IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. 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 28, 2018

Jeremy Tolman, Administrator
Life Care Center Of Post Falls
460 North Garden Plaza Court,
Post Falls, ID 83854-6437

Provider #: 135135

Dear Mr. Tolman:

On **December 14, 2018**, a survey was conducted at Life Care Center Of Post Falls 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 an isolated deficiency that constitutes actual 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.) **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 **January 7, 2019**. Failure to submit an acceptable PoC by **January 7, 2019**, may result in the imposition of civil monetary penalties by **January 30, 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 in column (X5).

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy(ies):

Civil Money Penalty

Denial of payment for new admissions effective March 14, 2019

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 14, 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.

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 **January 7, 2019**. If your request for informal dispute resolution is received after **January 7, 2019**, 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/
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 on December 10, 2018 to December 14, 2018. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Linda Kelly, RN Susette Mace, RN Carmen Blake, RN Susan Devereaux, RN Acronyms used in the report include: ADL = Activities of Daily Living AIT = Administrator in Training DON = Director of Nursing I&A = Incident & Accident LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set mg = milligrams OT = Occupational Therapy PRN = as needed PT = Physical Therapy RDCS = Regional Director of Clinical Services RLE = Right Lower Extremity RN = Registered Nurse UM = Unit Manager TAR = Treatment Administration Record			
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and	F 600		1/23/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/07/2019

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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 600	Continued From page 1 Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, I&A report review, and record review, it was determined the facility failed to ensure injuries caused by staff were recognized as abuse or neglect. This was true for 1 of 5 residents (Resident #93) who were reviewed for abuse/neglect. Resident #93 was harmed when the facility failed to provide two person toileting assistance per her care plan and care directive instructions. This failure created harm when Resident #93 had a fall that resulted in a head injury and required emergency transport and treatment at a local hospital. Findings include: Resident #93 was admitted to the facility on 10/22/17, with multiple diagnoses, including right sided hemiplegia and hemiparesis (weakness and partial paralysis) following a cerebral infarction (stroke). She was readmitted on 11/17/17, following left sided carotid endarterectomy (surgical removal of thickened areas of the innermost coat of an artery).	F 600	1. Resident #93 no longer resides in facility. 2. Review of the last 30 days of incidents that involved injuries caused by staff was completed to ensure that they were investigated for abuse/neglect and reported timely. 3. Nursing leadership was educated by the ED or designee on the components of thorough investigations to ensure that injuries caused by staff are recognized as abuse/neglect allegations and that timely reporting occurs. 4. Incidents will be reviewed daily through the clinical meeting (M-F) for thorough investigations and potential abuse/neglect reports. The RDCS or RVP will provide monthly review of incidents x3 months to ensure thorough investigations related to staff caused injuries are completed, reported and policies are followed. Incidents will be trended and reviewed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 600	Continued From page 2 Resident #93's Physician Orders included Plavix (an antiplatelet drug to prevent blood clotting) 75 mg daily and Aspirin (may interfere with blood clotting at low doses) 81 mg daily. Both medications were ordered on 11/17/17. Resident #93's care plan included the following: - Risk for abnormal bleeding or hemorrhage related to the use of anticoagulant medication, dated 10/23/17. Interventions included: administer medications, laboratory, and treatments as ordered; report to the physician any signs and/or symptoms of abnormal bleeding or hemorrhage. - Risk for fall related injury due to history of stroke and hemiparesis and hemiplegia, dated 10/22/17. Interventions included: fall risk assessment quarterly and PRN; provide environmental adaptations such as low bed, call light within reach on left side of resident, adequate lighting, area free of clutter; referral for PT and OT; provide and observe the use of adaptive equipment (wheelchair). - ADL self-care deficit due to stroke, dated 10/22/17. Interventions included: provide the amount of assistance/supervision needed, to the right of this intervention handwritten with a date of 11/3/17 was documented "2 person assist [with] transfer disk in Br [bathroom]." To the left of the intervention for assistance/supervision handwritten with a date of 11/15/17, "One assist transfer disk transfer @ bedside - sling on for all transfers."	F 600	through the monthly QAPI meeting for ongoing education and training. 5. The ED or designee will ensure ongoing 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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 600	Continued From page 3 Resident #93's record also included a Care Directive, dated 10/25/17 at 12:30 PM, which documented she required the assistance of 2 staff for transferring and toileting. Another Care Directive, dated 12/17/17 at 2:23 PM, documented she required the assistance of 2 staff members with a pivot disk and a sling for toileting. Resident #93's care plan and care directive were not followed. An I&A report, dated 12/16/17 at 7:30 PM, documented Resident #93 had a fall which resulted in a hematoma (a swelling of blood within the tissue), closed head injury, fracture, and lacerations (cut) to her face and arm. The report documented Resident #93 was sitting on the toilet and the aide saw her falling forward. The aide grabbed her right arm and the back of her brief causing Resident #93 to twist to her left side, and her head was struck on the right side by a grab bar. The report further documented Resident #93 was assessed, cold compresses were applied, and 911 was called. A Nursing Note, dated 12/17/17 at 5:09 AM, documented an LPN contacted the local hospital for an update on Resident #93. The note documented "I was told that she was admitted w/ a huge bleed and her outlook was not good." A Nursing Note, dated 12/17/17 at 1:44 PM, signed by LPN #1 documented "Evening shift for 12/16/17: At 19:30 [7:30 PM], I was at my med [medication] cart down the hall from [Resident #93's] room and had just finished talking to the residents [sic] husband when [CNA #3] came out	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 600	Continued From page 4 to the hall yelling 'I need help in her.' Upon entering the resident's bathroom, Resident was sitting on the toilet bleeding from the right side of her forehead. A large hematoma noted. Pressure was applied and pupils were assessed with good reaction. Resident also noted with a skin tear above her right eye brow, large bruising and skin tear to her right arm. Skin tears were cleansed and steri-stripped [a tape to hold skin together]. Was unable to do ROM to right arm due to stroke. Ice placed to forehead. Resident remained alert and able to answer questions shaking head yes or no. Resident was assist [sic] back to bed and 911 was notified due to being full code and on anticoagulation medication. EMTs [Emergency Medical Transport] were here to transport at 20:10 [8:10 PM]." On 12/13/18 at 12:08 PM, LPN #1 said she recalled Resident #93 and the incident on 12/16/17. LPN #1 said CNA #3 was with Resident #93 in her bathroom at the time of the incident. LPN #1 said CNA #3 told her she had turned away from Resident #93 to put clothes in a bag when she heard a noise and turned enough to see Resident #93 hit her head on the grab bar, then fell forward, head first. LPN #1 said CNA #3 told her she intercepted the fall because Resident #93 was falling head first to the floor, and when CNA #3 grabbed Resident #93's right arm and the back of her brief, the momentum caused Resident #93 to twist and hit the safety bar with the right side of her head. LPN #1 reviewed her documentation from 12/17/17, and said what she documented was different than what CNA #3 had told her. LPN #1 said she never considered abuse or rough	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 600	Continued From page 5 treatment because she knew CNA #3 and had worked with her for many years. LPN #1 said by the time she got to Resident #93's bathroom, there was blood on the safety bar, but none on the floor. She said Resident #93 had a cut on her right cheek and a huge lump on her head. LPN #1 said she checked Resident #93's neurological status, she was awake and alert, verbalized she was in pain, and she was able to move her head, and used her left arm to move her right arm. LPN #1 said CNA #3 and another CNA assisted Resident #93 from the bathroom to her bed. LPN #1 said Resident #93's spouse came in the room and she told him Resident #93 needed to go to the hospital. On 12/13/18 at 12:35 PM, LPN #1 accompanied the surveyor to where Resident #93 had resided in the facility. The bathroom was approximately 7 feet wide by 6 feet deep. The toilet was in the rear left corner and there was a safety bar behind the toilet and another safety bar was to the left of the toilet. Four feet in front of the toilet was a metal towel bar on the wall. The sink was 3 feet away and to the left of the toilet. The doorway was directly in front of the sink. LPN #1 demonstrated to the surveyor how CNA #3 explained to LPN #1 how she grabbed Resident #93's right arm and the back of her incontinence brief and it caused the resident to twist and hit her head on the safety bar on the left side of the toilet. LPN #1 said there was blood on the safety bar but none on the floor. She said there was a cut on Resident #93's cheek and a huge lump on her head. On 12/13/18 at 2:21 PM, LPN #1 said the transfer disc was by Resident #93's bed not in	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 600	Continued From page 6 her bathroom when the incident happened on 12/16/17. On 12/13/18 at 4:50 PM, the DON reviewed Resident #93's care plan and said it documented 2 person assistance with transfers and 1 person extensive assistance with toileting. The DON said Resident #93's care directive documented 2 person assistance with toileting. The DON said she did not investigate how Resident #93 was transferred onto the toilet, because Resident #93 did not fall during the transfer, she was on the toilet and her left arm slid off the grab bar causing her to fall forward and hit her head. The DON said the facility notified her around 2:00 AM or 3:00 AM Resident #93 had an incident and she was sent to the hospital and did not think it was that severe. The DON said the facility called her again around 6:00 AM to inform her Resident #93 may not live. The DON said after investigating the incident with CNA #3, she ruled out abuse or neglect. On 12/14/18 at 10:22 AM, the DON reviewed Resident #93's care plan and compared it to Resident #93's care directive, she said the therapy instructions to have 2 person toileting assistance should have been followed. The DON said the comprehensive care plan was not updated regarding the need for assistance by 2 staff during toileting, and the staff did not follow the care plan for Resident #93. The facility staff failed to follow Resident #93's care plan and care directives which resulted in harm.	F 600		
F 609	Reporting of Alleged Violations	F 609		1/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 609 SS=D	Continued From page 7 CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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 staff interview, I&A report review, and record review, it was determined the facility failed to report serious bodily injury to the Administrator and the State Survey Agency within 2 hours of the incident. This affected 1 of 5 residents (Resident #93) who were reviewed for	F 609	1. Resident #93 no longer resides in facility. 2. Review of the last 30 days of incidents that involved injuries caused by staff was completed to ensure that they were investigated for abuse/neglect and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 609	Continued From page 8 abuse/neglect and the other 94 residents who resided in the facility at risk for undetected abuse/neglect. Findings include: Resident #93 was admitted to the facility on 10/22/17, with multiple diagnoses, including right sided hemiplegia and hemiparesis (weakness and partial paralysis) following a cerebral infarction (stroke). She was readmitted on 11/17/17, following left sided carotid endarterectomy (surgical removal of thickened areas of the innermost coat of an artery). An I&A report, dated 12/16/17 at 7:30 PM, documented Resident #93 had a fall which resulted in a hematoma (a swelling of blood within the tissue), closed head injury, fracture, and lacerations (cut) to her face and arm. The report documented Resident #93 was sitting on the toilet and the aide saw her falling forward. The aide grabbed her right arm and the back of her brief causing Resident #93 to twist to her left side, and her head was struck on the right side by a grab bar. The report further documented Resident #93 was assessed, cold compresses were applied, and 911 was called. A Nursing Note, dated 12/17/17 at 5:09 AM, documented an LPN contacted the local hospital for an update on Resident #93. The note documented "I was told that she was admitted w/ a huge bleed and her outlook was not good. I texted our RCM [Resident Case Manager] and called the DON and updated them both about the admission to [hospital name] around 0200 [2:00 AM]." On 12/13/18 at 4:50 PM, the DON said she was	F 609	reported timely to required State agencies. 3. Nursing leadership was educated by the ED or designee on the components of thorough investigations to ensure that injuries caused by staff are recognized as abuse/neglect allegations and that timely reporting occurs. 4. Incidents will be reviewed daily through the clinical meeting (M-F) for thorough investigations and potential abuse/neglect reports. The RDCS or RVP will provide monthly review of incidents x3 months to ensure thorough investigations related to staff caused injuries are completed and policies are followed. Incidents will be trended and reviewed through the monthly QAPI meeting for ongoing education and training. 5. The ED or designee will ensure ongoing 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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 609	Continued From page 9 not notified of Resident #93's incident until the middle of the night of 12/17/17. The incident happened at 7:30 PM on 12/16/17. The DON said the facility reported the incident to the State Survey Agency on 12/17/17, when she came in to investigate the incident for Resident #93. The facility failed to report an incident which resulted in serious bodily injury to Resident #93 within 2 hours.	F 609		
F 610 SS=G	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 staff interview, I&A report review, and record review, it was determined the facility failed to ensure a resident's fall was thoroughly investigated. This was true for 1 of 5 residents (Resident #93) who were reviewed for fall	F 610	1. Resident #93 no longer resides in facility. 2. Review of the last 30 days of incidents that involved injuries caused by staff was completed to ensure that they were	1/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 10 investigations. Resident #93 was harmed when she sustained a head injury and required emergency transport and treatment at a local hospital. Findings include: Resident #93 was admitted to the facility on 10/22/17, with multiple diagnoses, including right sided hemiplegia and hemiparesis (weakness and partial paralysis) following a cerebral infarction (stroke). She was readmitted on 11/17/17, following left sided carotid endarterectomy (surgical removal of thickened areas of the innermost coat of an artery). Resident #93's care plan identified ADL self-care deficit due to stroke, dated 10/22/17. Interventions included: provide the amount of assistance/supervision needed, to the right of this intervention handwritten with a date of 11/3/17 was documented "2 person assist [with] transfer disk in Br [bathroom]." To the left of the intervention for assistance/supervision handwritten with a date of 11/15/17, "One assist transfer disk transfer @ bedside - sling on for all transfers." An I&A report, dated 12/16/17 at 7:30 PM, documented Resident #93 had a fall which resulted in a hematoma (a swelling of blood within the tissue), closed head injury, fracture, and lacerations (cut) to her face and arm. The report documented Resident #93 was sitting on the toilet and the aide saw her falling forward. The aide grabbed her right arm and the back of her brief causing Resident #93 to twist to her left side, and her head was struck on the right side by a grab bar. The report further documented Resident #93 was assessed, cold compresses	F 610	thoroughly investigated for abuse/neglect and reported timely. 3. Nursing leadership was educated by the ED or designee on the components of thorough investigations to ensure that injuries caused by staff are recognized as abuse/neglect allegations and that timely reporting occurs. 4. Incidents will be reviewed daily through the clinical meeting (M-F) for thorough investigations and potential abuse/neglect reports. The RDCS or RVP will provide monthly review of incidents x3 months to ensure thorough investigations related to staff caused injuries are completed and policies are followed. Incidents will be trended and reviewed through the monthly QAPI meeting for ongoing education and training. 5. The ED or designee will ensure ongoing 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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 11 were applied, and 911 was called. An Incident Follow-Up & Recommendation Form signed by the DON on 12/20/17, documented a summary of the investigation. The summary documented CNA #3 was assisting Resident #93 to get ready for bed. CNA #3 was at the sink in the bathroom with Resident #93, who was sitting on the toilet, when Resident #93 began to fall forward. The summary documented CNA #3 saw Resident #93 falling out of the corner of her eye and CNA #3 grabbed Resident #93's right forearm and the back of her brief attempting to pull her back onto the toilet. The summary stated Resident #93 had her left arm sitting on the grab bar prior to the fall and it was unclear if her arm slipped or if she lost balance and then her left arm slipped off the grab bar. The summary documented when CNA #3 grabbed Resident #93's forearm it caused her to turn to the left and caused her upper body to go forward, striking the right side of her head on a grab bar. The summary documented CNA #3 stated she ensured Resident #93 was seated safely and she yelled out for help. The summary documented LPN #1 and another CNA responded to the call for help, 911 was called and Resident #93 was sent to a local hospital for treatment. The Incident Follow-Up & Recommendation Form, signed by the DON on 12/20/17, documented the root cause of the incident was Resident #93 lost her balance while sitting on the toilet and fell forward, CNA #3 attempted to stop Resident #93 from falling, and Resident #93 hit her head on a grab bar. The summary report documented "Full investigation completed. The care plan was being followed as patient is	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 12 supervised at all times in the bathroom." The report did not include the care plan or care directives which documented Resident #93 required 2 person assistance with transfer disk in the bathroom. On 12/13/18 at 5:20 PM, the DON demonstrated how CNA #3 demonstrated to her what occurred in the bathroom with Resident #93 on 12/16/17. The DON said CNA #3 was standing on Resident #93's right side and grabbed her right arm and her brief at the waist level to move Resident #93 back onto the toilet from leaning forward. When asked why Resident #93's brief was pulled up while she was supposed to be using the bathroom, the DON stated it was a "good question" and "that doesn't make sense." When asked who and how was Resident #93 transferred to the toilet, the DON said she did not investigate that part, she only investigated from when Resident #93 fell forward from the toilet and hit her head. The facility investigation was not thorough for Resident #93.	F 610		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §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	F 622		1/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 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 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	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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 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 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 staff interview and record review, it was determined the facility failed to ensure	F 622	1. Resident #35 had family and resident notification of transfer/discharge.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 15 information was provided to the receiving hospital for an emergent situation for 1 of 2 residents (Resident #35) who were reviewed for transfers. This deficient practice had the potential to cause harm if the resident was not treated in a timely manner due to a lack of information. Findings include: Resident #35 was readmitted to the facility on 10/6/18, with multiple diagnoses including an urinary tract infection. A discharge MDS assessment, dated 10/2/18, documented Resident #35 was discharged to a hospital. A Nursing Note, dated 10/2/18 at 5:53 PM, documented Resident #35 had a change of condition and Resident #35 and his daughter requested to go to the hospital. Resident #35's record did not include documentation his physician was notified and ordered the transfer to the hospital, a verbal report was given to the hospital, or information regarding Resident #35 and his status was sent with him to the hospital. On 12/12/18 at 5:13 PM, LSW #1 stated Resident #35's record did not have documentation the Transfer/Discharge Form and paperwork were provided to the paramedics, there was a physician's order to transport him to the hospital, and the reason for admission to the hospital. LSW #1 stated the facility had a carbon copy of a Transfer/Discharge Form which nurse's documented the reason for the transfer to the hospital, a medication list, diagnoses, advance	F 622	Resident has since returned to the facility. 2. Review of the last 30 days of transfers to the hospital was completed to determine that current residents have been notified regarding transfer and discharge. 3. Nursing and SS staff were educated by the SDC or designee on proper transfer and discharge notifications and paperwork as it relates to hospital transfers. 4. Hospital transfers will be reviewed through the daily clinical meeting (M-F) weekly x4 then monthly x2 for required notifications and paperwork. Negative findings of these audits will be reviewed monthly x3 through the facility QAPI meeting for ongoing education and training. 5. The ED or designee will ensure ongoing 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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 16 directive, and verbal report to the hospital. There was no documentation in Resident #35's record the receiving hospital was provided information regarding his transfer.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of	F 623		1/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 623	Continued From page 17 this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 623	Continued From page 18 email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility policy review, and record review, it was determined the facility failed to ensure transfer notices were provided in writing to residents and the local ombudsman. This was true for 1 of 2 residents (Resident #35) who were reviewed for transfers. This failure had the potential for inappropriate care and treatment of residents if they were not made aware of or able to exercise their rights related to transfers. Findings include: The facility's policy and procedure for Transfers and Discharges, revised 9/1/17, documented,	F 623	1. Resident #35□s responsible party and State Ombudsman were notified of the resident□s transfer and return. 2. Review of the last 30 days of transfers to the hospital was completed to determine that current residents/responsible parties and the State Ombudsman have been notified regarding transfer and discharge. 3. Licensed nurses and SS staff were educated by the SDC or designee on proper transfer and discharge notifications and paperwork as it related	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 623	Continued From page 19 "The facility ensures that systems are implemented to provide written notification to the resident and resident representative prior to transfer. This written notification is provided on the Notice of Discharge or Transfer Form. This information will be presented in a language and manner that the resident/resident representative can understand." The facility policy also documented a written notification of the transfer was provided to the Office of the State Long-Term Care Ombudsman. This policy was not followed. Resident #35 was readmitted to the facility on 10/6/18, with multiple diagnoses including a urinary tract infection. A Nursing Note, dated 10/2/18, documented Resident #35 was sent to the emergency room via ambulance for evaluation. On 12/12/18 at 5:13 PM, the AIT and LSW #1 stated Resident #35's record did not include documentation he and his representative were notified in writing of the transfer to the hospital. The AIT stated the local ombudsman was not notified Resident #35 was transferred to the hospital on 10/2/18. The facility did not provide notification of a hospital transfer to Resident #35 or his representative, or the Office of the State Long-Term Care Ombudsman.	F 623	to hospital transfers. 4. Hospital transfers will be reviewed through the daily clinical meeting (M-F) weekly x4 then monthly x2 for required notifications and paperwork. Negative findings of these audits will be reviewed monthly x3 through the facility QAPI meeting for ongoing education and training. 5. The ED or designee will ensure ongoing compliance.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		1/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 625	Continued From page 20 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility policy review, and record review, it was determined the facility failed to ensure a second bed-hold notice was provided to a resident or their representative upon transfer to the hospital. This was true for 1 of 2 residents (Resident #35) who were reviewed for transfers. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time and may cause	F 625	1. Resident #35 was informed of bed hold policy and provided documentation. 2. Last 30 days of transferred residents were audited for bed holds to ensure bed hold notification was completed. Any residents currently out of the facility had documentation obtained. 3. Licensed nurses, SS, Business office and admissions were educated by the SDC or designee on the facility□s bed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 625	Continued From page 21 psychosocial distress if not informed they may be charged to reserve their bed/room. Findings include: The facility's Bed Hold policy and procedure, revised 11/28/16, documented, "Bed hold policies will be provided and explained to the patient upon admission and explained to the patient before each temporary absence... the facility will provide written information to the patient or patient representative that specifies: * The duration of the state bed-hold policy, if any, during which the patient is permitted to return and resume residence in the nursing facility. * The reserve bed payment policy in the state plan, if any * The facility policies regarding bed-hold." This policy was not followed. Resident #35 was readmitted to the facility on 10/6/18, with multiple diagnoses including a urinary tract infection. Resident #35 was transferred to the hospital on 10/2/18, and readmitted to the facility on 10/6/18. Resident #35's record did not include documentation Resident #35 or his family representative received a second bed-hold notification when he was transferred to the hospital. On 12/11/18 at 2:15 PM, Resident #35 stated he was in the hospital for a few days and returned to a different room.	F 625	hold policy. 4. Hospital transfers will be reviewed daily (M-F) through the clinical meeting weekly x4 and monthly x2 to ensure bed holds are presented. Negative findings of these audits will be reviewed monthly x3 through the facility QAPI meeting for ongoing education and training. 5. The ED or designee will ensure ongoing 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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 625	Continued From page 22 On 12/12/18 at 5:13 PM, the AIT stated Resident #35 and his family representative did not receive a second bed-hold notification.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		1/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 656	Continued From page 23 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to develop and implement comprehensive resident-centered care plans for 1 of 19 residents (Resident #32) whose care plans were reviewed. This failure created the potential for residents to receive inappropriate or inadequate care with a subsequent decline in health. Findings include: Resident #32 was readmitted to the facility on 11/20/18, with multiple diagnoses including a non-pressure ulcer to her left lower leg. a. Resident #32's care plan, dated 11/20/18, did not include an ADL care plan which directed staff how much assistance she required for bed mobility, transfers, dressing, eating, toileting, personal hygiene, and bathing. On 12/11/18 at 8:33 AM, Resident #32 stated she received bed baths twice a week. On 12/12/18 at 8:55 AM, CNA #5 stated Resident #32 preferred bed baths. On 12/12/18 at 09:55 AM, Resident #32 was	F 656	1. Resident #32 had their care plan reviewed for comprehensive completion to ensure that ADLs, bathing preferences and skin related issues were addressed. 2. Current residents admitted within the last 30-days had their care plans reviewed to ensure they included ADLs, skin related issues and bathing preferences. Review of the most recent skin checks was completed to ensure that any identified skin related issues were care planned. 3. Licensed nurses were educated by the SDC or designee on care plan completion to include ADLs, skin related issues and bathing preferences. 4. Care plans will be reviewed in conjunction with the resident□s MDS schedule and as needed with new condition onsets for areas related to ADLs, skin and bathing preferences. 5. The DON or designee will ensure ongoing 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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 656	Continued From page 24 observed receiving a bed bath, getting dressed, and Hoyer lifted (a mechanical lift) to her recliner by CNA #5 and CNA #6. On 12/12/18 at 3:03 PM, the DON stated Resident #32's shower preference was on the kardex not on the care plan. The DON stated Resident #32's shower preferences should have been on the care plan. On 12/12/18 at 3:04 PM, Unit Manager #2 stated Resident #32 should have had an ADL care plan that documented her bathing preferences. On 12/12/18 at 3:10 PM, CNA #7 stated she worked for an agency and did not have access to residents care plans or the kardex on the electronic system to know resident preferences and care needs. CNA #7 stated she asked other staff members or the resident on how to provide care to the resident. b. The facility failed to implement a care plan for weekly skin assessments for Resident #32. Resident #32's November 2018 and December 2018 TAR did not include weekly skin assessments. Resident #32's care plan, dated 11/20/18, did not include weekly skin assessments. On 12/12/18 at 12:03 PM, Unit Manager #2 stated weekly skin assessments were not implemented on the care plan when Resident #32 was readmitted to the facility on 11/20/18. c. Resident #32's readmission skin assessment,	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 656	Continued From page 25 dated 11/20/18 at 3:50 PM, documented she had a skin tear 1.0 cm x 1.0 cm on the back of her right thigh. Resident #32's care plan, dated 11/20/18, did not include the skin tear on the back of her right thigh. On 12/12/18 at 11:17 AM, Unit Manager #2 stated there was not a care plan for Resident #32's skin tear on the back of her right thigh. The facility failed to implement a comprehensive, resident-centered care plan for Resident #32.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		1/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 657	Continued From page 26 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents' care plans were regularly reviewed and revised as warranted for 1 of 19 residents (Resident #7) whose care plans were reviewed. This failure created the potential for harm when Resident #7's care plan was not revised to include interventions for pain management during wound care. Findings include: Resident #7 was admitted to the facility on 7/17/18, with multiple diagnoses including diabetes mellitus, low back pain, and a fractured sacrum. A significant change MDS assessment, dated 9/9/18, documented Resident #7 was cognitively intact with occasional mild pain with 2 Stage II pressure ulcers. Resident #7's care plan, dated 7/17/18, documented he received routine pain medication and to consider premedicating prior to treatments/therapies to optimize participation. The care plan did not include assessing pain prior to wound care. On 12/12/18 at 9:52 AM, Unit Manager #2 was observed providing wound care to Resident #7's	F 657	1. Resident #7 care plan was reviewed and updated to address his pain needs related to wound care. 2. Care plan audit was conducted on residents with wounds to ensure that pain management was addressed within the care plan. 3. Nursing staff educated by the SDC or designee in regards to assessment of pain during wound care and updating care plans to reflect those needs. 4. Care plans will be reviewed in conjunction with the resident□s MDS schedule and as needed with new condition onsets for areas related to pain management with wound care. 5. The DON or designee will ensure ongoing 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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 657	Continued From page 27 right calf area. Resident #7 cried out with pain during cleansing of the wound by Unit Manager #2. She continued to provide wound care without assessing Resident #7, offering pain medication, or stopping the procedure to relieve the pain. On 12/14/18 at 10:33 AM, Unit Manager #2 stated she did not assess Resident #7's pain level prior to the wound care and she should have offered and stopped when he cried out in pain. Unit Manager #2 stated the care plan was outdated and needed to be revised to address Resident #7's pain level before, during, and after wound care. Resident #7's care plan was not revised or updated to meet his pain needs related to his wound care.	F 657		
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, resident interview, family interview, staff interview, and record review, it was determined the facility failed to ensure residents who were unable to carry out ADLs received the necessary care and services to keep their finger and toenails clean and trimmed for 2 of 19 residents (#19 and #64) who were reviewed for ADL care. The failure created the potential for the residents to experience skin impairment, infection, and a negative effect to their psychosocial well-being. Findings include:	F 677	1. Residents #19 & 64 had their fingernails and toe nails cleaned and care plans reviewed and updated as needed. 2. Residents dependent with ADL care were audited for cleanliness of fingernails and toenails and care provided as needed. 3. NACs and LNs were educated by SDC or designee on the requirements of providing nail care to dependent residents.	1/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 28 1. Resident #19 was admitted to the facility on 9/16/18, with diagnoses which included dementia, respiratory failure, and high blood pressure. On 12/10/18 at 10:52 AM, Resident #19 was observed dozing in her recliner. Her relative was present and said the facility did not keep her fingernails clean. Her current care plan did not address nail care. On 12/11/18 at 3:50 PM, a dark line was observed under both of Resident #19's thumbnails near the finger tips. On 12/12/18 at 8:56 AM, Resident #19's fingernails were observed with a dark line under both thumbnails, as well as under the fingernails on the right middle finger and the left pointer finger. There was no documentation of nail care found in Resident #19's record. On 12/12/18 at 9:07 AM, CNA #8 said residents are supposed to get nail care with each bath or shower. She said she was the substitute shower aide that day. She said it was not something she did often, but she provided nail care when she bathed or showered a resident. She said she was not aware of any guidelines or policy and procedures to follow regarding nail care for non-diabetic residents. RN #2 joined the conversation and said nurses did the nail care for diabetic residents and documented it in their MAR. The RN said she did not know where nail	F 677	4. Daily manager round will be conducted (M-F) and nail care will be audited on 10% of the population weekly x4 and monthly x2. Negative findings will be corrected at time of discovery and trends will be reviewed through the monthly QAPI meeting x3 months. 5. The DON or designee will ensure ongoing 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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 29 care for non-diabetic residents was documented. On 12/12/18 at 9:10 AM, CNA #8 accompanied the surveyor into the 100 hall bathing room. CNA #8 showed the surveyor emery boards and nail clippers, and she looked unsuccessfully for nail brushes. She said the main shower aide usually kept the room stocked but there were no nail brushes in the room right then. On 12/12/18 at 9:35 AM, RN #2 accompanied the surveyor to Resident #19's room and with her permission, RN #2 looked at her fingernails then removed her socks to look at her toenails. RN #2 said both of Resident' #19's thumbnails, and the fingernails on her right middle finger and left pointer finger were dirty and needed to be cleaned, and the toenails on both of her big toes, the left 4th toe, and right 3rd and 4th toes were long and needed to be trimmed. On 12/14/18 at 9:23 AM, Unit Manager #1 said generally for non-diabetic residents the shower aides do nail care with the showers. She reviewed Resident #19's record and said nail care was not documented. 2. Resident #64 was admitted to the facility on 7/9/13, with multiple diagnoses including dementia and unspecified edema. Resident #64's current care plan did not address nail care. Resident #64's December 2018 MAR included instructions to, "Trim nails weekly on skin check day weekly every Wednesday." The instructions did not specify fingernails or toenails. A nurse's	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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 30 initials were documented on 12/5/18 and 12/12/18. On 12/13/18 at 10:13 AM, RN #2 was observed as she provided wound care to Resident #64's feet. After RN #2 removed her left slipper and stocking, Resident #64 commented her toenails were long and could "snag" on things. RN #2 agreed and said her toenails could use a trim. Upon completion of the wound care, RN #2 said the right toenails were long too and needed to be trimmed. Residents did not receive the necessary care and services to keep their nails clean and trimmed.	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 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility policy review, and record review, it was determined the facility failed to ensure professional standards of practice were followed for 3 of 25 residents (#9, #32, and #93) who were reviewed for standards of practice. Weekly skin assessments were not completed and neurological assessments were not completed or were incomplete after unwitnessed	F 684	1. Resident #9 was assessed for negative outcomes and none were noted. Resident #32 had orders implemented for skin tear and weekly skin assessments initiated and completed. Resident #93 no longer resides in the facility. 2. Review of the skin UDA dashboard was	1/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 31 falls. These failed practices had the potential to adversely affect or harm residents whose care and services were not delivered according to accepted standards of clinical practices. Findings include: 1. The facility's Pressure Ulcer/Injury Prevention and Management policy, dated 11/27/18, documented weekly skin assessments should be performed by a licensed nurse. When skin breakdown occurs, it required attention and a change in the plan of care to treat the resident. This policy was not followed. Resident #32 was readmitted to the facility on 11/20/18, with multiple diagnoses including a non-pressure ulcer to her left lower leg. a. On 12/11/18 at 8:50 AM, Resident #32 stated she had a skin tear to the back of her right thigh caused by the paramedics when she returned to the facility on 11/20/18. Resident #32 stated the facility had not monitored or treated her skin tear to the back of her right thigh. Resident #32 stated she went to the wound clinic weekly for wound care to her left lower extremity and they placed a dressing on the back of her right thigh for protection from the Hoyer lift (a mechanical lift) sling. A readmission skin assessment, dated 11/20/18 at 3:50 PM, documented Resident #32 had a skin tear 1.0 cm x 1.0 cm to the back of her right thigh. Resident #32's November 2018 TAR did not include assessing, monitoring, or treatment to her skin tear to the back of her right thigh.	F 684	completed to ensure that weekly skin checks were in place for all residents. Review of the last 30 days of unwitnessed falls was conducted to ensure neurological assessments were completed. Those with missing or incomplete assessments were assessed for negative effects. 3. Licensed nurses were educated by the SDC or designee on the required completion and documentation of weekly skin checks for residents. Education was also conducted on the policy for neurological assessments related to unwitnessed falls or falls with head injury. 4. Weekly skin checks will be audited weekly x4 and monthly x2 for presence on the UDA Dashboard. Unwitnessed falls will have investigations reviewed to ensure neurological assessments are thorough and complete. Negative findings of these audits will be presented to the monthly QAPI meeting x3 months. 5. The DON or designee will ensure ongoing 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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 32 Resident #32's care plan, dated 11/20/18, did not identify or include interventions for the skin tear to the back of her right thigh. On 12/12/18 at 9:55 AM, Resident #32 was observed with an undated adhesive dressing to the back of her right thigh. Resident #32 stated the wound clinic applied the dressing on 12/11/18. On 12/12/18 at 11:05 AM, LPN #1 stated Resident #32 had a pinpoint open area to the back of her right thigh and had a dressing on it to protect from irritation. LPN #1 stated the dressing change should have been ordered to be changed and monitored on Resident #32's TAR. LPN #1 was unable to provide documentation Resident #32's skin tear was being monitored, assessed, and treated in her record. On 12/12/18 at 11:09 AM, Unit Manager #2 was unaware Resident #32 had a skin tear to the back of her right thigh. On 12/12/18 at 11:10 AM, Unit Manager #2 asked Resident #32 if she had a skin tear to the back of her right thigh. Resident #32 stated "yes" and explained she received the skin tear during a transfer from the paramedics to the facility on 11/20/18. Unit Manager #2 removed the undated adhesive dressing on the back of Resident #32's right thigh. The dressing had no drainage and the skin tear was dry without signs or symptoms of infection. Resident #32 stated the wound clinic applied the dressing on 12/11/18, to keep the dressing on for protection from the Hoyer lift sling.	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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 33 On 12/12/18 at 11:17 AM, Unit manager #2 stated the wound clinic did not provide a progress note from Resident #32's appointment on 12/11/18. Unit Manager #2 provided the readmission skin assessment, dated 11/20/18, which documented Resident #32 had the skin tear to the back of her right thigh. She stated the nurse should have notified the physician, received orders for treatment, and care planned for wound care assessments, monitoring, and treatments to Resident #32's skin tear. b. The facility failed to implement weekly skin assessments for Resident #32. Resident #32's November 2018 and December 2018 TAR did not include weekly skin assessments. Resident #32's care plan, dated 11/20/18, did not include weekly skin assessments. On 12/12/18 at 12:03 PM, Unit Manager #2 stated weekly skin assessments were not implemented or completed when Resident #32 was readmitted to the facility on 11/20/18. 2. The facility's Neurological Assessment policy, dated 9/2008, documented the "Neurological Assessment Flow Sheet shall be initiated by a written physician's order...or when indicated by a resident assessment (e.g., head injury, post fall, neurological decompensation). Neurological assessments shall be performed at least every four hours for the first 24 hours and then at least every eight hours, unless ordered more or less frequently...or when the resident is determined 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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 34 be at risk for neurological decompensation...assessment and documentation shall include: *Date and time of assessment * Eye opening * Verbal response * Motor response * Pupillary response * Limb response." On 12/14/18 at 10:33 AM, UM #1 provided a blank 22 page Neurological Check List and said the staff were expected to complete the neurological assessments if a resident had an unwitnessed fall or had a potential for head injury. The 22 page Neurological Check List included the neurological assessments described above as well as the level of consciousness and vital signs (blood pressure, pulse, respiration rate, and temperature). The staff did not consistently assess residents' neurological status per the facility's policy. Examples include: a. I&A reports documented Resident #9's neurological status was not consistently assessed, or not assessed at all, after unwitnessed falls or falls with the potential for head injury as follows: - An I&A report, dated 8/2/18 at 7:30 PM, documented Resident #9 was found laying on her left side by her bed. An attached Neurological Assessment Flow Sheet documented her left and right pupillary response was not assessed for almost 4 hours and her vital signs were not assessed for 3 1/2 hours after she was found down. There were no assessments at 9:15 AM and 1:15 PM on 8/3/18.	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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 35 - An I&A report, dated 8/11/18 at 6:30 PM, documented Resident #9 was found on the floor between the toilet and the wall. An attached Neurological Assessment Flow Sheet documented her left pupil was not assessed for 3 1/4 hours and her right pupil was not assessed for 3 hours. - An I&A report, dated 9/3/18 at 4:00 PM, documented Resident #9 had a fall which was not witnessed. Resident #9 said she tried to transfer from her wheelchair to the bed and she missed the edge of the bed. An attached Neurological Assessment Flow Sheet documented only vital signs were assessed on 9/4/18 day shift, and no assessments were done on 9/5/18 for the day and evening shifts, or the 9/6/18 day shift. - An I&A report, dated 9/9/18 at 2:30 PM, documented Resident #9 was found on the floor by her bed. An attached Neurological Assessment Flow Sheet documented her verbal, motor, eye opening, level of consciousness, and limb movement was not assessed on 9/20/18 during the day shift, and there was a line drawn through all of the spaces for documentation on the 9/22/18 night and day shifts. - An I&A report, dated 10/7/18 at 3:45 PM, documented Resident #9 was found on the floor by her bed. There was no documented evidence in her clinical record her neurological status was assessed after the fall. - An I&A report, dated 10/18/18 at 10:38 AM, documented Resident #9 was observed kneeling next to her bed. An attached progress note dated	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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 36 10/18/18, documented her neurological status was within normal limits for her. However, there was no other documented evidence in her record that her neurological status was assessed after the fall. - An I&A report, dated 11/3/18 at 4:00 PM, documented Resident #9 was found sitting on the floor between her bed and the window. She denied pain "but stated that she had hit her head and pointed at the air conditioner unit under the window..." An attached Neurological Assessment Flow Sheet documented her pupillary response and limb movement was not assessed for more than 2 days. On 12/14/18 at 10:33 AM, Unit Manager #1 said Resident #9's neurological status was not consistently assessed after she experienced unwitnessed falls. b. An I&A report, dated 12/16/17 at 7:30 PM, documented Resident #93 had a fall which resulted in a hematoma (a swelling of blood within the tissue), closed head injury, fracture, and lacerations (cuts) to her face and arm. The report documented Resident #93 was on anticoagulant medication. The report documented she was, "Alert, but forgetful," she did not lose consciousness after the incident, and she was sent to a hospital at 8:10 PM on 12/16/17 by ambulance for treatment. A Neurological Assessment Flow Sheet attached to the I&A report documented Resident #93's vital signs were assessed on 12/16/17 at 7:30 PM, but there was no documentation her neurological status (level of consciousness, verbal response,	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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 37 motor response, eyes open, movement of her arms and legs, and pupil size and reaction) was assessed. On 12/13/18 at 12:08 PM, LPN #1 said she recalled the 12/16/17, incident and Resident #93 had a cut on her right cheek and a huge lump on her head. LPN #1 said she checked Resident #93's neurological status and she was awake and alert, she said she was in pain, and she moved her head and used her left arm to move her right arm. LPN #1 reviewed the neurological assessment sheet for 12/16/17. and said she did not document the resident's neurological status. On 12/13/18 at 4:50 PM, the DON reviewed Resident #93's Neurological Assessment Flow sheet attached to the I&A report of the 12/16/17 fall. The DON said there were no neurological assessments done on 12/16/17 after the fall but there should have been at least 2 sets of 15 minute assessments. The facility failed to follow standards of practice related to skin and neurological assessments.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		1/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 686	Continued From page 38 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy review, and record review, it was determined the facility failed to prevent the development of avoidable pressure ulcers. This was true for 2 of 5 residents (#7, and #64) reviewed for pressure ulcers. Resident #7 was harmed when he developed a stage III pressure ulcer to the back of his right calf. Resident #64 was harmed when she developed unstageable pressure ulcers to her feet. Findings include: The facility's policy for Pressure Ulcer/Injury Prevention and Management, dated 11/27/18, documented: * A comprehensive skin assessment on admission and re-admission to the center may identify pre-existing signs of possible deep tissue damage already present. * A risk assessment tool, Braden Scale, determines the patient's risk for pressure ulcer development. * A skin assessment should be performed weekly by a licensed nurse. * Measures to maintain and improve the patient's tissue tolerance to pressure are implemented in the plan of care: - skin inspections with attention to bony prominences;	F 686	1. Resident #7 Braden assessment and care plan/care directive reviewed and updated with current interventions. Nursing wound observation tool reviewed for accuracy with changes reflected on wound care observation tool. Resident #64 had treatment records checked to ensure skin assessments active. Physician order verified for appropriate treatments. Validated weekly skin assessment completion and checked for foot assessments. Wound tool updated with documented pain and foot assessments. 2. House wide skin sweep completed with documentation and MD notification. Housewide audit of Braden□s. Residents with wounds will have treatments audited for completion and documentation. Residents identified as at risk for developing PU will have IDT review for appropriate PU prevention interventions. Care plans updated on identified residents. 3. Licensed nurses were educated by the SDC or designee on validating treatment records and the point click care dashboard (UDA) as well as proper follow up documentation and communicating skin issues to required parties.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 686	Continued From page 39 - minimize injury due to shear and friction through proper positioning, transfers, and turning schedules; - measures to protect the patient against the adverse effects of external mechanical forces, such as pressure, friction and shear; - reposition at least every 2-4 hours; - utilize positioning devices to keep bony prominences from direct contact; - ensure proper body alignment when side-lying; - when skin breakdown occurs, it requires attention and a change in the plan of care to appropriately treat the patient 1. Resident #7 was admitted to the facility on 7/17/18, with multiple diagnoses including diabetes mellitus, low back pain, and a fractured sacrum. An Initial Data Collection Tool/Nursing Service, dated 7/17/18, documented Resident #7 had no pressure ulcers to his right lower leg and pedal pulses were present. A Braden Scale for predicting pressure score risk, dated 7/17/18, documented Resident #7 was at risk for pressure related to predisposing medical conditions including heart disease, decreased or impaired bed/chair mobility, and pain affecting movement. A Braden Scale for predicting pressure score risk, dated 9/1/18, documented Resident #7 was at risk for developing a pressure ulcer. The predisposing medical conditions and risk factors were blank. A significant change MDS assessment, dated	F 686	4. Nursing leadership will audit the resident treatment records, wound observation tool weekly x4 and monthly x2. Wound observation tool will be audited weekly x90 days to ensure correct measurements. Negative findings of these audits will be presented to the monthly QAPI meeting x3 months. 5. The DON or designee will ensure ongoing 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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 686	Continued From page 40 9/9/18, documented Resident #7 was cognitively intact with occasional mild pain with 2 Stage II pressure ulcers. Resident #7's care plan, dated 11/13/18, documented staff were to encourage resident to stay off of his right side, implement a bariatric air mattress with bolsters, assess and measure wound, and administer wound treatments as ordered, treat pain prior to treatment/turning, and weekly treatment documentation to include measurements of each area of skin breakdown. The September 2018 weekly skin check documentation for Resident #7 were completed on 9/7/18, 9/14/18, and 9/21/18. The weekly skin check on 9/28/18 was left blank. A nurse's progress note, dated 9/29/18, documented Resident #7 had an open area to his posterior RLE (right lower extremity) measuring 2.5 cm x 1.5 cm x 0.2 cm with minimal drainage. The physician was notified and an adhesive dressing was applied. The progress note also documented pillows were in place under RLE to offload pressure to calf and ankle, and frequent checks and rotations were implemented every 2 hours and PRN. A physician's order for Resident #7's wound care, dated 9/29/18, documented staff were to cleanse open area to posterior RLE with normal saline, apply calcium alginate, and cover with an Allevyn dressing every 3 days and PRN. A pressure ulcer status record, dated 9/29/18, documented Resident #7 had a stage II pressure ulcer to his right posterior RLE measuring 2.5 cm	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 686	Continued From page 41 x 1.5 cm x 0.2 cm with 30% granulation and no necrotic tissue. A nurse's progress note, dated 10/5/18 for a late entry 10/2/18, documented Resident #7's RLE wound was not improving with measurements of 2.3 cm x 1.4 cm x 0.2 cm. The wound bed had 90% slough with pink edges and scant amount of serosanguinous drainage. The physician was notified with new wound care orders. A nurse's progress note, dated 10/13/18 at 11:23 PM, documented Resident #7's right calf ulcer continued to have slough, possibly due to in state of evolution. A Nursing Wound Observation Tool, dated 11/13/18, documented Resident #7's right posterior calf wound was acquired in the facility on 11/14/18. The measurements were 3.6 cm x 2.5 cm x 0.3 cm and a stage IV pressure ulcer with 60% slough, 40% necrotic tissue and the overall impression of visible tissue was worsening. The wound observation tool documented Resident #7 had an additional open area to his right posterior calf with measurements 1.0 cm x 2.1 cm x 0.1 cm and had 70% slough with 30% necrotic tissue and small amount of serosanguineous drainage. On 12/11/18 at 2:30 PM, UM #2 stated Resident #7 acquired the first pressure ulcer on 9/29/18 and acquired the second pressure ulcer on 11/13/18. UM #2 stated the Nursing Wound Observation Tool was documented as an error. A physician's order, dated 11/13/18, referred Resident #7 to PT for wound care treatment.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 686	Continued From page 42 A PT note, dated 11/14/18, documented Resident #7 was provided CPI (Cell Proliferation Induction) wound treatment for stage III wound care. PT documented Resident #7 had 2-3 small wound clusters within the overall perimeter to right posterior leg with eschar/necrosis. A PT note, dated 11/16/18, documented Resident #7 had a total of 3 wounds: * Wound #1: Measured 4.0 cm x 3.6 cm x 0.3 cm with 90% yellow eschar; * Wound #2: Measured 2.0 cm x 1.5 cm with black eschar at center; * Wound #3: Measured 1.5 cm x 0.5 cm mainly pink wound bed with 15% eschar. The wounds had a mild foul odor with minimal yellow/brown drainage. PT documented the wounds were debrided. PT services continued on 11/19/18, 11/20/18, 11/21/18, and 11/26/18. PT documented on 11/27/18, treatments were discontinued related to little benefit to the wounds. A Nursing Wound Observation Tool, dated 11/27/18, documented Resident #7's right posterior calf was unstageable with measurements of 7.1 cm x 5.0 cm x 0.1 cm with 60% slough tissue and 40% necrotic tissue in the wound bed with small amount of serosanguinous drainage. Resident #7 was referred to the wound clinic. The second wound on the right posterior calf documented it was unstageable with measurements 2.4 cm x 3.0 cm x 0.2 cm with 80% slough in the wound bed and a small amount of serosanguineous drainage. The tool documented Resident #7 was experiencing pain	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 686	Continued From page 43 with wound care treatments and Oxycodone was effective when given prior to wound care. A wound clinic progress note, dated 11/29/18, documented Resident #7's wound started from pressure and was worsening due to poor circulation, edema, and inability to tolerate being in one position due to chronic back pain. The Physician Assistant (PA) documented Resident #7 had weak pedal pulses and would set up a vascular surgeon consult for a second opinion. The PA documented, "This is a difficult wound to heal, does have risk for cellulitis/amputation." There was no vascular studies in Resident #7's record. Resident #7's care plan, revised 12/7/18, documented Resident #7 developed a stage III pressure ulcer to his right posterior calf related to diabetes and immobility. On 12/12/18 at 9:40 AM, UM #2 stated Resident #7's pressure ulcer was caused by him sitting in a recliner where the open space of the recliner caused pressure to his right posterior leg. UM #2 stated the facility did not identify the pressure ulcer until the wound was open. On 12/12/18 at 9:45 AM, UM #2 and UM #3 were observed providing wound care to Resident #7's right posterior calf. UM #2 stated the lower open area to the right calf measured 5 cm x 1.5 cm x 0.4 cm with 80% slough and 20% red maceration. UM #2 stated the upper area of the wound measured 3.0 cm x 6.5 x 0.4 cm. UM #2 stated the third open area was located on the back of the right leg just below the knee and was	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 686	Continued From page 44 "caused due to vascular status, not pressure." UM #2 stated the open area was dark red/black in color and measured 3.0 cm x 1.5 cm x 0.4 cm with 90% eschar and was unstageable. On 12/12/18 at 3:45 PM, UM #2 stated there were no weekly skin assessments completed in October 2018. UM #2 stated Resident #7's pressure ulcer was facility acquired and should have been prevented with repositioning and padding the recliner with pillows. UM #2 stated the wound "began as a pressure ulcer and now we are having a hard time healing because of poor circulation." 2. Resident #64 was admitted to the facility on 7/9/13, with multiple diagnoses including dementia and unspecified edema. Resident #64's quarterly MDS assessment, dated 8/16/18, documented she understood others and they understood her; she needed limited 1 person physical assistance with dressing and 1 person supervision with personal hygiene; and, she did not have any skin ulcers. A 9/20/18 fax order request/notification form documented, Resident #64 had an open area measuring 0.6 cm x 0.6 cm, superficial to her left medial foot caused from shoes with slight swelling & redness to surrounding area and blanching. It also documented the other red areas were all intact and there was blanching to both feet due to shoes. On 9/21/18, the physician ordered skin prep to the red areas on both feet twice a day and to	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 686	Continued From page 45 apply a foam dressing to the open area on the left medial foot and red areas every 3 days and PRN until resolved; and, encourage her to not wear her leather shoes. Resident #64's care plan documented on 11/6/18 she had "potential/actual" skin impairment of the left and right medial foot related to tight fitting shoes. Interventions created 11/6/18 included instructions for staff to: * assess the location, size, and treatment of the injury; * report abnormalities, failure to heal, and signs and symptoms of infection or maceration to the physician; * follow facility protocols for treatment; and, * document weekly treatment, including measurements (width, length, depth) of each area of skin breakdown, tissue type, exudate, and any other notable changes or observations. A 11/6/18 fax order request/notification form documented a "New" 0.4 cm x 0.4 cm scab on her right medial foot. An order, also dated 11/6/18, documented skin prep was to be applied to the area twice a day until resolved and to monitor for signs and symptoms of complications every day for 1 week. Resident #64's 11/16/18 quarterly MDS assessment documented she had 2 unhealed and unstageable pressure ulcers. Resident #64's Order Recap Report, dated 8/1/18 to 12/31/18, documented a 10/14/18 order for a foam dressing to the open area on her left	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 686	Continued From page 46 medial foot and "red areas" every 3 days and PRN until resolved. On 11/16/18, the order was changed from a night time treatment to a day time treatment. On 12/12/18 at 10:10 AM and 5:04 PM, Resident #64 was observed self propelling in her wheelchair in the hallways and near the main dining. She was wearing moccasin type slippers and during both observations a border dressing was partially visible at the medial aspect (arch) on both of her feet with redness along the top and upper sides of the dressings. The redness was greater on the left foot than the right foot. On 12/11/18 at 3:06 PM, LPN #2 stated that Resident #64 did not have pressure ulcers. On 12/13/18 at 9:11 AM, RN #2 said she planned to change Resident #64's bilateral foot dressings in an hour. On 12/13/18 at 10:13 AM, RN #2 RN stated she had pre-medicated Resident #64 with Tylenol 30 minutes earlier. Resident #64 agreed to the bilateral foot dressing changes and for the surveyor to observe. RN #2 washed her hands and applied gloves, then she knelt down and removed Resident #64's left slipper, thigh high stocking, and a 2x2 border dressing. A scant amount of red-brown drainage was on the dressing. The entire area where the dressing had been was bright red and moist, and where the dressing's adhesive border had been was bright pink. Resident #64 said, "Oh, that's tender," as she pointed at the open ulcer on her left foot. The ulcer was circular and about 0.5 cm in diameter with approximately 80% to 90% pale yellow	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 686	Continued From page 47 slough in the wound bed. RN #2 changed her gloves and swabbed the area surrounding the ulcer with Skin prep, fanned it dry, then applied a new 2x2 border dressing over the left foot wound. She then reapplied the left stocking and slipper. RN #2 changed her gloves, removed the right slipper, stocking, and 2x2 border dressing. The dressing was dry and RN #2 said the right foot ulcer looked much better. There was a tiny (#2 pencil dot size) scabbed area at the upper aspect of the arch of her right foot. There was no redness or swelling in the area. RN #2 changed her gloves and applied Skin prep over area, fanned it dry, applied a new 2x2 border dressing, then reapplied her right stocking and slipper. Resident #64'2 TARs for September through the day shift on December 14, 2018 documented: * Weekly skin assessments were done in September 2018. Weekly skin assessments were not included in the TARs or the MARs, for October through December 2018. * Skin prep to the red areas on both feet was applied twice a day from 9/20/18 to 9/30/18, and 10/23/18 through the day shift on 12/14/18. An "X" was typed in each space for documentation from 10/1/18 to 10/22/18, * A foam dressing to the left medial foot open area and red areas was applied every 3 days, and PRN, from 9/20/18 to 9/29/18, then from 10/26/18 to 11/1/18, 11/7/18 to 11/13/18, twice on 11/16/18, and from 11/19/18 to 12/13/18. An "X" was typed in each space for documentation from 10/1/18 to 10/22/18. In addition, the spaces for documentation on 10/23/18 and 11/4/18 were	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 686	Continued From page 48 blank. * Skin prep was applied topically to the right medial foot scab every shift from 12/1/8 through the day shift on 12/14/18. These instructions for skin prep were dated 11/6/18; however, they were not included in the November 2018 TAR or MAR. Resident #64's Progress Notes, dated 9/18/18 through 12/13/18 at 11:19 AM documented: * 9/20/18 at 4:01 PM - An LN notified the nurse Resident #64 had an area to her left foot and it had not been not assessed due to Resident #64 being in activities and dining on 9/19/18, the afternooon of the notification. The nurse and DON went in to see resident once resident returned to the unit on the afternoon of 9/20/18 at 1:20 PM. The progress note documented an open area on left medial foot, measuring 0.6 cm x 0.6 cm with a slightly moist scab. Other red areas were noted, and all areas of the toes on the right foot were blanching. Further documented was redness and slight swelling to an open area on left foot, and the red area was fully blanching, tender to touch, and shoes directly matched the red and open areas as the cause. Resident #64 was educated and agreed to not wear her leather shoes until the open area resolved. The nurse and DON left to get supplies and when they returned, Resident #64 was wearing the leather shoes. She did not recall the education or the ulcer on her foot. The leather shoes were removed and non-skid socks were applied. The leather shoes were put in the closet. An addendum at 4:11 PM documented Resident #64's representative was contacted and agreed	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 686	Continued From page 49 to provide "new looser fitting shoes" and to remove the leather shoes from the room. * 10/4/18 at 3:33 PM - A scab to left medial foot measuring 0.6 cm x 0.6 cm, [unable to assess depth] due to scab and calloused edges. The documentation said other areas of redness continue to blanch and Resident #64 had been wearing her new shoes with no new areas of concern. The note documented monitoring would continue for areas of rubbing during weekly wound rounds. * 10/16/18 at 2:34 PM - Trace edema noted to feet, varies. * 11/6/18 at 8:26 AM - Wound rounds for Resident #64 noted scab to right medial foot measured 0.4 cm x 0.4 cm, red peri-wound blanching, and resident denied pain. Resident #64 continued to wear some of her tight shoes versus new loose shoes and an inability to redirect, and at times, resident was willing to change shoes. Scab matched area to other foot, shoe caused friction/abrasion likely the the cause to right foot as well. The tight shoes were moved out of reach. Skin prep applied to scab and left open to air. * 11/15/18 at 10:56 AM - Resident #64 was encouraged to wear loose fitting non skid footwear and weekly skin checks were recommended. On 12/14/18 at 9:03 AM, UM #1 said Resident #64 "insisted" on wearing leather shoes that were tight. The UM said the resident had scant edema in her feet at the time and a blister developed on	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 686	Continued From page 50 the medial aspect of her left foot on 9/20/18. The UM said she removed the leather shoes and the family took them home. She said she evaluated Resident #64's other shoes and the family brought in a different pair of black shoes. The UM said the black shoes were not tight initially but a blister developed on the medial aspect of Resident #64's right foot on 11/6/18. UM #1 said she initiated foot assessments every shift after the left foot blister was found but she did not find documented evidence her feet were assessed every shift. The UM said RN #2 informed her on 12/13/18 that Resident #64's left foot ulcer was "angry" and tender. On 12/14/18 at 12:45 PM, UM #1 said she sent a request to the physician that morning for a treatment change to Resident #64's left foot ulcer. The UM said she had not seen the ulcer herself but that RN #2 had described it to her as "angry" on 12/13/18. The UM stated that RN #2 did not document the status of the left or the right foot ulcers after she provided the wound care and dressing changes on 12/13/18. The UM provided Wound Observation Tools and said it was all she could find. One set of Wound Observation Tools documented the left foot wound characteristics and measurements on 10/17/18, 10/25/18, 11/1/18, and 11/6/18. All of Tools documented it was a stage 2 facility acquired pressure ulcer with a scab and the depth could not be determined. Another set of Wound Observation Tools contained documentation for the left and right foot wound characteristics and measurements	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 686	Continued From page 51 combined on 11/13/18, 11/21/18, 11/30/18, and 12/6/18. All of them documented the facility acquired wound location as the left medial foot and the right medial foot, and the wound type as "Other." The 11/30/18 Wound Observation Tool documented Resident #64 reported the left wound hurt more than the right wound and it felt better after the dressing was applied. The 12/6/18 Wound Observation Tool documented no wound related pain. UM #2 said she combined the assessments for the left and right wounds because the Wound Observation Tools were lengthy. UM #2 said they did not consistently monitor Resident #64's feet for impairment and they could do better regarding identifying, assessing, and monitoring her bilateral foot pressure ulcers.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, hospital records, and record review it was determined the facility failed to provide adequate supervision and assistance for 1 of 5 residents (Resident #93) reviewed for falls and accident hazards. Resident #93 was harmed when the facility failed to provide two person toileting assistance as instructed by PT	F 689	1. Resident #93 no longer resides in facility. 2. Incidents for the last 30 days were reviewed to ensure that accidents were not related to not following the plan of care or inadequate supervision. 3. Staff were educated by the SDC or	1/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 689	Continued From page 52 and OT, and per her care plan and care directive instructions. The fall resulted in a head injury and required emergency transport to a hospital for treatment. Findings include: Resident #93 was admitted to the facility on 10/22/17, with multiple diagnoses including right sided hemiplegia and hemiparesis following a cerebral infarction (stroke). She was readmitted on 11/17/17 following a left side carotid endarterectomy (surgical removal of thickened areas of the innermost coat of an artery). Resident #93's admission MDS assessment, dated 10/29/17, documented she did not speak but she understood others and they usually understood her; she had modified independence in cognitive skills for daily decision making with some difficulty in new situations only; she required extensive 1 person assistance with transfers, dressing, toilet use, and personal hygiene; she was not steady and only able to stabilize with staff assistance when moving from a seated to a standing position and moving on and off the toilet; and the direct care staff believed she was capable of increased independence in at least some ADLs. Resident #93's December 2017 Physician Orders included Plavix (an antiplatelet drug) 75 mg daily and Aspirin (it may interfere with clotting at low doses) 81 mg daily, both of which were started 11/17/17. Resident #93's December 2017 MAR documented the Plavix and aspirin were administered as ordered.	F 689	designee on following the CP/CD as it relates to resident care and reporting of accidents timely to ensure adequate supervision is maintained. 4. Incidents will be reviewed through daily clinical meeting (M-F) to ensure that adequate supervision and accident policies are followed. Negative findings will be trended and corrected immediately and reported to State as required. Incidents will be reviewed in monthly QAPI x3 months for further education and training opportunities. 5. The ED or designee will ensure ongoing 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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 689	Continued From page 53 Her comprehensive care plan documented the following: * Risk for abnormal bleeding or hemorrhage related to the anticoagulant medication, dated 10/23/17. * Risk for physical injury related to falls, dated 10/22/17. Interventions included resident/family teaching regarding safety measures to reduce her fall risk; referral to PT/OT for screening/treatment as needed; environmental adaptations included low bed; provide and observe the use of adaptive equipment (wheelchair); remind and reinforce safety awareness; and, offer toileting upon rising, before/after meals, at bedtime, and PRN. A new intervention was added on 10/24/17, which directed staff to lead to the left. * ADL self-care deficit, dated 10/22/17. Interventions included to provide the amount of assistance/supervision Resident #93 needed. Added on 11/3/17 - A 2 person assist with transfer disk was to be used in the bathroom; and, on 11/15/17, 1 assist transfer with disk transfer at bedside and a sling to be on for all transfers, was added. Two Care Directives were in Resident #93's clinical record. Resident #93's 10/25/17 Care Directive documented she needed assistance of 2 for transfers with a sling on during transfers; and assistance of 2 staff members with toileting. Resident #93's therapy records documented the	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 689	Continued From page 54 following: * 12/1/17 at 4:30 PM by an OT - "...CNA admits that transfer disc was not in room and she did not use it for transfers. Located transfer disc and education provided that disc necessary for all transfers to avoid twist and pain" to her right lower extremity. * 12/5/17 at 3:22 PM by an OT - "...Education to nurse...concern about transfer technique being followed...Re-education provided...transfer disc should be used for all transfers to avoid twisting of ankle. Nurse stating she will pass on information." And, "...seen for toileting retraining. Completed with CNA...Used sling and grab bar as well as transfer disc for optimal positioning and safe transfer technique...One person provided...assist to maintain stand while 2nd person provided max assist..." with clothing management and hygiene. Transfer completed with minimum assistance of 2 people. * 12/12/17 at 3:28 PM by a PTA - "...needing to use bathroom during this session...2 person assist needed for personal hygiene and clothing management..." * 12/14/17 at 12:49 PM by an OT - "...seen for toileting retraining completing stand and transfer with min assist x 1 and grab bar with pivot disc while 2nd person completed hygiene and clothing mgmt [management]..." * 12/15/17 at 1:32 PM by a PT - treat with OT during standing balance activity with functional toileting task with the transfer disc.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 689	Continued From page 55 * 12/15/17 at 1:34 PM by an OT - seen for toileting due to pt [patient] needing assist x 2 for safety. An I&A report, with the date 12/18/17 at the bottom, documented Resident #93 had an intercepted fall on 12/16/17 at 7:30 PM resulting in a hematoma (a swelling of blood within the tissue), closed head injury, fracture, and laceration (cut) to her face and arm. It documented, Resident #93 was sitting on the toilet. The aide saw her starting to fall forward and grabbed her right arm and the back of the brief and hip area. This caused Resident #93 to twist to the left, striking the right side of her forehead on the grab bar. The aide got the resident stable on the toilet and yelled for help. The I&A report documented Resident #93 was assessed, cold compresses were applied, 911 was called, and she was sent to a hospital at 8:10 PM. It documented at the time of the incident Resident #93 was on anticoagulant medication, her balance and/or gait was abnormal, she was "leaning over," and no assistive devices were in use. The I&A report documented Resident #93 was "alert, but forgetful" and did not lose consciousness after the incident. It also documented she had "expired." Hospital records documented Resident #93 was brought to the emergency department from the facility on 12/16/17 after a fall. She was assessed to have, "Catastrophic right acute subdural with 3.4 cm midline shift that is not compatible with life," radiographic and clinical evidence of "herniation," and platelet dysfunction due to Plavix use.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 689	Continued From page 56 On 12/13/18 at 12:08 PM, LPN #1 said she recalled Resident #93 and the incident on 12/16/17. LPN #1 said CNA #3 was with Resident #93 in her bathroom at the time of the incident. LPN #1 said CNA #3 told her she had turned away from Resident #93 to put clothes in a bag when she heard a noise and turned enough to see Resident #93 hit her head on the grab bar, then fell forward, head first. LPN #1 said CNA #3 told her she intercepted the fall because Resident #93 was falling head first to the floor, and when CNA #3 grabbed Resident #93's right arm and the back of her brief, the momentum caused Resident #93 to twist and hit the safety bar with the right side of her head. LPN #1 reviewed her documentation from 12/17/17, and said what she documented was different than what CNA #3 had told her. LPN #1 said she never considered abuse or rough treatment because she knew CNA #3 and had worked with her for many years. LPN #1 said by the time she got to Resident #93's bathroom, there was blood on the safety bar, but none on the floor. She said Resident #93 had a cut on her right cheek and a huge lump on her head. LPN #1 said she checked Resident #93's neurological status, she was awake and alert, verbalized she was in pain, and she was able to move her head, and used her left arm to move her right arm. LPN #1 said CNA #3 and another CNA assisted Resident #93 from the bathroom to her bed. LPN #1 said Resident #93's spouse came in the room and she told him Resident #93 needed to go to the hospital. On 12/13/18 at 12:35 PM, LPN #1 accompanied	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 689	Continued From page 57 the surveyor to where Resident #93 had resided in the facility. The bathroom was approximately 7 feet wide by 6 feet deep. The toilet was in the rear left corner and there was a safety bar behind the toilet and another safety bar was to the left of the toilet. Four feet in front of the toilet was a metal towel bar on the wall. The sink was 3 feet away and to the left of the toilet. The doorway was directly in front of the sink. LPN #1 demonstrated to the surveyor how CNA #3 explained to LPN #1 how she grabbed Resident #93's right arm and the back of her incontinence brief and it caused the resident to twist and hit her head on the safety bar on the left side of the toilet. LPN #1 said there was blood on the safety bar but none on the floor. She said there was a cut on Resident #93's cheek and a huge lump on her head. On 12/13/18 at 2:21 PM, LPN #1 said the transfer disc was by Resident #93's bed not in her bathroom when the incident happened on 12/16/17. On 12/13/18 at 4:50 PM, the DON reviewed Resident #93's care plan and said it documented 2 person assistance with transfers and 1 person extensive assistance with toileting. The DON said Resident #93's care directive documented 2 person assistance with toileting. The DON said she did not investigate how Resident #93 was transferred onto the toilet, because Resident #93 did not fall during the transfer, she was on the toilet and her left arm slid off the grab bar causing her to fall forward and hit her head. On 12/13/18 at 12:45 PM, Resident #93's spouse said the facility had 2 people help her in the	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 689	Continued From page 58 bathroom until 12/16/17 when only 1 staff helped her. He said they had the "disc thing" and all but one staff member often neglected to use it and that made her have to work harder. He said he stepped out of the room when the CNA helped her to the bathroom and he returned to her room when he heard someone yelling for help. He said she was "slumped over" on the toilet bleeding "profusely" and there was a "pool" of blood on the floor, and a "1 inch" cut on her right cheek and a huge lump on her head. On 12/13/18 at 2:21 PM, LPN #1 said the transfer disc was by Resident #93's bed, not in the bathroom, when the incident happened on 12/16/17. On 12/14/18 at 9:52 AM, OT #1 reviewed resident's PT/OT documentation for December 2017. The OT said 2 people were needed to assist Resident #93 with toileting and transfers and the therapy staff had instructed the nursing staff regarding her care. On 12/14/18 at 10:22 AM, the DON re-reviewed Resident #93's care plan and care directives, then she reviewed the therapy documentation and said that 2 person toileting assistance should have been followed. On 12/14/18 at 11:23 AM, the RDCS said she had two concerns regarding Resident #93's incident on 12/16/17: the 1 person transfer and toileting; and the CNA left the resident alone in bathroom to get help after the incident. Resident #93 she experienced a fall resulting in a severe head injury when the facility failed to	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 689	Continued From page 59 ensure two people provided assistance with toileting and used the necessary equipment for transfers as care planned and instructed by the therapy staff.	F 689		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review, and record review, it was determined the facility failed to ensure residents' pain level was assessed prior to wound care. This was true for 1 of 2 residents (Resident #7) reviewed for pain management. Resident #7 was harmed when he experienced increased pain during a dressing change and the facility did not identify and treat it. Findings include: The facility's Pain Management policy, dated 11/2016, expected staff to recognize when the resident was experiencing pain and identify circumstances when pain can be anticipated. An individualized pain management care plan was to be developed and initiated when pain indicators were identified upon admission, change in condition, and with any event. Staff were to implement a pain management system to help residents attain or maintain their highest practicable level of well-being by preventing or managing pain.	F 697	1. Resident #7 had pain assessment completed and care plan updated related to pain management with wound care. 2. Residents receiving wound care had pain assessments completed to ensure adequate management is in place. MD notification and care plan updates were made as needed. 3. Licensed nurses were educated by SDC or designee on assessing for pain management during wound care. 4. Audits will be conducted on residents with wounds to ensure that pain management during dressing changes is effective weekly x4 and monthly x2. Negative findings will be presented to the monthly QAPI meeting for ongoing education and training x3 months. 5. The DON or designee will ensure ongoing compliance.	1/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 697	Continued From page 60 Resident #7 was admitted to the facility on 7/17/18, with multiple diagnoses including diabetes mellitus, low back pain, and a fractured sacrum. A significant change MDS assessment, dated 9/9/18, documented Resident #7 developed 2 Stage II pressure ulcers in the facility and experienced mild pain. A physician's order, dated 12/10/18, documented Resident #7 was to receive Oxycodone 5 mg every 6 hours (midnight, 6:00AM, noon and 6:00PM) for pain. Resident #7's December 2018 MAR documented he received Oxycodone 5 mg on 12/12/18 at 6:00 AM and his pain level was documented as an 8 out of 10 on the pain scale. On 12/12/18 at 9:52 AM, Unit Manager #2 was observed providing wound care to Resident #7's open area to his right calf area. Resident #7 cried out in pain during the cleansing of the wound by Unit Manager #2 and she continued to provide wound care without assessing, offering pain medication, or stopping the procedure to relieve the pain. On 12/12/18 at 10:33 AM, Unit Manager #2 stated she should have assessed Resident #7's pain level prior to the dressing change and should have stopped when he yelled out in pain. Unit Manager #2 stated she should have completed the dressing change 30 minutes after he received his pain medication not 3 1/2 hours later. Resident #7 was harmed when the facility failed	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 697	Continued From page 61 to stop the dressing change when he cried out in pain.	F 697		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758		1/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 758	Continued From page 62 are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure resident specific behaviors were identified and monitored for 1 of 5 residents (Resident #48) reviewed for psychotropic medication use. The failure created the potential for harm if Resident #48's antipsychotic medication was unnecessary or ineffective. Findings include: Resident #48 was admitted to the facility on 10/2/18 with multiple diagnoses, including major depressive disorders (single episode) and dementia without behavioral disturbance. The Baseline Care Plan, dated 10/2/18, documented she had cognitive deficits with short-term memory loss related to dementia, and mood and behavior problems (not specified) related to the dementia and depression with the psychoactive medications Seroquel and Prozac in use. A 10/25/18 physician visit note documented	F 758	1. Resident #48 had MD notified of antipsychotic usage without appropriate diagnose/behaviors. Medication was reduced and discontinued. 2. Residents receiving psychotropic medication were audited to ensure that resident specific behaviors were being monitored. Care plans were updated as needed. 3. Licensed nurses and SS staff were educated on the requirements for ensuring that resident specific behaviors were monitored in conjunction with psychotropic medication usage. 4. Resident behavior monitoring will be audited weekly x4 and monthly x2 to ensure that documentation is present and notifications are made as needed. 5. The DON or designee will ensure ongoing 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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 758	Continued From page 63 Resident #48's insight was poor and recent abnormal memory. The assessment and plan for her dementia was to monitor behaviors, continue the Seroquel "for now" and consider a gradual dose reduction (GDR) "soon." The assessment and plan for her depression was to continue the Prozac, monitor behaviors, and no GDR at this time. Resident #48's comprehensive care plan documented the following: * 10/10/18, revised 11/9/18 - Dementia, currently prescribed Seroquel for dementia without behaviors. Resident #48 exhibits impaired decision making on non-compliance and self transferring and impaired cognition on her physical limitations and strength. The goals included she would develop skills to cope with her cognitive decline and maintain safety; and, she would be able to communicate basic needs by 1/9/19. The only intervention was for a program of activities to accommodate Resident #48's abilities. * 11/29/18 - A behavior problem of progression of dementia as evidenced by loss of independence and her home. Her baseline behavior was to ask to go home. The goal was Resident #48 would not experience behaviors harmful to herself. Interventions included administration of medications as ordered, anticipate and meet her needs, intervene as necessary to protect the rights and safety of others. Approach and speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. The non-pharmacological interventions were to validate Resident #48's feelings of loss,	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 758	Continued From page 64 and reassure her this was her home and she was safe there. * 10/10/18 - Fluoxetine (generic Prozac) for signs and symptoms related to depression with a goal for Resident #48 to remain free of signs and symptoms of distress, depression, anxiety or sad mood through 1/9/19. Interventions included administration of ordered medications and to observe for and report as needed any signs and symptoms of depression (including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, or tearfulness). Resident #48's active physician orders as of 12/14/18 included Seroquel 50 mg at bedtime for dementia without behavioral disturbance and fluoxetine 20 mg daily for depression. Resident #48's MARs for October, November and December 2018 documented the Seroquel and Prozac were administered as ordered. Resident #48's November 2018 Behavior/Intervention Monthly Flow Record documented: * 1 - Signs and symptoms of depression with interventions to redirect and validate feelings. Zeros were documented on the day shift on 11/1/18, 11/6/18, 11/7/18, 11/8/19, 11/12/18, 11/13/18 and 11/18/18; and, on the evening shift on 11/4/18, 11/5/18, 11/10/18 11/11/18, 11/16/18, 11/17/18, and 11/22/18. All of the other spaces to document on the day, evening, and night shifts were blank.	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 758	Continued From page 65 * 2 - Signs and symptoms of dementia with interventions for active listening and redirection. Zeros were documented on the day shift on 11/1/18, 11/6/18, 11/7/;18, 11/8/18, and 11/12/18 through 11/30/18; and on the evening shift on 11/4/18, 11/5/18, 11/10/18 11/11/18, 11/16/18, 11/17/18, and 11/22/18. All of the other spaces to document on the day, evening, and night shifts were blank. Resident #48's December 2018 Behavior/Intervention Monthly Flow Record documented: * 1 - Loss of independence and home with interventions to validate her feelings and reassure care provided. Zeros were documented on the day shift on 12/1/18, 12/2/18, 12/3/18, and 12/6/18. All of the other spaces to document on the day, evening, and night shifts were blank. * 2 - Was blank. Resident #48's Progress Notes for October to December 13, 2018 did not contain documentation of behaviors or behavior monitoring. On 12/13/18 at 9:42 AM and 10:13 AM, Resident #48 was observed in her room with the door open and the room dark. She appeared to be asleep. At 11:01 AM, she was awake and the light was on in her room; however, she declined to allow the surveyor into her room. On 12/13/18 at 6:00 PM, UM #1 said she was admitted with Seroquel for the dementia and	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 758	Continued From page 66 Prozac for depression. The UM reviewed the December 2018 behavior monitor and said she was monitored for loss of independence and her home as evidenced by sadness and self-isolating. UM #1 stated dementia by itself was not an adequate reason for the Seroquel but she had not been in the facility 3 months yet and they had planned to review her medications at 3 months. UM #1 said pharmacy had reviewed her medications and no recommendations were made. On 12/13/18 at 6:09 PM, LSW #1 said she had not worked with Resident #48 and Behavior Meetings were conducted on 12/12/18 and 12/13/18. LSW #1 said the DON, all SWs, and Unit Managers attended the meeting and the physician pharmacist attended monthly GDR meeting. LSW #1 looked unsuccessfully for documentation of the last GDR meeting. On 12/14/18 at 8:41 AM, LSW #2 said she talked with the AIT, who was also a LSW, and they agreed resident specific behaviors needed to be identified and monitored related to Resident #48's Seroquel and Prozac use. LSW #2, said Resident #48 "stays to herself and isolates herself" and "loss of independence and home" was the only behavior they were currently monitoring. On 12/14/18 at 8:50 AM, the AIT said she had just spoken to the pharmacist they look at antipsychotic medications every 3 months and antidepressants every 2 quarters. On 12/14/18 at 9:35 AM, UM #1 said the interdisciplinary team talked about her Seroquel	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 758	Continued From page 67 the night before. And, at 10:52 AM, UM #1 provided a signed order, dated 10/4/18, clarifying the diagnosis for Seroquel as dementia with behavioral symptoms related to dementia. On 12/14/18 at 12:15 PM, UM #1 said she did not find any other Behavior Monitors in Resident #48's clinical record or the Behavior Monitor binder at the nurses' station.	F 758		
F 880 SS=E	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: §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,	F 880		1/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 68 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. §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	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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 69 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy review, and record review, it was determined the facility failed to ensure staff performed appropriate glove use/changes, hand hygiene, and implemented infection prevention measures during wound care. This was true for 3 of 19 residents (#7, #45, and #64) who were observed for infection control. These deficient practices created the potential for harm by exposing residents to the risk of infection and cross contamination. Findings include: The facility's Hand Hygiene policy, revised 4/1/15, documented the purpose of appropriate hand hygiene was to decrease the risk of transmission of infection. The policy documented when hands were visibly dirty, contaminated, or soiled, wash with non-anti-microbial or anti-microbial soap and water. According to the Centers for Disease Control and Prevention (CDC), website accessed on 12/20/18, hand hygiene should be performed after removing gloves, after contact with blood, body fluids or excretions, mucous membranes, after contact with inanimate objects in the immediate vicinity of the patient, and if hands will be moving from a contaminated body site to a clean body site during patient care. The CDC also stated "When using alcohol-based hand sanitizer: Put product on hands and rub hands together; Cover all surfaces until hands feel dry; This should take around 20 seconds." "When cleaning your hands with soap and water,	F 880	1. Resident #45, 64 and 7 had wounds assessed for s/sx of infections and none were noted. 2. Review of November and December infection control logs were completed to identify negative trends with wounds that could be related to hand hygiene and none were noted. 3. Licensed nurses completed HCA training of ABCs of wound care and signed facility Wound Care agreements. 4. Nursing leadership will observe wound care with return demonstrations with random LNs weekly x4 and monthly x2. Negative findings will be corrected at time of discovery and trends will be reviewed through the facility□s monthly Infection control meeting x3 months. 5. The DON or designee will ensure ongoing 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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 70 wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds...rinse...The focus should be on cleaning your hands at the right times." 1. On 12/14/18 at 9:13 AM, the Staff Development Coordinator (SDC) and RN #1 were observed performing a wound vac dressing change to Resident #45. The SDC removed the old dressing from Resident #45's sacral wound and washed her hands and put on clean gloves. The SDC completed cleaning the wound with normal saline and gauze and did not remove her gloves or perform hand hygiene, then she laid out and applied the underlying tegaderm for the gauze vacuum tail. RN #1 entered the room to assist the SDC with wound care. RN #1 put on vinyl gloves and placed her gloved hands on Resident #45's bed linen. RN #1 applied a blue pair of gloves over the vinyl gloves and assisted positioning Resident #45 on his side for the SDC to continue with applying the clear adhesive dressing around the wound. The SDC positioned the black foam for the tail end (where the actual vacuum tubing would be applied) and RN #1 was holding the foam in place to be covered with another clear adhesive dressing while still wearing the blue gloves. The SDC inserted the black foam into the wound with the same gloved finger. RN #1 was holding the black foam piece bridging to the tail piece with the same blue gloved finger. The SDC applied the clear adhesive dressing secured over the black foam area. RN #1 and SDC removed their gloves and performed hand hygiene. The SDC attached the suction tubing to the wound vac machine and	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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 71 turned on the machine. On 12/14/18 at 10:00 AM, the RDCS stated double gloving was not part of the facility's wound care procedures. 2. On 12/13/18 at 10:13 AM, RN #2 was observed as she provided a dressing change and wound care to Resident #64's bilateral feet pressure ulcers. RN #2 washed her hands and applied gloves, then knelt down and removed the resident's left slipper, thigh high stocking, and a 2 by 2 dressing with an adhesive border. A small amount of red-brown drainage was on the old dressing and the area under the dressing was bright red. A lighter bright pink color was in the area where the adhesive dressing border had been. Resident #64 complained "Oh, that's tender" as she pointed directly at the 0.5 cm open ulcer on her left foot. RN #2 changed her gloves, without performing any type of hand hygiene, then she applied Skin prep to the area, fanned it dry, and applied a 2 by 2 inch border dressing over her left foot wound. RN #2 then reapplied the left stocking and slipper and changed her gloves, without performing any type of hand hygiene, and removed the right slipper, stocking, and a 2 by 2 border dressing, which did not have any drainage on it. The RN commented that the right foot ulcer was much better. The RN changed her gloves, again without performing any type of hand hygiene, then she applied Skin prep over area, fanned it dry, and applied a 2 by 2 border adhesive dressing, then she reapplied the right stocking and slipper. RN #2 then removed her gloves and washed her hands. On 12/13/18 at 10:24 AM, RN #2 said she	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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 72 changed her gloves between the old dressing removal and wound care on both of Resident #64's feet and in between the left foot wound care and the right foot wound care. RN #2 said she did not wash or sanitize her hands between the glove changes but she should have. 3. On 12/12/18 at 9:52 AM, Unit Manager #2 and Unit Manager #3 were observed a dressing change for Resident #7. Unit Manager #2 opened the dressing supplies and asked Unit Manager #3 if she had scissors to cut the Aquacel Silver dressing to fit the shape of the wound bed. Unit Manager #3 reached into her pocket for the pair of scissors and placed them on the bedside table with the dressing supplies. Unit Manager #2 cut the Aquacel Silver dressing to size with the scissors Unit Manager #3 supplied. Unit Manager #2 removed the dirty dressing from Resident #7's right lower leg. Unit Manager #2 removed her gloves and put clean gloves on. Unit Manager #2 cleaned the wound with saline and removed her dirty gloves and put clean gloves on. Unit Manager #2 measured the wound, removed her gloves and put clean gloves on. Unit Manager #2 placed the hydrocollid wound dressing over the wound, covered with an ABD pad, wrapped gauze around to keep dressing in place and secured with tape. Unit Manager #2 removed her gloves and cleansed her hands with a sanitizer. The facility's undated Wound Care/Treatment Clean Dressing Change policy documented clean hands/hand hygiene per policy. If scissors were required to cut a dressing, use clean scissors with an alcohol prep for 60 seconds before and after use.	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
	135135		12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

(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 73 On 12/12/18 at 10:33 AM, Unit Manager #2 stated she did not wash or sanitize her hands between changing gloves through the dressing change. Unit Manager #2 stated she should have cleansed the scissors prior to using them. During an interview with the Infection Control Nurse (ICN) on 12/14/2018 at 8:30 AM, the ICN stated staff are to use the hopper (a toilet-like sink used to flush human waste into the sewer) and spray nozzle to remove solid waste material from cloth items prior to laundering. The Infection Control Nurse stated, while there is Personal Protective Equipment (PPE) available in the soiled utility room, staff could be exposed to infected material while cleaning the cloth items. Observation of the facility's laundry area with the Infection Control Nurse and the Corporate Nurse on 12/14/2018 at 8:45 AM, confirmed the facility's practice of rinsing the soiled cloth items in the hopper. An interview at the time of the observation, confirmed the use of a hopper and the facility's failure to disinfect soiled items prior to spot treating and washing, resulted in an increased risk of cross contamination of laundry items.	F 880		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MDS001415		12/14/2018

NAME OF PROVIDER OR SUPPLIER
LIFE CARE CENTER OF POST FALLS

STREET ADDRESS, CITY, STATE, ZIP CODE
460 NORTH GARDEN PLAZA COURT
POST FALLS, ID 83854

(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) COMPLETE DATE
C 000	INITIAL COMMENTS The following deficiency was cited during the State licensure survey conducted at the facility from December 10, 2018 to December 14, 2018. The surveyors conducting the survey were: Jenny Walker, RN, Team Leader Linda Kelly, RN Susette Mace, RN Carmen Blake, RN Susan Devereaux, RN Acronyms: DON = Director of Nursing RN = Registered Nurse	C 000		
C 763	02.200,02,c,iii When Average Census 90 or More iii. In SNFs with an average occupancy rate of ninety (90) or more patients/residents a registered professional nurse shall be on duty at all times. This Rule is not met as evidenced by: Based on the posted nurse staffing information and daily unit assignment sheets, it was determined the facility failed to ensure a RN (Registered Nurse) charge nurse was staffed on all shifts when the resident census was 90 and above. This was true for 8 out of 21 days were reviewed between 11/18/18 through 12/8/18. The census during that time ranged from 93 to 97 residents. Findings include: The facility Three Week Nursing Schedule dated 11/18/18 through 12/8/18, were reviewed with the resident census of 90 or more and no RN	C 763	1. Facility will continue to advertise/recruit for RNs to meet state standard for RN coverage. 2. The DON and/or ED will review staffing weekly for 4 weeks and monthly for 2 months to identify open shifts requiring RN coverage and adjust schedule accordingly. 3. Schedules will also be reviewed monthly at QAPI meetings for 3 months to examine further opportunities. 4. The ED of designee will ensure ongoing compliance.	1/23/19

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 01/07/19

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MDS001415		**12/14/2018**

NAME OF PROVIDER OR SUPPLIER

LIFE CARE CENTER OF POST FALLS

STREET ADDRESS, CITY, STATE, ZIP CODE

460 NORTH GARDEN PLAZA COURT
POST FALLS, ID 83854

(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) COMPLETE DATE
C 763	Continued From page 1 coverage was provided on the night shifts as follows: * 11/24/18 census was 93 * 11/30/18 census was 94 * 12/1/18 census was 95 * 12/2/18 census was 95 * 12/3/18 census was 97 * 12/6/18 census was 95 * 12/7/18 census was 93 * 12/8/18 census was 94 On 12/14/18 at 9:45 AM, the DON stated she was aware they did not have RN coverage for the night shift with the resident census of 90 or more.	C 763		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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

April 8, 2019

Peter Kautz, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Mr. Kautz:

On **December 14, 2018**, an unannounced on-site complaint survey was conducted at Life Care Center of Post Falls. The complaint was investigated during an unannounced federal recertification and complaint investigation survey conducted at the facility on December 10, 2018 through December 14, 2018.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007707

ALLEGATION #1:

The facility failed to provide adequate supervision, which resulted in a significant head injury that required emergency care and treatment for a resident.

FINDINGS # 1:

The clinical records of twenty-five residents were reviewed, including five residents who had falls. Incident and Accident (I&A) event reports for the previous 12 months were reviewed. Hospital records were also reviewed.

Interviews were conducted with several residents, three family members, several nurses and Certified Nursing Assistants (CNA), the Director of Nursing Services (DNS), and the Regional Director of Clinical Services (RDCS).
Numerous observations were made of nursing staff interacting with and providing direct care for residents, including transfers and toileting assistance.

One resident's clinical record documented she received an antiplatelet medication (interrupts clotting) and low-dose aspirin (may interfere with clotting at low doses) daily, she required 2-person assistance with transfers and toileting, and a pivot disc and arm sling were needed for transfers. Therapy progress notes documented CNAs and nurses were trained and directed several times to have two staff present when providing toileting assistance and to use the pivot disc and arm sling for all transfers.

An I&A event report documented the resident had a fall on 12/16/17 while using the toilet and only one CNA was present at the time of the fall. The report documented the fall resulted in a hematoma (swelling of blood within the tissue), closed head injury, fracture, and laceration (cut) to her face and arm. It documented she was transported by ambulance to a local hospital emergency room 40 minutes after the fall.

Her hospital records documented she had a "Catastrophic" subdural hematoma that was not compatible with life.

A nurse and the DNS both stated only one CNA, not two staff, was present when the resident fell on 12/16/17.

The RDCS said the CNA provided a one-person transfer and one-person toileting assistance when the resident fell on 12/16/17, and the CNA left the resident alone in the bathroom when she went to get help after the resident fell.

The resident experienced a fall resulting in a severe head injury when the facility failed to ensure two people provided assistance with toileting and used the necessary equipment for transfers as care planned and instructed by the therapy staff.

Based on the investigative findings, the allegation was substantiated and the facility was cited for the deficient practice at F600, F610 and F689 for failure to protect the resident from neglect, thoroughly investigate incidents, and provide adequate supervision to prevent falls.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility did not ensure professional standards of practice were followed.

FINDINGS #2:

The clinical records of twenty-five residents were reviewed. I&A event reports and facility policies and procedures for neurological assessments and the prevention and management of skin injuries were also reviewed.

Interviews were conducted with several residents, three family members, several nurses, including two Unit Managers, and the DNS.

The clinical records and I&A reports for two residents documented their neurological status was not consistently assessed, or not assessed at all, after falls or injuries that could, or did, result in changes in their neurological status. A Unit Manager confirmed the staff did not assess/monitor, the residents' neurological status according to the facility's policy and procedure.

Another resident's clinical record contained documentation that her right thigh skin injury was not monitored, assessed, or treated and weekly skin assessments were not being done. A Unit Manager confirmed the facility's policy and procedure for prevention and management of skin injuries was not followed.

Based on the investigative findings, the allegation was substantiated and the facility was cited for deficient practice at F684 for failure to follow professional standards of practice.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility did not respond in a timely manner to concerns about positioning for a resident who leaned forward in her wheelchair.

FINDINGS #3:

The clinical records of twenty-five residents were reviewed. Grievance files, Resident Council minutes, and I&A event reports for the previous 12 months were reviewed. The facility's Grievance policy was also reviewed.

Interviews were conducted with several residents, a Resident Group with 10 residents present, three family members, several nurses and Certified Nursing Assistants, two Unit Managers, social services staff, and the DNS.

There were no written grievances or concerns related to positioning issues.

All of the residents, including those in the Resident Group interview, and the family members said the facility responded to and worked quickly to resolve their grievances. They did not voice any concerns about positioning.

All of the staff interviewed said they had been trained on the facility's Grievance policy and they would take written or verbal concerns seriously. All of the staff said they had not received or heard of concerns about positioning.

One resident's clinical record documented concerns about positioning and that interventions were promptly implemented, re-evaluated, and modified when needed.

The clinical records of twenty-five residents were reviewed. Incident and Accident (I&A) event reports and facility policies and procedures for neurological assessments and the prevention and management of skin injuries were also reviewed.

Based on the investigative findings the allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility did not implement interventions to ensure a resident's nutritional needs were being met.

FINDINGS #4:

The clinical records of six residents were reviewed regarding their nutritional status. Interviews were conducted with several residents, three family members, several nurses, two Unit Managers, the DNS, and the dietary manager.

One resident's clinical record documented her diet was downgraded after she had a stroke. The record documented the facility monitored her nutritional status and physician ordered nutritional supplements were provided in between meals and when she ate less than 50% of a meal.

The record documented she liked the nutritional supplements and consumed 75% to 100% of the in between meal nutritional supplements. The record also documented that as time progressed, she frequently ate less than 50% of the meals but consumed 75% to 100% of the nutritional supplement in place of the meals; and, she gained weight.

The clinical records of the other five residents reviewed documented their nutritional needs were met.

The residents who were interviewed said their nutritional needs were being met.

There were no written or verbal grievances related to residents' nutritional needs not being met.

Based on the investigative findings the allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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

April 8, 2019

Peter Kautz, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Mr. Kautz:

On **December 10, 2018** through **December 14, 2018**, an unannounced on-site complaint survey was conducted at Life Care Center of Post Falls. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00007719

ALLEGATION #1:

The facility did not alleviate or control resident's pain.

FINDINGS #1:

A total of 25 resident records were reviewed, three family members were interviewed, staff was interviewed, the Ombudsman was interviewed, a Resident Council meeting was attended, and observations were conducted.

A meeting was held with the Resident Council. During the meeting there were no complaints by the members of not having their pain managed. Review of 6 months of Resident Council notes found there was no issue with pain management.

The record for one resident, did not include documentation the resident's pain was not managed. The facility assessed her pain level and what triggered her pain and adjusted her medication. The record stated it took the resident about 3 weeks to get her pain under control but was successful with an identified pain level of zero within the 3-week period.

Another resident's record documented their pain was not controlled. The resident's record included a physician's order for Oxycodone 5 mg every 6 hours for pain. The medication administration record of the resident documented he received Oxycodone 5 mg on 12/12/18 at 6:00 AM and his pain level was documented as an 8 out of 10 on the pain scale.

The resident had his wound dressing changed later the same day by a Unit Manager, which was observed, and he cried out in pain during the cleansing of the wound. She continued to provide wound care without assessing, offering pain medication, or stopping the procedure to relieve the pain.

The Unit Manager stated she should have assessed the resident's pain level prior to the dressing change and should have stopped when he yelled out in pain.

The allegation was substantiated and a deficiency was cited at F697.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

A resident fell and received an injury.

FINDINGS #2:

During the investigation survey 25 resident records were reviewed, staff were interviewed, and facility investigations were reviewed.

One resident's record included a hospital report, prior to the resident's admission to the facility, which documented the resident was admitted related to a fall at her assisted living facility and was in great pain. Review of the CT scan completed at the hospital documented the resident had two previous hip replacements and a hip revision. The CT scan report documented evidence the hip socket of the resident was affected by a disease process. The resident had an x-ray completed by the facility 3 days after admission, which was related to increased pain during therapy services. The x-ray did show a dislocation of the left hip but also showed the bones are osteopenic.
Another resident's record included an investigation and accident report which stated the resident had an intercepted fall. The resident's fall resulted in a hematoma (a swelling of blood within the tissue), closed head injury, fracture, and cuts to her face and arm. The investigation documented the resident was on the toilet when she started to fall and the aide grabbed her arm and her brief attempting to stop the fall. The investigaiton documented the resident was sent to the hospital with EMS.

The allegation was substantiated and a deficiency was cited at F689.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

Residents did not receive therapy as ordered.

FINDINGS #3:

During the investigation 25 resident records were reviewed for therapy services.

One resident's record included a physician's order for skilled Physical Therapy five times a week for 12 weeks. The resident's record included therapy notes which documented the therapy was provided as ordered. The resident's record also included an order for Occupational Therapy six times a week for 12 weeks. The record included therapy notes which documented the therapy was provided as ordered.

Based on investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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

June 4, 2019

Peter Kautz, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Mr. Kautz:

On **December 10, 2018** through **December 14, 2018**, an unannounced on-site complaint survey was conducted at Life Care Center of Post Falls. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007570

ALLEGATION #1:

The facility's night shift is short staffed.

FINDINGS #1:

Observations were conducted throughout the facility on multiple days and differing shifts. Multiple interviews were conducted with residents and family members; including a Resident Council with ten resident attendees. Nursing staff schedules were reviewed.

The investigation revealed a number of nights where only one licensed nurse was assigned to the Medicare wing. However, the current practice is to assign a Licensed Nurse and a CNA to the Medicare Wing. Therefore, as the facility has instituted a different staffing pattern, there was no associated citation.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #2:

The food was not palatable and the facility does not honor residents' preferences.

FINDINGS #2:

Observations were conducted throughout the facility, including the kitchen and different dining rooms, on multiple days and differing shifts. Multiple interviews were conducted with residents and family members; including a Resident Council with ten resident attendees; and staff members. A test tray (that included soup, the main entrée and pureed food) was requested and tasted by two surveyors.

The investigation revealed eggs were of the correct temperature upon plating. The test tray was the last one plated for the Medicare wing transport cart, and the last tray served from that cart. The temperature of the food was taken on the last tray out and was found to be of a palatable temperature. The soup, and main entrée (including side dishes) were tasted and found to be palatable. The meal tickets were plated as requested and there were no complaints by residents (either during one to one interviews, or in the Resident Council meeting) of not having enough food.

Therefore, due to lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

One of the allegations was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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

Sincerely,

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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

June 4, 2019

Peter Kautz, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Mr. Kautz:

On **December 10, 2018** through **December 14, 2018**, an unannounced on-site complaint survey was conducted at Life Care Center of Post Falls. The compaint was investigated in conjunction with the annual Recertification survey. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007652

ALLEGATION #1:

The facility neglects residents' medical and therapy needs.

FINDINGS #1:

Twenty-five residents were reviewed in the sample during the investigation. Numerous observations were made throughout the facility. Interviews were conducted with residents, the Ombudsman, multiple staff members and three family members. A meeting was held with the facility's group Resident Council with no concerns related therapy services.

Additionally, 6 months of Resident Council minutes were reviewed no concerns were documented related to therapy services.

Records of one resident documented the resident was assessed by the admitting nurse on arrival to the facility. The record documented the resident's incision, wounds, IV and PICC line sites The resident also had fluid filled blisters present on both ankles upon admission.

The Physician Assistant examination, stated the resident did well post-operatively and required fluid balance management due to fluid build-up around the resident's lungs.

A Physical Therapy assessment, stated the resident appeared reluctant to participate due to the fatigue following surgery. The Physical Therapy plan for treatment included training the resident to move safely from lying/seated/standing position, repositioning in bed, elevating feet to prevent further swelling, increasing stamina for walking and strength improvement. The record documented the resident refused to participate in Physical Therapy on several occasions.

An Occupational Therapy assessment documented the resident needed training and strengthening specifically with Activities of Daily Living- personal cares including grooming, toileting, transfers from lying/seated/standing positions, dressing and bathing.

A chest x-ray documented the resident had evidence of potential pneumonia, and the resident was started on oral antibiotics at that time.

The resident's edema of the lower extremities was assessed at least daily by a registered nurse, with the physician's staff being updated with the resident's weights and edema status. Medication and therapies were changed/added to address the resident's medical conditions.

Due to lack of sufficient evidence, the allegation was unsubstantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility is short staffed causing medical needs to be neglected.

FINDINGS #2:

Twenty-five residents were reviewed during the investigation. Numerous observations were made throughout the facility. Interviews were conducted with residents, the Ombudsman, multiple staff members and three family members. A meeting was held with the facility's group Resident Council with no concerns related therapy services.

Additionally, 6 months of Resident Council minutes were reviewed and documented no concerns related to therapy services.

The investigation revealed the resident was assessed by a registered nurse at least daily. Changes in the resident's status were noted, documented and reported to the attending physician. Orders for medications and treatment were reviewed and changed as necessary. Review of the resident's Treatment Administration Records documented the dressings were changed daily as ordered and additional dressing changes were provided as needed.

The resident had dressing to the bilateral lower legs and feet that were changed daily and as needed.

During the survey, there was no evidence staff failed to communicate important resident information during shift changes and as needed.

Due to lack of sufficient evidence, the allegation was unsubstantiated.

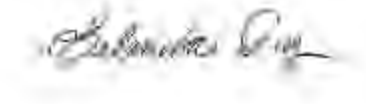
CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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

June 11, 2019

Peter Kautz, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Mr. Kautz:

On **December 10, 2018** to **December 14, 2018**, an unannounced rccertification and complaint survey was conducted at Life Care Center of Post Falls. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00007788

ALLEGATION #1:

Surgical wound care was not provided as ordered by the physician and the physician was not notified of changes to the surgical wound.

FINDINGS #1:

Wound observations were conducted with different nurses and different shifts. Interviews were conducted with residents and family members; including a Resident Council with ten residents in attendance.

One resident's record was reviewed and the wound care order by the physician was for the adaptic dressing to be changed every other day. The resident ' s record included documentation the dressing was changed as ordered by the physician. The resident ' s wound condition changed and it was noted by staff. The resident ' s record documented the physician was notified and the orders were updated.

Based on investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

A resident's meal was delayed by 45 minutes.

FINDINGS #2:

Observations were conducted in the kitchen and the different dining rooms, on more than one day and during different meals. Interviews were conducted with residents and family members; including a Resident Council with ten resident attendees; and staff members. A tasting tray was requested and tested by two surveyors.

The test tray was the last one plated for the Medicare wing transport cart, and the last tray served from that cart. The food temperature was tested when removed from the cart and was found to be of a palatable temperature. The soup, and main entrée (including side dishes) were tasted and found to be palatable. During observations of the meal service on the Medicare wing, staff was noted to go to the kitchen in response to resident requests. Residents were observed to sit at different places in the dining room for different meals. Residents in all dining rooms were observed to arrive early, under their own power, for social time prior to the meals. The meal tickets were plated as requested and there were no complaints by residents, either during one to one interview or in the Resident Council meeting, of not having enough food.

Based on investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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

July 10, 2019

Peter Kautz, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Mr. Kautz:

On **December 10, 2019** through **December 14, 2018**, an unannounced on-site complaint survey was conducted at Life Care Center of Post Falls This complaint was investigated in conjunction with the annual recertification survey. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007691

ALLEGATION #1:

Resident care needs are not being met.

FINDINGS #1:

During the investigation, observations and resident and staff interviews were conducted. Resident records including admission orders were reviewed.

Three resident records and one closed record were reviewed for new admission orders and the facility followed the physician's orders that were written on admit to the facility.

One resident's record documented they were admitted in December 2017, from a hospice house to receive rehabilitation. The resident was diagnosed with breast cancer that spread to the brain, and they were also diagnosed with cirrhosis of the liver.

The admission orders included Ativan every hour if needed for anxiety and increased behaviors. The resident was very anxious, confused, and angry due to being in a new environment.

The resident was adamant on not allowing staff to assist with personal cares and also declined to work with therapy. The facility staff attempted to redirect the resident without success. The physician was notified and other medications were prescribed to alleviate some of the stress the resident was exhibiting without success. The hospice nurse documented the resident would be better if they were back in familiar surroundings at the hospice house, and the resident returned to the hospice house shortly thereafter.

Based on the investigative findings the allegation could not be substantiated, and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj