of Resident #7's room on 11/28/18 from 2:11 PM to 4:14 PM, the staff did not reposition her, place a pillow between her knees, or apply her left-hand palm protector. At 4:14 PM, LPN #1 entered Resident #7's room. Resident #7 was lying on her back in bed while LPN #1 attended to her feeding pump. At that time, CNA #3 entered the room and straightened the pillow under Resident #7's head. Neither LPN #1 nor CNA #3 attempted to reposition Resident #7 or apply a palm protector to her left hand before leaving the room. During observations on 11/29/18 at 10:45 AM and 5:00 PM, Resident #7 rested on her back in bed partially covered by her sheet. No pillows or other positioning devices were in place between her knees or elsewhere in the bed, and her left	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 23 hand did not have a palm protector in place. On 11/30/18 at 9:50 AM, the wound nurse stated she began work at the facility in May 2018, and she had not yet obtained her wound care certification but she attended a training course on pressure ulcer prevention since that time. The wound nurse stated Resident #7 had "little padding over her coccyx [lower back]" and was "at high risk for pressure ulcers." The wound nurse stated Resident #7's pressure ulcer prevention strategies included weekly skin checks, being on the "Last up, first down" list for all meals (although she received all her nutrition and fluids through a gastric tube), and the application of a skin protectant to her right buttock twice daily and barrier cream after each episode of incontinence. The wound nurse said Resident #7 was turned and repositioned every two hours, and she was to wear pressure-relieving boots to both feet at all times. Resident #7's skin had an area of scar tissue over her coccyx that extended to both buttocks, which the wound nurse stated was a result of healed pressure ulcers. Resident #7's left hand had a firm contracture of all fingers toward the palm of the hand. The wound nurse was able to work with and partially open her hand, and no wounds or odor were present. The center of Resident #7's palm was moist with some flaking to the surrounding skin. RN #2 was unaware of Resident #7's orders for staff to apply a palm protector to the resident's left hand at all times and to apply a palm protector to her right hand at night. On 11/30/18 at 10:20 AM, CNA #1 stated Resident #7's pressure ulcer preventions	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 24 measures included applying a barrier cream to her skin after incontinence care, to make sure she had her heel boots on, and to tell the nurse about any new pressure ulcers that developed. At that time, the wound nurse said to CNA #1, "What about repositioning?" and CNA #1 and CNA #2 stated, "Yes, and repositioning every two hours." Neither CNA #1 nor CNA #2 was aware of the order to apply and maintain a palm protector to Resident #7's left hand at all times, to apply a palm protector to her resident's right hand at night, and the other pressure relieving interventions on Resident #7's care plan. On 11/30/18 at 4:33 PM, the DNS stated he expected the staff to apply the pressure ulcer prevention interventions listed on Resident #7's care plan. 2. Resident #49 was admitted to the facility on 3/21/18 with diagnoses that included cerebral palsy, neuromuscular dysfunction of the bladder, and anxiety disorder. Resident #49's quarterly MDS assessment, dated 11/1/18, documented she was cognitively intact for daily decision-making and required extensive assistance of one person for bed mobility, transfers, toileting, and bathing. Resident #49's November 2018 physician orders documented orders on 8/23/18 for providing care to her urostomy stoma (a urostomy is a surgical procedure which diverts the normal flow of urine from the kidneys and ureters into an artificial opening). The order included an ostomy care protocol which documented staff were to change the stoma wafer and bag every 5 days on the day	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 25 shift and as needed. The protocol stated if the wafer and bag had been changed within the last 24 hours, it was ok to change them at the next scheduled time. Resident #49's active care plan was revised on 9/19/18, to state she had a urostomy for her bladder related to cerebral palsy with neurogenic bladder. The interventions included: * Ostomy care per protocol, revision date 6/8/18 * Urostomy appliance change per physician's orders, revision date 3/21/18. On 11/26/18 at 4:30 PM, Resident #49 stated she had an ileal conduit [a type of urostomy] and the stoma wafer and drainage bag were changed on her bath days, every Thursday and Sunday. Resident #49 stated she had her shower yesterday (Sunday), and she needed the wafer and bag replaced over her stoma site but the nurse on duty that day did not seem comfortable with doing the procedure even though she told the nurse she could walk her through it. Resident #49 said the nurse did not come back to complete the procedure. Resident #49 then stated the evening shift nurse on Sunday also did not know how to apply the wafer and drainage bag, so she "had to wait from 12:30 PM until 10:00 PM when the night shift nurse came on duty to get my bag put on." Resident #49 stated not having her stoma covered with a bag caused the stoma to dry out and that was very painful. When asked to rate her pain experience using a zero to 10 scale (with zero indicating no pain and 10 indicating the worst pain ever felt) during the nine and one-half hours before the night shift nurse replaced her wafer and bag, Resident #49	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 26 said it was a "5." Resident #49 also stated she had anxiety, and was on "pins and needles" all day and evening waiting for someone to come in and put her bag on. Resident #49 said she could not get out of bed because there was no bag on her stoma. Resident #49 added there was another nurse who was also new to the facility that did not know how to care for her urostomy. Resident #49's November 2018 ADL documentation indicated Resident #49 received a shower on Sunday, 11/25/18, and the last time the staff assisted her to transfer that day was at 1:59 PM. Resident #49's Progress Notes for 11/25/18 from 4:10 AM through 10:36 PM, provided no documentation to indicate the staff changed her urostomy wafer and bag that day. Resident #49's November 2018 TAR documented the Urostomy Care protocol order, dated 8/23/18 was discontinued on 11/6/18, and a new order was received on 11/6/18 at 8:21 PM, which directed the staff to "Change wafer [and] bag every 5 days and prn... [on the] evening shift every Friday." The TAR documented Resident #49's urostomy wafer and bag were changed on the evening shift on Friday and not changed again until the day shift on Thursday, 11/29/18. On 11/30/18 at 4:33 PM, the DNS stated the last time the facility provided an in-service on ostomy care was in February 2018, and the nursing staff who worked with Resident #49 on Sunday, 11/25/18, were new to the facility and did not receive ostomy training. When asked how he ensured the staff had the appropriate skill level to	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 27 provide care to the residents as ordered, the DNS stated he expected any staff member who needed training in an area to make him aware of the concern and they could provide training. The DNS stated the facility did not have a policy and procedure for ostomy care.	F 684		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident, family, and staff interviews, it was determined the facility failed to ensure residents received treatment and services for a restorative nursing program. This was true for 4 of 6 residents (#3, #30, #38, and #213) reviewed for restorative nursing services. This failure created the potential for harm if residents	F 688	1. Four residents (#3, #30, #38 and #213)had were affected by the deficient practice. In the event that facility need necessitates the use of the RNA on the floor, activities department will continue to provide back up services to the RNA program for the group RNA programs.	1/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 28 experienced a decline in ROM. Findings include: The facility's Rehabilitative Nursing Care policy, dated April 2007, documented the rehabilitative nursing care program was designed to assist residents with routine ROM exercises to achieve and maintain an optimal level of self-care and independence. 1. Resident #3 was admitted to the facility on 5/10/18 with multiple diagnoses, including stroke, left-sided hemiplegia and hemiparesis (paralysis and weakness), and reduced mobility. Admission and quarterly MDS assessments, dated 5/17/18 and 8/17/18, documented Resident #3 was severely cognitively impaired, required extensive assistance from two people for ADLs, and had limited ROM impairments in both upper and lower extremities. Resident #3's physician's progress note, dated 5/11/18, documented he had an impairment with mobility. A care conference summary, dated 11/14/18, documented Resident #3's family member voiced a concern he should be receiving therapy services and was told the RCM would look into that. Resident #3's current care plan directed staff to maintain current level of function in various ADL functions due to limited mobility related to deconditioning. The care plan did not include a restorative nursing program. On 11/26/18 at 4:06 PM, Resident #3's family	F 688	2. All residents have the potential to be affected by the deficient practice. Staffing patterns reviewed and indicated that there is staff scheduled to meet the needs of the residents current conditions. Only exception to this was when RNA was pulled to the floor for cares. 3. Facility will continue to monitor staffing based off census and acuity. Staffing Coordinator Administrator will monitor for appropriate amount of staff. Facility will exercise due diligence in attempting to fill open shifts due to call ins so that RNA may return to floor as soon as is practicable. In the event that facility need necessitates the use of the RNA on the floor, activities department will continue to provide backup services to the RNA program for the group RNA programs. . Additionally, the facility has reorganized and revamped the onboarding process for C.N.A staff to ensure they receive both a general orientation as well as a job specific orientation. Further, the facility has implemented a mentor program where facility accepts applications from seasoned staff and, if approved by facility, C.N.A staff become mentors to new hires. The new C.N.A staff are assigned a mentor and run a parallel shift with mentor for 4 weeks and mentor and new hire both sign of on tasks to show understanding and competency. Once the mentor process is completed, facility has pledged a monetary compensation for the mentor based off length of employment of the staff member the mentor trained to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 29 member said he had not been receiving ROM services and was told he was on a waiting list for those services due to a lack of staff who provided ROM services. Resident #3's family member said she did not want him to decline in his mobility. The family member said and Resident #3 was observed to have flaccid hands (limp) and both feet were slightly contracted. On 11/27/18 at 7:57 AM and 10:15 AM, on 11/28/18 at 3:42 PM, and on 11/29/18 at 7:56 AM and 10:57 AM, Resident #3 was in his tilt back wheelchair. Both feet appeared to be slightly contracted and both hands were flaccid. On 11/30/18 at 8:51 AM, LPN #2 said Resident #3 had limited mobility in his hands and feet. LPN #2 said the resident could use his call pad and hold items. On 11/30/18 at 10:12 AM, the Director of Therapy with the Restorative Nursing Assistant RN (RNA RN) present, said the therapy department evaluated and recommended ROM programs specific for each residents' needs. The Director of Therapy said Resident #3 had never been screened for the RNA program and had not received physician orders for therapy to evaluate or to treat. The RNA RN said the resident was transferred from another skilled nursing facility and was only to be at the current facility for a few weeks until a different facility had a space available. The RNA RN said nursing staff had not seen a decline in his mobility since his admission and an RNA referral was not completed. The RNA RN said she was not aware of the family member's concern regarding ROM services and he had not been added to the RNA waiting list.	F 688	incentivizes the seasoned staff member to provide high quality training. This monetary compensation is in addition to referral bonuses as well as sign on bonuses offered by facility. This two-pronged approach is designed to increase recruitment of C.N.A staff as well as to reduce turnover rates to ensure that facility is staffed with quality staff members. Finally, facility utilized two trained RNA□s who work opposite schedules to better meet the needs of residents who would benefit from an RNA program. DNS or designee will audit RNA charting Q weekly x12 to determine the effectiveness of facilities mitigation plan and adjust as needed. Results of these audits will be brought to QAPI for 3 months and then Quarterly x2 quarters until substantial compliance has been met. Facility will also utilize feed back from Abaqis satisfaction surveys and resident council minuets to ensure continuing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 30 The RNA RN said due to short staffing issues, the facility could only accommodate 11 residents on the RNA program for the entire facility at one time. On 11/30/18, the RNA RN provided a list of 5 residents on the RNA waiting list. The list did not include Resident #3. 2.a. Resident #30 was admitted to the facility on 9/26/17 with multiple diagnoses, including multiple sclerosis and incomplete quadriplegia (partial damage to the spinal cord, where some motor and sensory function remains). An annual MDS assessment, dated 10/7/18, documented Resident #30 had limited ROM impairments in both upper and lower extremities and required extensive assistance from two people for bed mobility, transfers, and dressing. Resident #30's current care plan and RNA program documentation directed staff to provide Passive and Active ROM each day (Sunday through Saturday) for 15 minutes to his upper and lower extremities to prevent contractures and decline, which included foam block squeezes between his legs and therabands for ROM. Resident #30's ROM October 2018 RNA participation records documented he was provided RNA services 14 out of 31 opportunities. Resident #30's ROM November 2018 RNA participation records documented he was provided RNA services 10 out of 28 opportunities. On 11 of 28 documented	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 31 opportunities, the RNA staff was pulled to work the floor as a CNA. On 11/26/18 at 10:29 AM, Resident #30 said he was not always receiving his ROM due to RNA staff being pulled to work the floor. On 11/26/18 at 3:25 PM, on 11/27/18 at 8:58 AM, and on 11/28/18 at 7:54 AM, Resident #30 was in his electric wheelchair with both hands slightly contracted and both feet resting on his wheelchair foot rest. b. Resident #38 was readmitted to the facility on 7/31/17 with multiple diagnoses, including incomplete quadriplegia and muscle wasting and atrophy. A quarterly MDS assessment, dated 10/18/18, documented Resident #38 had limited ROM impairments in both upper and lower extremities and required extensive assistance from two people for bed mobility, transfers, and dressing. Resident #38's current care plan and RNA program documentation directed staff to provide Passive ROM each day (Sunday through Saturday) for 15 minutes to his upper and lower extremities and both hands to prevent decline in body position and reduce pain. Resident #38's ROM October 2018 RNA participation records documented he was provided RNA services 17 out of 31 opportunities. Resident #38's ROM November 2018 RNA participation records documented he was	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 32 provided RNA services 15 out of 28 opportunities. On 8 out of 28 documented opportunities, the RNA staff was pulled to work the floor as a CNA. On 11/26/18 at 2:59 PM, Resident #38 said he was not receiving his ROM as frequently as he should. On 11/26/18 at 2:59 PM, on 11/28/18 at 12:08 PM, and on 11/29/18 at 9:58 AM, Resident #38 was in his air bed with both hands contracted with splints in them. Both of his feet were contracted and rested above his bed with his legs on a foot cradle. On 11/29/18 at 9:58 AM, Resident #38 said he could use his call light pad and touched his thumb to activate it. He said he was concerned of his hands declining if he did not receive his ROM. c. Resident #213 was admitted to the facility on 11/24/17 with multiple diagnoses, including difficulty in walking, a history of falls, and morbid obesity. A quarterly MDS assessment, dated 8/22/18, documented Resident #213 had limited ROM impairments in both lower extremities and required extensive assistance from two people for bed mobility, transfers, and dressing. Resident #213's current care plan and RNA program documentation directed staff to provide Active ROM each day (Sunday through Saturday) for 15 minutes with therabands to his lower extremities to improve or maintain self-performance in moving self in bed.	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 33 Resident #213's ROM October 2018 RNA participation records documented he was provided or refused RNA services 7 out of 30 opportunities. On 2 out of 30 documented opportunities, the RNA staff was pulled to work the floor as a CNA. Resident #213's ROM November 2018 RNA participation records documented he was provided or refused RNA services 6 out of 27 opportunities. On 9 out of 27 documented opportunities, the RNA staff was pulled to work the floor as a CNA. On 11/26/18 at 4:02 PM, Resident #213 said he was not receiving his ROM due to RNA staff being pulled to work the floor. On 11/28/18 at 8:00 AM, Resident #213 was in bed and said the RNA staff came to his room that morning and told him he would not receive his ROM that day because she was being pulled to the floor to work as a CNA. On 11/28/18 2:40 PM, RNA #1 said she was pulled away from ROM services that day to work the floor. She said she had been pulled to the floor frequently over the past month or two because the facility was short staffed. On 11/28/18 3:02 PM, RNA #2 said she had been pulled away from ROM services several times over the past few months. RNA #2 said when she was pulled, the facility's Activity Director (AD) was notified and that department was to help pick up the missed ROM services.	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 34 On 11/30/18 at 10:12 AM, the RNA RN said due to short staffing issues, the facility could only accommodate 11 residents on the RNA program for the entire facility at one time. She said there was one RNA in the facility seven days a week and lately the RNA staff had been pulled off ROM duties to help cover the floor due to the lack of staffing. The RNA RN said ROM for Resident #30, Resident #38 and Resident #213 was not being completed consistently due to the lack of staff. She said the AD was a Recreation Therapist and her aide was a CNA and were to help complete residents' ROM services when the RNA was pulled to the floor. On 11/30/18 at 11:48 AM, the AD said she completed group exercises and could help walk with residents. The AD said she did not complete individual ROM services with residents. The AD said her activity aide was a CNA and her main duties were with the activity department Thursday through Monday. The AD said the activity aide helped out the RNA program when she had time. She said the main duty of the activity aide was to provide activities to the residents and the RNA duties were secondary.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		1/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 35 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, facility policy and procedure review and record review, it was determined the facility failed to ensure residents' urinary care needs were met in a manner that decreased the risk of urinary tract infections and damage from the catheter. This was true for 1 of 1 resident (#8) reviewed for urinary catheters. This failed practice created the potential for harm should residents experience urinary tract infections and complications from mishandling the catheter. Findings include:	F 690	1. One resident (#8) was affected by this deficiency. Resident #8 was assessed for any signs or symptoms of infection/ UTI. Resident has not shown any s/s of infection. 2. Any resident who has a Foley Catheter has the potential to be affected by the deficient practice. Foley Catheter education for all direct care staff with competencies to be done.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 36 The facility's policy and procedure for Urinary Catheter Care, revised October 2010, documented the following: * The urinary drainage bag must be positioned lower than the level of the bladder at all times to prevent urine in the tubing and drainage bag from flowing back into the bladder. * Ensure the catheter tubing and drainage bag are kept off the floor. Resident #8 was re-admitted to the facility on 1/10/17 with multiple diagnoses, including quadriplegia and neuromuscular dysfunction of the bladder. Resident #8's physician orders, dated 11/28/18, documented he had a suprapubic catheter. Resident #8's current care plan documented the following: * He had a suprapubic catheter related to neurogenic bladder, history of urinary tract infection, urine colonized with E. coli (a bacteria), and history of MRSA (Methicillin Resistant Staph Aureus-a type of bacteria that is resistant to some antibiotics). * Staff were directed to keep the urinary bag below the level of the bladder. On 11/27/18 at 10:18 AM, CNA #5 was providing care to Resident #8 while he was in bed and was preparing to get him out of bed. His urinary drainage bag was lying directly on the floor next to the right side of the bed. Three minutes later, CNA #4 entered the room to assist with	F 690	3. All direct care staff (licensed nursing staff) will receive in service on Foley catheter care related to infection control and proper placement. Competencies to be done for all direct care staff (licensed nursing staff) on Foley Catheter care related to infection control and proper placement. This is to be done by DNS or designee. 4. Facility will conduct Audits on a random sample of direct care staff (Licensed nursing staff) 3-5 times weekly for one month. These audits will be conducted by DNS or designee. Results of these audits will be brought to monthly QAPI committee x3 months and quarterly x2 quarters until substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 37 transferring him out of bed. CNA #4 picked up the urinary drainage bag off the floor and placed it on the bed. Resident #8 was lying on the sling for the Hoyer lift, and CNA #4 and CNA #5 attached the sling to the Hoyer lift and prepared to transfer him from bed. CNA #4 picked up his urinary drainage bag off the bed and attached it to the upper portion of the Hoyer sling, near his left arm and above the level of the bladder. As Resident #8 was lifted off the bed in the Hoyer sling and transferred to his wheelchair, the urinary drainage bag was elevated approximately 12 to 18 inches above the level of his bladder. On 11/27/18 at 10:24 AM, CNA #4 said Resident #8's urinary drainage bag should be lower than the level of his bladder, and it was not quite below his bladder when it was hanging from the Hoyer sling. CNA #4 said she did not have a better place to hang the urinary drainage bag when transferring him. CNA #4 said she found his urinary drainage bag on the floor and she picked it up. CNA #4 said the floor was not typically a good place for the urinary drainage bag and she did not know why it was there. On 11/27/18 at 1:30 PM, CNA #5 said Resident #8's urinary drainage bag should not be above the level of the catheter's insertion and it should remain below the level of the bladder. CNA #5 said the urinary drainage bag should not be on the floor and she noticed it was on the floor. On 11/29/18 at 7:46 AM, the DNS said Resident #8's urinary drainage bag should not have been on the floor, it should not have been placed above the bladder, and it should not have been hung on the Hoyer sling. The DNS said the	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 38 urinary bag could get caught on the Hoyer.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy and procedures, the facility failed to ensure oxygen tubing, humidifier bottles, and nebulizer tubing were changed weekly as ordered and dated when changed, and a tracheostomy mask was covered with a bag when not in use. This was true for 3 of 4 sampled residents who received oxygen (#7, #18, and #47) and 1 of 1 resident reviewed who had a tracheostomy (#7). This failure created the potential for harm from respiratory infections due to the growth of pathogens (organisms that cause illness). Findings include: Review of the facility's undated information grid titled, "Respiratory Equipment Change and Cleaning Guidelines" directed the staff to: a. Change the nasal cannula & tubing every-other week, and as needed and to date them when changed.	F 695	1. Three residents (#7, #18, and #47) were affected by the deficient practice. All respiratory equipment for the three mentioned residents have been checked and are now in compliance. Care plans and orders reviewed and updated as appropriate. 2. Any resident on oxygen, nebulizers or tracheostomy mister have the potential to be affected by the deficient practice. A full building sweep of all residents with respiratory equipment has been done and are now in compliance with facility standards and protocols. DNS, RCM and Designee to complete these audits. 3. All direct care staff (licensed nursing staff) will receive in service on respiratory tubing changes, labeling, dating and time frames. All direct care staff (licensed nursing staff) will receive in service on proper placement of respiratory	1/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 39 b. Change the oxygen humidifiers once a month, and as needed and to "Date when changed." c. Change the hand-held nebulizer once a week and as needed and to label with "Name, [and] date." d. Change oxygen face mask weekly and as needed and to "Date when changed," and to "store in a plastic bag when not in use." e. "Ventilators/Tubing...tubing change monthly" and to "Document in [the] medical record when done." a. Resident #7 was admitted to the facility on 3/11/14 with diagnoses that included a history of unspecified head injury and quadriplegia (the severely limited ability, or inability to voluntarily move all four extremities). Resident #7's November 2018 Order Summary Report, documented he had a tracheostomy (a surgically-created opening in the windpipe through which a breathing tube is inserted to aide breathing), and included an order for "Cool mist to trach [tracheostomy] at NOC [night] at bedtime." On 11/26/18 at 11:34 AM, Resident #7 had a tracheostomy humidification system at the side of his bed, which included a humidifier bottle, blue aerosol tubing (flexible, corrugated tubing that can be used to deliver cool or warm aerosol mist to a mask or tracheostomy tube), and tracheostomy aerosol mask (a type of mask that fits over a tracheostomy tube for the delivery of oxygen or aerosol mist). The system, which was	F 695	equipment i.e. masks and tubing, while not being used. Care plans and orders to be reviewed and updated as appropriate for all residents with respiratory equipment. These audits to be conducted by DNS or designee. 4. Resident-in-Room audits to be conducted daily x5 days of first 7 days for first week, then weekly x4 and monthly x3. Results of these audits to be brought to QAPI committee x3 months and Quarterly x2 until substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 40 powered off, did not have a date on the humidifier bottle, aerosol tubing, or the mask to indicate when the components were last changed out. The tracheostomy mask was not in a protective bag or cover to help prevent contamination of the mask when not in use. On 11/26/18 at 3:54 PM, 11/28/18 at 2:11 PM, and 11/28/18 at 4:14 PM, Resident #7's humidifier bottle, aerosol tubing, and mask remained undated, and the mask remained uncovered. Resident #7's active care plan documented he had inadequate or compromised respiratory function as evidenced by a tracheostomy. The documented interventions for the management of Resident #7's respiratory needs did not include directions for changing and dating Resident #7's humidifier bottle, aerosol tubing, and mask, nor did it direct the staff to cover Resident #7's tracheostomy mask when not in use. Resident #7's Progress Notes from 8/28/18 at 11:41 AM through 11/28/18 at 8:41 PM provided no documentation to indicate when the staff had last changed out Resident #7's humidifier bottle, aerosol tubing, and tracheostomy mask. Resident #7's November 2018 TAR did not document when the staff last changed Resident #7's humidifier bottle, aerosol tubing, and tracheostomy mask. b. Resident #18 was readmitted to the facility on 9/11/18 with diagnoses that included pulmonary fibrosis, interstitial pulmonary disease, and acute and chronic respiratory failure with hypoxia (low	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 41 oxygen level). Resident #18's November 2018 Order Summary Report documented the following orders, dated 9/11/18: * "O2 [oxygen] at 6 liters per minute via n/c [nasal cannula] continuous every shift." * "O2 tubing, cannula, neb [nebulizer] equip [equipment], bags, etc. to be changed Q [every] week on Sunday by night shift. Tubing to be initialed and dated..." * "DuoNeb Solution [an inhaled medication that dilates the respiratory passages]...inhale orally four times a day" and "every 2 hours as needed." * "DuoNeb Solution...inhale orally four times a day" On 11/26/18 at 2:10 PM, Resident #18 had just completed a nebulizer treatment and received oxygen at 6 liters per minute through tubing and a nasal cannula, which was connected to a humidifier bottle on her bedside oxygen concentrator. The oxygen tubing, humidifier bottle, and the nebulizer tubing were not dated or initialed by the staff as ordered. c. Resident #47 was re-admitted to the facility on 11/9/18 with diagnoses that included acute bronchitis and chronic obstructive pulmonary disease. Resident #47's November 2018 Order Summary Report documented an order dated 11/9/18 that read: "O2 tubing, cannula, neb[ulizer] equip,	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 42 bags, etc. to be changed Q [every] week on Sunday by night shift. Tubing to be initialed and dated..." On 11/27/18 at 8:51 AM, Resident #47 received oxygen at 4 liters per minute through tubing and a nasal cannula. The oxygen tubing was dated,"11/16" indicating the tubing had not been changed since 11/16/18. On 11/28/18 at 4:14 PM, when asked about the facility's policy and procedures for the care and changing out of respiratory equipment, LPN #1 stated he did not know that information. On 11/28/18 at 4:20 PM, when asked about the facility's policy and procedures for the care and changing of respiratory equipment, RCM #2 stated he did not know the answers, but would check the facility's policies and procedures for the information.	F 695		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services	F 725		1/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 43 by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on review of resident records, staffing logs, policy review, Resident Council group interview, resident and resident family interviews, and staff interviews, it was determined the facility failed to ensure there was sufficient staffing to provide for the needs of residents. This was true for 5 of 13 Resident Council Members in the group interview (#18, #30, #40, #47 and #50) and for 3 of 15 residents (#3, #38, and #213) reviewed for staffing. This deficient practice created the potential for physical and psychosocial harm if residents experienced a delay in care or did not receive ordered therapies. Findings include: The facility's Staffing Policy, revised April 2007, documented, "Our facility provides adequate staffing to meet needed care and services for our resident population." a. Resident #3 was admitted to the facility on 5/10/18 with multiple diagnoses, including stroke, left-sided hemiplegia and hemiparesis (paralysis	F 725	1. Five resident Council Members (#18, #30,#40, #47 and #50) and three other residents (#3, #38 and #213) were affected by the deficient practice of having sufficient staffing. Residents reviewed to validate that their plan of care and needs are met. 2. All residents have to the potential to be affected by the deficient practice. Staffing patterns reviewed and indicated that there is staff scheduled to meet the needs of the residents current conditions. The only exception to this was when RNA was pulled to the floor to provide cares. 3. Facility will continue to monitor staffing based off of census and acuity. Staffing Coordinator/ Administrator will monitor for appropriate amount of staff. Facility will exercise due diligence in attempting to fill open shifts due to call ins that the RNA may return to the floor as soon as is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 44 and weakness), and reduced mobility. On 11/26/18 at 4:06 PM, Resident #3's family member said he had not been receiving ROM services and was told he was on a waiting list for those services due to a lack of staff who provided ROM services. The family member said she did not want Resident #3 to have a deline in his mobility. On 11/30/18, the RNA RN provided a list of 5 residents on the RNA waiting list. The list did not include Resident #3. b. Resident #30 was admitted to the facility on 9/26/17 with multiple diagnoses, including multiple sclerosis and incomplete quadriplegia. Resident #30's ROM October 2018 RNA participation records documented he was provided RNA services 14 out of 31 opportunities. Resident #30's ROM November 2018 RNA participation records documented he was provided RNA services 10 out of 28 opportunities. On 11 of 28 documented opportunities documented, the RNA staff was pulled to work the floor as a CNA. On 11/26/18 at 10:29 AM, Resident #30 said he was not always receiving his ROM due to RNA staff being pulled to work the floor. c. Resident #38 was readmitted to the facility on 7/31/17 with multiple diagnoses, including incomplete quadriplegia and muscle wasting and atrophy.	F 725	practicable. In the event that the facilities needs necessitates the use of the RNA on the floor, activities department will continue to provide backup services to the RNA program for the group RNA programs. . Additionally, the facility has reorganized and revamped the onboarding process for C.N.A staff to ensure they receive both a general orientation as well as a job specific orientation. Further, the facility has implemented a mentor program where facility accepts applications from seasoned staff and, if approved by facility, C.N.A staff become mentors to new hires. The new C.N.A staff are assigned a mentor and run a parallel shift with mentor for 4 weeks and mentor and new hire both sign of on tasks to show understanding and competency. Once the mentor process is completed, facility has pledged a monetary compensation for the mentor based off length of employment of the staff member the mentor trained to incentivizes the seasoned staff member to provide high quality training. This monetary compensation is in addition to referral bonuses as well as sign on bonuses offered by facility. This two-pronged approach is designed to increase recruitment of C.N.A staff as well as to reduce turnover rates to ensure that facility is staffed with quality staff members. Finally, facility utilized two trained RNA□s who work opposite schedules to better meet the needs of residents who would benefit from an RNA program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 45 Resident #38's ROM October 2018 RNA participation records documented he was provided RNA services 17 out of 31 opportunities. Resident #38's ROM November 2018 RNA participation records documented he was provided RNA services 15 out of 28 opportunities. On 8 of 28 opportunities documented, the RNA staff was pulled to work the floor as a CNA. On 11/26/18 at 2:59 PM, Resident #38 said he was not receiving his ROM as frequently as he should. d. Resident #213 was admitted to the facility on 11/24/17 with multiple diagnoses, including difficulty in walking, a history of falls, and morbid obesity. Resident #213's ROM October 2018 RNA participation records documented he was provided or refused RNA services 7 out of 30 opportunities. On 2 out of 30 opportunities documented, the RNA staff was pulled to work the floor as a CNA. Resident #213's ROM November 2018 RNA participation records documented he was provided or refused RNA services 6 out of 27 opportunities. On 9 of 27 opportunities documented, the RNA staff was pulled to work the floor as a CNA. On 11/26/18 at 4:02 PM, Resident #213 said he was not receiving his ROM due to RNA staff	F 725	4. DNS or designee will audit RNA charting Q weekly x12 to determine effectiveness of facilities mitigation plan and adjust as needed. results of these audits will be brought to QAPI for 3 months and quarterly x2 quarters until substantial compliance has been met. Facility will also utilize feed back from Abaqis satisfaction surveys and resident council minutes to ensure continuing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 46 being pulled to work the floor. On 11/28/18 at 8:00 AM, Resident #213 was in bed and said the RNA staff came to his room that morning and told him he would not receive his ROM that day because the RNA was being pulled to the floor to work as a CNA. Review of the facility staffing logs for November 2018 documented 12 RNA shifts were not assigned or the RNA was pulled to staff the floor as a CNA. On 11/28/18 at 2:40 PM, RNA #1 said she was pulled from away from ROM services that day to work the floor. She said she was pulled to the floor frequently for the past month or two because the facility was short staffed. On 11/28/18 at 3:02 PM, RNA #2 said she was pulled away from ROM services several times for the past few months. On 11/30/18 at 10:12 AM, the RNA RN said due to short staffing, the facility could only accommodate 11 residents on the RNA program for the entire facility at one time. She said there was one RNA in the facility seven days a week and lately the RNA staff had been pulled off ROM duties to help cover the floor due to the lack of staffing. The RNA RN said ROM for Residents #30, #38 and #213 were not getting completed consistently due to lack of staff. On 11/27/18 at 11:34 AM, during the resident group interview, Residents #18, #30, #40, #47, and #50 said there were not enough staff in the facility. They said call lights would sometimes	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 47 take an hour or more to be answered. On 11/29/18 at 10:20 AM, CNA #5 said she did not always have enough time to complete all of her tasks. She stated there were times when she was unable to assist her assigned residents with feeding because she was trying to answer all of the call lights and help get residents ready for dining. She said when this happened, someone else would have to feed her assigned residents. CNA #5 also said she has received group telephone texts on a daily basis from the Staffing Coordinator requesting staff to cover unfilled shifts. On 11/29/18 at 11:35 AM, LPN #3 said when there was not enough staff, she had difficulty completing her tasks. She stated sometimes she got behind on testing her assigned residents' blood sugars and administering insulin and other medications. She said there had been recent days when her morning medications were not administered to residents until 11:30 AM, and for her, "that [late in the morning] was pushing it." LPN #3 also said for the last few months she had received more requests to work extra. She said recently it was difficult when CNAs were pulled from the floor to care for a resident requiring 1:1 staffing, leaving the floor short of CNA assistance. On 11/30/18 at 9:40 AM, the Staffing Coordinator said the facility was actively recruiting for more staff. On 11/30/18 at 9:46 AM, the facility's Staffing Coordinator and Administrator agreed the RNA position had been pulled several times during the	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 48 month of November 2018 to staff as a CNA. They said it had been an issue when a vacant CNA shift could not be filled, the CNA position had priority for resident cares over the restorative therapy tasks. The facility was unable to provide adequate staffing to meet needed care and services for their resident population.	F 725		
F 812 SS=F	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, interview, and review of the U.S. Food and Drug Administration's 2017 Food Code, the facility failed to follow professionally-accepted sanitation and food	F 812	1. No resident was affected by this deficient practice, but all save one resident had the potential to be affected. there was no signs or symptoms of	1/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 49 handling practices to prevent the outbreak of foodborne illness. This was true when the staff failed to cover and date ready-to-eat refrigerated food items, failed to store domed plate covers in a manner to minimize the potential for contamination, and failed to ensure an exit door to the facility grounds sealed tightly when shut to minimize the potential for entry of pests and vermin. This deficient practice had the potential to affect the 57 of 58 residents who received their meals from the facility's kitchen, and created the potential for harm from foodborne illness. Findings include: Review of the U.S. Food and Drug Administration's "2017 Food Code," provided the following information: * Preventing Food and Ingredient Contamination 3-302.11 (A) Food shall be protected from cross contamination by storing the food in packages, covered containers, or wrappings. * 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) - refrigerated, ready-to-eat food that is prepared and held for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded when held at a temperature of (41ºF) [41 degrees Fahrenheit] or less for a maximum of 7 days. * 6-202.15 Outer Openings, Protected. (A) - outer openings shall be protected against the entry of insects and rodents by solid, self-closing, tight-fitting doors. * 4-903.11 Equipment, Utensils, Linens, and	F 812	foodborne illness noted in any residents during this time. 2. it was determined that 57 of 58 residents who received their meals in the facility's kitchen had the potential to be affected by this deficient practice. Back door was fixed prior to survey departure. Kitchen staff educated on proper professionally accepted sanitation and food handling practices to prevent the outbreak of foodborne illness to be conducted by Dietary Manger or designee. 3.Dietary Manager or designee to in-service all kitchen staff on covering/dating food and the proper storage of domed plate covers when not in use. 4. Meal Service Preparation QAPI audits to be done daily x5 during the first week, then weekly x4 and monthly x3. results of these audits will be brought to QAPI for 3 months and quarterly x2 until substantial compliance has been met. These audits to be conducted by dietary manger or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 50 Single-Service and Single-Use Articles (B) Clean utensils shall be stored covered or inverted. The following observations were made during the initial tour of the kitchen with the Food Services Director (FSD) on 11/26/18, beginning at 10:20 AM. * At 10:30 AM, the walk-in refrigerator contained a small metal tray cart enclosed on all but two sides that held trays of various ready-to-eat food items. Two of the trays held several small bowls of Jell-O and fresh fruit, none of which were covered or dated. During an interview at the time of the observation, the FSD stated the food items in the cart were quick access foods to be used that day for resident snacks. The FSD stated since the top of the cart protected the bowls of food on the top tray from contamination, and the top tray protected the bowls of food on second tray from contamination, the bowls of Jell-O and fruit did not require covers. * At 10:42 AM, a kitchen exit door opened directly to the facility grounds and provided access to the facility's trash compactor. There was a gap between the non-hinged side of the door and the door frame when fully closed. The gap extended upward approximately 15 inches from the lower corner of the door. At its widest point (at the bottom corner of the door), the gap measured approximately 3/8-inch wide, and gradually narrowed as it progressed upward. During an interview at this same time, the FSD stated the director of maintenance was aware of the gap, but had not had time to fix the gap. * At 10:52 AM, in the kitchen area opposite the	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 51 steam table, several hall-tray carts and non-enclosed metal rolling carts held 23 stacks of domed plate covers (four to eight plate covers to each stack), sat inverted (open side up) on top of the hall-tray carts and rolling carts. During an interview at this same time, the FSD acknowledged the plate covers should not be stacked in an inverted manner, but then stated, "If we try to stack them facing down, the covers slide off one another." The FSD stated she had not looked into other methods of storing the plate covers in a manner that minimized the potential for contamination. On 11/30/18 at 4:33 PM, the Administrator acknowledged the domed plate covers should be stored "open side down" to prevent the residents' food from being contaminated by anything that fell onto the inside of the plate covers. The Administrator was unaware of the gap in the exit door, but indicated it would be a "quick fix."	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		1/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 52 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 53 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, facility policy and procedure review and record review, it was determined the facility failed to ensure infection control measures were consistently implemented during care of urinary catheters. This was true for 1 of 1 resident (#8) reviewed for urinary catheters. This failed practice created the potential for harm should residents experience urinary tract infections. Findings include: The facility's policy and procedure for Urinary Catheter Care, revised October 2010, documented the following: * The urinary drainage bag must be positioned lower than the level of the bladder at all times to prevent urine in the tubing and drainage bag from flowing back into the bladder. * Ensure the catheter tubing and drainage bag are kept off the floor. Resident #8 was re-admitted to the facility on 1/10/17 with multiple diagnoses, including	F 880	1. One resident (#8) was affected by the deficient practice. Resident #8 was assessed for any signs or symptoms of infection/ UTI. Resident has not shown any s/s of infection. 2. Any resident who has a Foley Catheter has the potential to be affected by this deficient practice. Foley Catheter education for all direct care staff with competencies to be done. 3. All direct care staff (licensed nursing staff) will receive in-services on Foley catheter care related to infection control and proper placement. Competencies to be done for all direct care staff (licensed nursing staff) on Foley Catheter care related to infection control and proper placement. This is to be done by DNS or designee. 4. Facility will conduct audits on a random	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 54 quadriplegia and neuromuscular dysfunction of the bladder. Resident #8's physician orders, dated 11/28/18, documented he had a suprapubic catheter. Resident #8's current care plan documented the following: * He had a suprapubic catheter related to neurogenic bladder, history of urinary tract infection, urine colonized with E. coli (a bacteria), and history of MRSA (Methicillin Resistant Staph Aureus-a type of bacteria that is resistant to some antibiotics). * Staff were directed to keep the urinary bag below the level of the bladder. On 11/27/18 at 10:18 AM, CNA #5 was providing care to Resident #8 while he was in bed and was preparing to get him out of bed. His urinary drainage bag was lying directly on the floor next to the right side of the bed. Three minutes later, CNA #4 entered the room to assist with transferring him out of bed. CNA #4 picked up the urinary drainage bag off the floor and placed it on the bed. Resident #8 was lying on the sling for the Hoyer lift, and CNA #4 and CNA #5 attached the sling to the Hoyer lift and prepared to transfer him from bed. CNA #4 picked up his urinary drainage bag off the bed and attached it to the upper portion of the Hoyer sling, near his left arm and above the level of the bladder. As he was lifted off the bed in the Hoyer sling and transferred to his wheelchair, the urinary drainage bag was elevated approximately 12 to 18 inches above the level of his bladder.	F 880	sample of direct care staff (licensed nursing staff) 3-5 times weekly for one month. These audits to be conducted by DNS or designee. result of these audits will be brought to monthly QAPI committee x 3 months and quarterly x2 quarters until substantial compliance has been meet.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 55 On 11/27/18 at 10:24 AM, CNA #4 said Resident #8's urinary drainage bag should be lower than the level of his bladder, and it was not quite below his bladder when it was hanging from the Hoyer sling. CNA #4 said she did not have a better place to hang the urinary drainage bag when transferring Resident #8. CNA #4 said she found Resident #8's urinary drainage bag on the floor and she picked it up. CNA #4 said the floor was not typically a good place for the urinary drainage bag and she did not know why it was there. On 11/27/18 at 1:30 PM, CNA #5 said Resident #8's urinary drainage bag should not be above the level of the catheter's insertion and it should remain below the level of the bladder. CNA #5 said the urinary drainage bag should not be on the floor and she noticed it was on the floor. On 11/29/18 at 7:46 AM, the DNS said Resident #8's urinary drainage bag should not have been on the floor and it should not have been placed above the bladder.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically	F 883		1/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 56 contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 57 pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and policy review, it was determined the facility failed to ensure residents received or were re-offered, the pneumococcal vaccines per the Centers for Disease Control (CDC) recommendations for 3 of 5 residents (#7, #8, and #32) reviewed for Pneumococcal immunization. This failure created the potential for harm should residents contract pneumonia. Findings include: The facility's Pneumococcal Vaccine Policy Statement, revised August 2016, documented: * All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. * Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. * Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission. The Centers for Disease Control and Prevention website, accessed on 12/6/18, recommendations stated for those who have not received any	F 883	1. Three residents (#7, #8, and #38) were affected by the deficient practice. These residents were reviewed and appropriate action taken to bring these residents into regulatory compliance. 2. All residents coming into the facility have the potential to be affected by this deficient practice. All current residents to be reviewed by SDN, DNS or designee to ensure all pneumococcal immunizations are up to date and documented appropriately. 3. Pneumococcal Screen to be added to current admission process by DNS or designee. 4. Random resident audits will be conducted on Pneumococcal immunizations to ensure compliance weekly x4, then monthly x3. These audits will be conducted by SDC, DNS or designee. results of these audits will be brought to monthly QAPI committee x3 months and quarterly x2 quarters until substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 58 pneumococcal vaccines, or those with unknown vaccination history: * Administer 1 dose of PPSV23 [pneumococcal polysaccharide vaccine] at 19 through 64 years. * Administer 1 dose of PCV13 [pneumococcal conjugate vaccine] at 65 years or older. This dose should be given at least 1 year after PPSV23. * Administer 1 final dose of PPSV23 at 65 years or older. This dose should be given at least 1 year after PCV13 and at least 5 years after the most recent dose of PPSV23. The above policy and CDC Guidelines were not followed. Examples include: a. Resident #7's medical record documented she received the first pneumococcal vaccine on 1/1/03 but the second pneumococcal vaccine was not offered or administered. b. Resident #8's medical record documented she received the first pneumococcal vaccine on 1/1/02 but the second pneumococcal vaccine was not offered or administered. c. Resident #32's medical record documented she received the first pneumococcal vaccine on 6/26/14 but the second pneumococcal vaccine was not offered or administered to her. On 11/30/18 at 11:35 AM, the DNS said he just found out about 2 weeks ago, 2 residents had orders written for the pneumococcal vaccine but were never processed. On 11/30/18 at 11:45 AM, the Infection Control Nurse said the facility was working on a	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135077		**11/30/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	**1001 SOUTH HILTON STREET** **BOISE, ID 83705**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 59 Performance Improvement Project to ensure all residents received required vaccines. She stated she knew the facility was out of compliance with the pneumonia vaccines.	F 883		