IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE– Governor
DAVE JEPPESEN– Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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March 7, 2019

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

Provider #: 135038

Dear Mr. Rudd Jr:

On **February 19, 2019**, we conducted an on-site revisit and a complaint investigation to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **December 21, 2018**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

F0000 -- S/S: -- -- Initial Comments
F0622 -- S/S: G -- 483.15(c)(1)(i)(ii)(2)(i)-(iii) -- Transfer And Discharge Requirements
F0623 -- S/S: G -- 483.15(c)(3)-(6)(8) -- Notice Requirements Before Transfer/discharge
F0689 -- S/S: D -- 483.25(d)(1)(2) -- Free Of Accident Hazards/supervision/devices

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 **March 18, 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.

- 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*.

As noted in the Bureau of Facility Standards' letter of **November 23, 2018**, following the survey of **October 26, 2018**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for imposition of a civil money penalty, Denial of Payment for New Admissions and termination of the provider agreement on **April 26, 2019**, if substantial compliance is not achieved by that time. The findings of non-compliance on **February 19, 2019**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **January 15, 2019**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **January 31, 2019**

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, it will provide you with a separate

formal notification of that determination.

If you believe the deficiencies have been corrected, you may contact please 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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 **March 18, 2019**. If your request for informal dispute resolution is received after **March 18, 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
	135038		R 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BOISE	808 NORTH CURTIS ROAD BOISE, ID 83706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		
	The following deficiencies were cited during the federal recertification on-site follow-up and complaint survey conducted at the facility from February 11, 2019 through February 19, 2019. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Presie Billington, RN Sharon Dunn, RD Survey Abbreviations: CMS = Centers for Medicare and Medicaid Services DON = Director of Nursing OT = Occupational Therapy PT = Physical Therapy SW = Social Worker			
F 622 SS=G	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 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;	F 622		3/20/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/17/2019

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.

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F 622	Continued From page 1 (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 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	F 622		

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F 622	Continued From page 2 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 record review, policy review, family interview, and staff interview, it was determined the facility failed to ensure residents were not involuntarily transferred and/or discharged. This was true for 4 of 8 residents (#224, #225, #226, & #227) who were admitted to the facility after 2/1/19. Resident #225 was harmed when he was unnecessarily discharged prior to his completion of therapy. The deficient practice had the	F 622	This Plan of Correction is required under Federal and State Regulations and Statutes applicable to long-term care providers. The Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is specifically denied.The submission of this Plan of	

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F 622	Continued From page 3 potential to cause physical or psychosocial harm for residents #224, #226, and #227 when they were unnecessarily discharged and/or transferred to another setting. Findings include: The facility's Transfers and Discharges policy, dated 9/1/17, documented the facility provided equal care regardless of payment source. Transfers and discharges may occur when: * Residents' welfare and needs could not be met * Residents' health improved sufficiently to return home or to a less restrictive environment and no longer needed the services provided by the facility * Residents' health or safety or the health or safety of individuals were endangered due to the clinical or behavioral status * Residents' failed to pay for their stay * When the facility ceased to operate This policy was not followed. On 2/19/19 at 4:15 PM, the SW said she was told by the DON and the Administrator on 2/13/19 the facility was not going to be paid for residents who were admitted after 2/1/19, due to a non-payment status. She said she was told by the DON and the Administrator to approach residents and families to transfer the non-payment status residents to a sister facility, transfer to another facility, or discharge them home. The SW said some of the residents said, "So you're kicking us out?" The SW said she tried to educate the residents and explained the payment issues to them. The SW said she felt bad and said it was difficult for her to explain the situation to the residents and their representatives. The SW said	F 622	Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied. Additional Abbreviations: Daily = Monday through Friday (with regard to audits) DX = Diagnosis UM = Unit Manager SDC = Staff Development Coordinator QA = Quality Assurance IDT □ Interdisciplinary Team LN = Licensed Nurse F 622 Corrective Action: 1.Resident # 225 discharged home on 2/14/2019. 2.Resident # 227 discharged home on 2/16/2019. 3.Resident #226 discharged on 2/15/2019. 4.Resident #224 discharged on 2/15/2019. Identification: 1.Facility to review resident discharges in the last 30 days to ensure residents were not involuntarily discharged. 2.All residents discharging are identified as potentially being affected by this deficiency. Systemic Changes:	

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F 622	Continued From page 4 some of the residents and their representatives agreed to be transferred to their sister facility and some were discharged home. On 2/19/19 at 5:30 PM, the DON said during a meeting with several staff members, which included corporate staff on 2/13/19, the decision was made to approach residents and family members and initiate transfers and discharges of residents admitted after the facility's non-payment date of 2/1/19. She said the residents and families were approached with options to transfer, discharge, or stay in the facility. The DON said she was not personally involved with discussing these options with the residents and/or their family members. The DON said the facility staff did not approach or attempt to discharge or transfer any newly admitted residents who received peritoneal dialysis. On 2/19/19 at 5:59 PM, the Administrator said there was a meeting with their regional staff on 2/13/19, regarding the results of their revisit survey combined with a complaint survey. He said because of their non-payment status he directed his staff to talk to the residents and their representatives and give them the option to be transferred to their sister facility, stay in the facility, or to go home if they were able to. He said these discharges were facility initiated discharges. The Administrator said the facility did not attempt to discharge or transfer any resident who required peritoneal dialysis since they had a contract with a local dialysis center. Residents were either discharged home or transferred to another facility. Examples include:	F 622	1.Inservice provided to IDT on facility Transfer and Discharge policy and CMS regulations regarding transfers and discharges. 2.The facility has a policy to ensure that any 30 day Involuntary Discharges follow the regulation guidelines for resident-centered care. 3.Reason for Discharge is discussed, documented, and evaluated by the facility IDT and discussed with resident / representative. a.Discharge is necessary for resident□s welfare. b.Resident□s needs cannot be met by facility. c.Safety of individuals in facility is endangered due to the clinical or behavioral status of the resident. d.Health of individuals in the facility would otherwise be endangered. e.Resident has failed to pay for a stay at the facility. 4.Documentation in the Resident Record includes: a.Reason for Discharge b.If due to inability to meet the resident□s needs, documentation needs to include: i.Facility□s attempt to meet the resident□s needs. ii.The service available at the receiving facility to meet the resident□s needs. iii.The resident□s physician (in the facility) must include in their notes that the discharge is necessary for the resident□s welfare, the resident□s needs cannot be met in the facility, or the resident□s health	

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F 622	Continued From page 5 1. Resident #225 was admitted to the facility on 2/6/19, with multiple diagnoses including Parkinson's disease, muscle weakness, difficulty in walking, post-traumatic stress disorder, encephalopathy (brain malfunction), and malignant neoplasm of the brain (brain tumor). Resident #225 was discharged to home with home health on 2/14/19, 8 days later. Resident #225's PT evaluation and treatment plan, dated 2/7/19, documented short and long-term goals, with target dates of 3/6/19 and 4/5/19 respectively. The goals were as follows: * Safely perform bed mobility tasks with maximum assistance and 75% tactile cues (prompting by touch). * Safely propel his wheelchair 50 feet with moderate assistance. * Improve his bilateral lower extremity strength from 3/5 to 4/5 (muscle strength grade). * Ambulate 25 feet over even surfaces with a rolling walker with one-person maximum assistance. Resident #225's PT discharge summary, dated 2/15/19, documented he was discharged from PT on 2/13/19, and the status of his short and long-term goals were: * Bed mobility tasks required total dependence on others with 90% tactile cues and he lacked the trunk strength and coordination to perform without total assistance. * He could safely propel his wheelchair 20 feet with maximum assistance and he lacked bilateral upper extremity strength and activity tolerance to perform independently.	F 622	has improved and they no longer need the services in the facility. c.Resident□s physician documentation must include: i.Specific needs the facility could not meet. ii.Facility efforts to meet those needs. iii.Specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility. iv.If the discharge is because the safety of individuals in the facility is endangered by the discharging resident or the health of the individuals in the facility would otherwise be endangered by the discharging resident. Monitor: 1.DNS or Designee to conduct audit of Notices of Transfer / Discharge to ensure resident(s) have not been not been transferred or discharged involuntarily unless correct measures have been followed. 2.Audits to begin on 3/19/2019, and will continue at the following frequencies: Daily x two (2) weeks Weekly x six (6) weeks Monthly x 90 days 3.Administrator to review audits and report findings to QA Committee.	

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F 622	Continued From page 6 * His bilateral lower extremity strength was 3/5. * He required two-person assistance to stand. Resident #225's OT evaluation and treatment plan, dated 2/7/19, documented his spouse wanted him to be able to sit on and use a bedside commode. The Occupational Therapist documented Resident #225 demonstrated good rehabilitation potential due to strong family support, stable medical condition, and compliance with skilled training. Resident #225's OT short-term goals, with a target date of 2/20/19, were as follows: * Safely and efficiently perform upper body dressing with maximum assistance and 25% verbal cues for initiation or termination of tasks * Safely perform bed mobility tasks and 25% verbal cues * Safely complete transfers with maximum assistance of one-person from his bed to his bedside commode Resident #225's OT discharge summary, dated 2/15/19, documented he was discharged from OT on 2/13/19 and the status of his short-term goals were as follows: * He required total dependence without any attempts to initiate the task with 50% verbal cues * He could safely perform bed mobility tasks with total dependence with 50% verbal cues * He could safely transfer to the bed side commode with total dependence of staff Resident #225's OT discharge recommendations, dated 2/15/19, were for home health to follow up	F 622		

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F 622	Continued From page 7 with continued therapy, a low bed, and 24-hour care. Resident #225's physician progress notes, dated 2/12/19, documented he was admitted to the facility for therapy and ongoing care and "therapy is just getting started." Resident #225's Social Services note, undated, documented the SW told his spouse the facility was in a non-payment status due to the result of the facility's revisit and complaint survey which resulted in 2 minor deficiencies and the facility was not getting paid for Resident #225's stay. The note documented his spouse was given the option to transfer him to another rehabilitation facility or discharge him home. The spouse did not want to have Resident #225 taken to a new environment with different staff and was going to take him home with home health. The note did not include documentation there was an option given to stay in the facility. Resident #225's discharge summary, dated 2/14/19, documented he was sent home with a referral to a home health agency for outpatient rehabilitation. The summary documented his spouse requested the discharge home after the facility informed them of the facility's revisit survey. Resident #225's Notice of Resident Transfer or Discharge form, dated 2/14/19, documented he was discharged home "due to CMS denial of payment." A progress note, dated 2/17/19, documented the Regional Director of Business Development	F 622		

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F 622	Continued From page 8 called to check on Resident #225's status at home. The spouse said PT had completed their evaluation and was scheduled to start in-home therapy on 2/18/19, and OT was scheduled to evaluate him on 2/18/19. The spouse was informed if she had any difficulties, Resident #225 was welcome to return to the facility for further care. On 2/19/19 at 1:10 PM, Resident #225's spouse said the SW approached her on 2/13/19 to arrange a transfer for him to a sister facility that week to continue his therapy and care. She said she was told by the SW the facility was in trouble with the state and was not going to get paid for Resident #225's stay, along with 5 other residents. She said she was very upset because Resident #225 needed at least one more week of therapy. She was told Resident #225 could not remain in the facility but could be discharged home with a home health agency and outpatient therapy. The spouse said Resident #225 could not handle the stress to be transferred to "yet another" facility because the changes were really hard on him. The spouse said she had opted to take him home instead and said had he been allowed to stay in the facility, he could have progressed quicker with his therapy. On 2/19/19 at 4:15 PM, the SW said she approached Resident #225's spouse to transfer to another facility because he still needed rehabilitation services and staying in the facility was not an option. She said Resident #225's spouse chose to take him home with home health services and outpatient rehabilitation. The SW said on 2/15/19 she was informed by the DON residents and families were now being	F 622		

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F 622	Continued From page 9 allowed to stay in the facility as an option instead of transferring or discharging residents. Resident #225 was discharged on 2/14/19. On 2/19/19 at 5:30 PM, the DON said the SW note for Resident #225 did not document they were given an option to stay in the facility. The DON said she thought Resident #225 was ready to go home when he was discharged. Resident #225 required additional therapy services and was involuntarily discharged prior to the completion of those services. 2. Resident #227 was admitted to the facility on 2/8/19, with multiple diagnoses which included aftercare following joint replacement surgery, muscle weakness, and hypertension. Resident #227 was discharged home on 2/16/19 with outpatient physical therapy, 8 days later. Resident #227's care plan, dated 2/8/19, stated she expressed pain related to her total knee replacement and staff were directed to put ice to her knee and to educate her and her family on pain management. The care plan also stated Resident #227 needed assistance and therapy services to maintain or attain her prior level of function and staff were directed to assess her needs for therapy services. Resident #227's OT plan of treatment, dated 2/9/19, documented the following short-term goals with a target date of 2/22/19. The goals were written as follows: *Safely perform upper body/lower body bathing with stand by assist	F 622		

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F 622	Continued From page 10 *Safely perform toileting tasks using raised toilet seat *Safely and efficiently perform upper body dressing *Safely and efficiently perform lower body dressing, including sock/shoes and retrieving all items from closet/drawers *Exhibit a decrease in pain with movement to 3 out of 10, on a 1-10 pain scale with 1 being the lowest and 10 the highest, in the right shoulder to increase patient's ability to perform upper body dressing with set-up *Demonstrate ability to safely complete functional transfers and ambulation up to 100 feet with least restrictive assistive device *Enhance balance abilities An OT discharge summary, dated 2/15/19, documented Resident #227 had made consistent progress with her skilled interventions. Resident #227's PT plan of treatment documented the following short-term goals with a target date of 3/2/19. The goals were written as follows: *Decrease risk of falls *Safely perform functional transfers *Safely ambulate on level surfaces 100 feet using a two-wheeled walker with stand by assist with continuous steps and with normalized gait pattern 85% of the time to increase independence within household environment *Improve her right lower extremity gross strength to 4/5 to allow her to safely ambulate using an assistive device A PT discharge summary, dated 2/14/19,	F 622		

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F 622	Continued From page 11 documented Resident #227 had met her short and long-term goals, and she needed a reacher (a long handle with a grabber on one end) and a two-wheeled walker. A social services note, dated 2/15/19 at 4:10 PM, documented the SW told Resident #227 and her family the facility was on a non-payment status due to the result of the facility's revisit survey combined with a complaint survey resulting in 2 minor tags and because of that they have the option of transferring Resident #227 to another facility or home as she was able to ambulate with her front wheeled walker independently. Resident #227 chose to go home with outpatient rehabilitation therapy. On 2/19/19 at 1:38 PM, during a telephone interview, Resident #227's representative said the facility "kicked us out." The family representative said they were told by facility staff the facility was not getting paid by Medicare and Resident #227 had to move to another facility or go home. The family representative also said Resident #227 was 89 years old and just had knee replacement surgery and he wanted her to stay more days in the facility to complete her physical therapy. The family representative said Resident #227 decided to go home with outpatient physical therapy. On 2/19/19, at 4:17 PM, during a telephone interview, the SW said she told Resident #227 and her family representative the facility was in a non-payment status due to the 2 minor tags the facility received after their revisit survey and Resident #227 had to move to another facility or go home. The SW said Resident #227 was able	F 622		

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F 622	Continued From page 12 to use her 2-wheeled walker independently and chose to go home with outpatient physical therapy. 3. Resident #226 was admitted to the facility on 2/8/19, with multiple diagnoses including aftercare for digestive system surgery, muscle weakness, and difficulty in walking, Resident #226 was transferred to another facility on 2/14/19, 6 days later. Resident #226's OT short-term goals, dated 2/9/19, with a target date of 2/15/19, included sitting upright in her wheelchair for 1-2 hours, self-perform activities of daily living, and use a bedside commode with one-person assistance. Resident #226's PT short-term goals, dated 2/10/19, with a target date of 3/2/19 and 3/9/19, included increased sitting balance and posture, safely transferring with assistance, and improve bilateral lower extremity strength. Resident #226's OT and PT discharge summary recommendations, dated 2/15/19, documented she was transferred to a sister facility for continued therapy care. Resident #226's physician progress notes, dated 2/12/19, documented her therapy was "going slow so far." A social services note, undated, documented the SW told Resident #226's responsible party the facility was in a non-payment status due to the result of the facility's revisit and complaint survey which resulted in 2 minor deficiencies and was not getting paid for Resident #226's stay. The	F 622		

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F 622	Continued From page 13 note documented the responsible party and Resident #226 were given the option to transfer her to another rehabilitation facility or discharge her home. The SW documented Resident #226 was going to be provided the same OT and PT and the same doctors if she was transferred to the sister facility. The responsible party and Resident #226 agreed to the transfer. The note did not include documentation an option was given to stay in the facility. Resident #226's Discharge/Transfer Order and Notice of Resident Transfer or Discharge forms, dated 2/13/19 and 2/14/19, documented she was discharged due to "CMS denial of payment." Resident #226's nurse progress note, dated 2/15/19, included a late entry for 2/14/19, regarding her transfer. The note documented the responsible party and Resident #226 were given the option to transfer her to a sister facility or another rehabilitation facility. The note documented they chose to go to a sister facility. On 2/19/19 at 1:30 PM, Resident #226's responsible party said the SW informed him and Resident #226 the facility failed an inspection and was not going to get paid for her stay. He said the SW told them Resident #226 needed to be transferred to a sister facility to continue her therapy and care. He said the SW did not offer them any other choice and he would have preferred not to have her transferred because it was closer to him than the sister facility. He said it was inconvenient, but Resident #226 was doing well at the new facility. On 2/19/19 at 4:15 PM, the SW said she spoke	F 622		

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F 622	Continued From page 14 to the responsible party and Resident #226 regarding the transfer due to the non-payment status. She said at first, they were confused with the need to transfer and thought she was being kicked out but they were reassured Resident #226 was going to receive the same level of care at the sister facility and then they agreed to the transfer. On 2/19/19 at 5:30 PM, the DON said the SW note for Resident #226 did not include documentation the responsible party or Resident #226 was given an option to stay in the facility. 4. Resident #224 was admitted to the facility on 2/7/19, with multiple diagnoses which included hemiplegia (paralysis) and hemiparesis (weakness) secondary to a stroke. Resident #224 was discharged to another facility on 2/15/19, 8 days later. A Perspective Pay Status assessment, dated 2/14/19, documented Resident #224 was cognitively intact and he required the assistance of 1-2 staff members with activities of daily living and set-up for eating. Resident #224's care plan, dated 2/7/19, documented he needed assistance and therapy services to maintain his prior level of function and staff were directed to assess his needs for therapy and PT and OT services were ordered. A social services note, dated 2/15/19 at 3:10 PM, documented the SW told Resident #224 the facility was in a non-payment status due to the result of their revisit survey combined with the complaint survey resulting in 2 minor tags and	F 622		

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F 622	Continued From page 15 Resident #224 had the option to go to their sister facility or go to another facility of his choice. The progress note documented Resident #224 asked the SW if he was going to receive the same kind of therapy at the other facility, and the SW said he would receive the same therapy and the same physician was going to see him at their sister facility. The progress note documented Resident #224 agreed to go to the sister facility. On 2/19/19 at 5:30 PM, the Unit Manager, with the DON, said Resident #224 was not ready to go home and he was given the option to move to their sister facility or to another facility of his choice. The Unit Manager said Resident #224 chose to transfer to their sister facility to continue his therapy.	F 622		
F 623 SS=G	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.	F 623		3/20/19

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F 623	Continued From page 16 (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 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	F 623		

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F 623	Continued From page 17 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 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 record review, policy review, family	F 623	F 623	

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F 623	Continued From page 18 interview, and staff interview, it was determined the facility failed to ensure residents were given at least 30 days notice before discharge and/or the intent to discharge and failed to notify the State Long Term Care Ombudsman. This was true for 6 of 8 residents (#222, #224, #225, #226, #227 & #229) who were admitted to the facility after 2/1/19. Resident #225 was harmed when he was unnecessarily discharged without proper notice and prior to his completion of therapy. The deficient practice had the potential to cause physical or psychosocial harm for residents #222, #224, #226, #227, and #229 when they were not made aware of or able to exercise their rights related to transfers and discharges. Findings include: The facility's Transfers and Discharges policy, dated 9/1/17, documented for facility initiated transfers or discharges, the facility must provide a notice of discharge to the resident and resident representative along with a copy of the notice to the Office of the State Long Term Care Ombudsman at least 30 days prior to the discharge. The notice must also be sent to the ombudsman at the same time. Written notice of transfers and discharges from the facility must include contact information for advocacy for individuals with intellectual and developmental disabilities, mental disorders or other related disabilities. This policy was not followed. On 2/19/19 at 4:15 PM, the SW said she was told by the DON and the Administrator on 2/13/19, the facility was not going to be paid for residents who were admitted after 2/1/19, due to the	F 623	Corrective Action: 1. The Notice of Discharge for the each of the six (6) residents identified in the 2567 have been sent to the State Ombudsman. 2. Residents #222, #224, #225, #226, and #227 have discharged from the facility. 3. Resident #229 chose to remain in the facility and is still receiving services as ordered. Identification: 1. All residents being discharged are identified as potentially being affected by this deficiency. 2. Residents remaining in the facility we asked if they were approached by facility staff and asked to discharge prior to completion of therapy services. No other residents were identified. Systemic Changes: 1.Facility IDT inserviced regarding facility policy on Transfers and Discharges. 2.Facility IDT also inserviced regarding CMS and State regulations on Transfer and Discharges. a. Notice of Transfer / Timing of Notice i. Notice of Transfer / discharge must be made by the facility at least 30 days before the resident is transferred / discharged. ii. Notify the resident / resident□s representative of: 1. The transfer / discharge 2. The reason for the move, in writing and in a language and manner the resident / representative understand.	

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F 623	Continued From page 19 non-payment status. She said she was told by the DON and the Administrator to approach residents and families to transfer the non-payment status residents to a sister facility, transfer to another facility, or discharge home. The SW said on 2/15/19, she was informed by the DON residents and families were now being allowed to stay in the facility as an option instead of transferring or discharging residents. She said she notified the ombudsman of transfers and discharges at the beginning of each month for the previous month and was not aware facility initiated discharges required a 30 day notice. On 2/19/19 at 5:30 PM, the DON said during a meeting with several staff members, which included corporate staff on 2/13/19, the decision was made to approach residents and family members and initiate transfers and discharges of residents admitted after the facility's non-payment date of 2/1/19. She said the residents and families were to be approached with options to transfer, discharge, or stay in the facility. The DON said she was not personally involved with discussing these options with the residents and/or their family members. The DON said the SW handled notification to the ombudsman and knew she sent a monthly list. The DON said she was not aware prior to a facility initiated discharge a 30 day notice was required. On 2/19/19 at 5:59 PM, the Administrator said there was a meeting with their regional staff on 2/13/19, regarding the results of their revisit survey combined with a complaint survey. He said because of their non-payment status he directed his staff to talk to the residents and their	F 623	iii. Send a copy of the Notice to a representative of the Office of the State LTC Ombudsman. iv. The resident□s medical record must contain evidence that the Notice was sent to the Ombudsman. Monitor: 1. DNS or Designee to conduct audit of facility discharge documentation to ensure compliance. Documentation to be audited will include: a. Resident medical record b. Notice of Transfer / Discharge 2. Audits to be conducted at the following frequencies: a. Daily for four (4) weeks b. Weekly for four (4) weeks c. Monthly for three (3) months 3. Findings to be reviewed by Administrator and reported to QA Committee	

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F 623	Continued From page 20 representatives and give them the option to be transferred to their sister facility, stay in the facility, or to go home if they were able to. He said these discharges were facility initiated discharges. The Administrator said the facility did not attempt to discharge or transfer any resident who required peritoneal dialysis since they had a contract with a local dialysis center. Residents were not provided at least 30 days notice before their discharge and/or intent to discharge. Examples include: 1. Resident #225 was admitted to the facility on 2/6/19 with multiple diagnoses, including Parkinson's disease, muscle weakness, difficulty in walking, post-traumatic stress disorder, encephalopathy (brain malfunction), and malignant neoplasm of the brain (brain tumor). Resident #225 was discharged to home with home health on 2/14/19, 8 days later. A social services note, undated, documented the SW told Resident #225's spouse the facility was in a non-payment status due to the result of the facility's revisit and complaint survey which resulted in 2 minor deficiencies and was not getting paid for Resident #225's stay. The note documented his spouse was given the option to transfer him to another rehabilitation facility or discharge him home. The spouse did not want to have him introduced to a new environment with different staff and was going to take him home with home health. The note did not include documentation an option was given to stay in the facility. Resident #225's discharge summary, dated	F 623		

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F 623	Continued From page 21 2/14/19, documented he was sent home with a referral to a home health agency for outpatient rehabilitation. The summary documented his spouse requested the discharge home after the facility informed them due to the facility's revisit survey, Resident #225 needed to be transferred to a sister facility or another rehabilitation facility. Resident #225's Notice of Resident Transfer or Discharge form, dated and signed by Resident #225's spouse on 2/14/19, documented he was to be discharged on 2/14/19 "due to CMS denial of payment." The notice did not document it was sent to the ombudsman and did not document the correct contact information for the state agency for developmentally disabled residents and the state agency for mentally ill residents. Resident #225's progress note, dated 2/17/19, documented the Regional Director of Business Development called to check on his status at home. The spouse said PT had completed their evaluation and was scheduled to start on 2/18/19 and OT was scheduled to evaluate him on 2/18/19. The spouse was informed if she had any difficulties, Resident #225 was welcome to return to the facility for further care and the spouse denied concerns. On 2/19/19 at 1:10 PM, Resident #225's spouse said the SW had approached her on 2/13/19, to arrange a transfer for him to a sister facility to continue his therapy and care. She said she was told by the SW the facility was in trouble with the state and was not going to get paid for Resident #225's stay, along with 5 other residents. She said she was very upset because Resident #225 needed at least one more week of therapy and	F 623		

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(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 22 they were told he could not remain in the facility that long but could be discharged home with home health and outpatient therapy. The spouse said Resident #225 could not handle the stress to be transferred to "yet another" facility because the changes were hard on him. The spouse said she had opted to take him home instead and said had he been allowed to stay in the facility, he could have progressed quicker with his therapy. On 2/19/19 at 4:15 PM, the SW said she approached Resident #225's spouse to transfer to another facility because he still needed rehabilitation services and staying in the facility was not an option. She said his spouse chose to take Resident #225 home with home health services and outpatient rehabilitation. The SW said on 2/15/19, she was informed by the DON residents and families were now being allowed to stay in the facility as an option instead of transferring or discharging residents. Resident #225 was discharged on 2/14/19. The SW said she had not notified the ombudsman in writing of Resident #225's discharge. On 2/19/19 at 5:30 PM, the DON said the SW note for Resident #225 did not document the spouse was given an option to stay in the facility. The DON said she thought Resident #225 was ready to go home when he was discharged. Resident #225 required additional therapy services and was involuntarily discharged, without proper notice and prior to the completion of therapy services, which resulted in physical harm to him when he was not provided those services.	F 623		

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F 623	Continued From page 23 2. Resident #227 was admitted to the facility on 2/8/19, with multiple diagnoses which included aftercare following joint replacement surgery, muscle weakness, and hypertension. Resident #227 was discharged home on 2/16/19 with outpatient physical therapy, 8 days later. A social services note, dated 2/15/19 at 4:10 PM, documented the SW told Resident #227 and her family the facility was on a non-payment status due to the result of the facility's revisit survey combined with a complaint survey resulting in 2 minor tags and because of that they have the option of transferring Resident #227 to another facility or home as she was able to ambulate with her front wheeled walker independently. Resident #227 chose to go home with outpatient rehabilitation therapy. A Notice of Resident Transfer or Discharge Form, dated 2/15/19, documented Resident #227 was discharged home on 2/16/19, due to her health improving sufficiently that she no longer needed the services provided by the facility. The notice did not document it was sent to the ombudsman and did not document the correct contact information for the state agency for developmentally disabled residents and the state agency for mentally ill residents. Resident #227's clinical record did not include an advance 30 day notice of her discharge. On 2/19/19 at 1:38 PM, during a telephone interview, Resident #227's representative said the facility "kicked us out." The family representative said they were told by facility staff the facility was not getting paid by Medicare and Resident #227 had to move to another facility or	F 623		

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F 623	Continued From page 24 go home. The family representative also said Resident #227 was 89 years old and just had knee replacement surgery and he wanted her to stay more days in the facility to complete her physical therapy. The family representative said Resident #227 decided to go home with outpatient physical therapy. On 2/19/19, at 4:17 PM, during a telephone interview, the SW said she told Resident #227 and her family representative the facility was in a non-payment status due to the 2 minor tags the facility received after their revisit survey and Resident #227 had to move to another facility or go home. The SW said Resident #227 was able to use her 2-wheeled walker independently and chose to go home with outpatient physical therapy. 3. Resident #226 was admitted to the facility on 2/8/19, with multiple diagnoses including aftercare for digestive system surgery, muscle weakness, and difficulty in walking, Resident #226 was transferred to another facility on 2/14/19, 6 days later. A social services note, undated, documented the SW told Resident #226's responsible party the facility was in a non-payment status due to the result of the facility's revisit and complaint survey which resulted in 2 minor deficiencies and was not getting paid for Resident #226's stay. The note documented the responsible party and Resident #226 were given the option to transfer her to another rehabilitation facility or discharge her home. The SW documented Resident #226 was going to be provided the same OT and PT and the same doctors if she was transferred to	F 623		

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F 623	Continued From page 25 the sister facility. The responsible party and Resident #226 agreed to the transfer. The note did not include documentation an option was given to stay in the facility. Resident #226's Discharge/Transfer Order and Notice of Resident Transfer or Discharge forms, dated 2/13/19 and 2/14/19, documented she was discharged due to "CMS denial of payment." Resident #226's nurse progress note, dated 2/15/19, included a late entry for 2/14/19, regarding her transfer. The note documented the responsible party and Resident #226 were given the option to transfer her to a sister facility or another rehabilitation facility. The note documented they chose to go to a sister facility. On 2/19/19 at 1:30 PM, Resident #226's responsible party said the SW informed him and Resident #226 the facility failed an inspection and was not going to get paid for her stay. He said the SW told them Resident #226 needed to be transferred to a sister facility to continue her therapy and care. He said the SW did not offer them any other choice and he would have preferred not to have her transferred because it was closer to him than the sister facility. He said it was inconvenient, but Resident #226 was doing well at the new facility. On 2/19/19 at 4:15 PM, the SW said she spoke to the responsible party and Resident #226 regarding the transfer due to the non-payment status. She said at first, they were confused with the need to transfer and thought the resident was being kicked out, but they were reassured Resident #226 was going to receive the same	F 623		

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F 623	Continued From page 26 level of care at the sister facility and then they agreed to the transfer. On 2/19/19 at 5:30 PM, the DON said the SW note for Resident #226 did not include documentation the responsible party or Resident #226 was given an option to stay in the facility. 4. Resident #224 was admitted to the facility on 2/7/19, with multiple diagnoses which included hemiplegia (paralysis) and hemiparesis (weakness) secondary to a stroke. Resident #224 was discharged to another facility on 2/15/19, 8 days later. A social services note, dated 2/15/19 at 3:10 PM, documented the SW told Resident #224 the facility was in a non-payment status due to the result of their revisit survey combined with the complaint survey resulting in 2 minor tags and Resident #224 had the option to go to their sister facility or go to another facility of his choice. The progress note documented Resident #224 asked the SW if he was going to receive the same kind of therapy at the other facility, and the SW said he would receive the same therapy and the same physician was going to see him at their sister facility. The progress note documented Resident #224 agreed to go to the sister facility. A Notice of Resident Transfer or Discharge, dated 2/14/19, was signed by Resident #224. The notice documented Resident #224 was transferred "Per CMS denial of payment." On 2/19/19 at 5:30 PM, the Unit Manager, with the DON, said Resident #224 was not ready to go home and he was given the option to move to	F 623		

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F 623	Continued From page 27 their sister facility or to another facility of his choice. The Unit Manager said Resident #224 chose to transfer to their sister facility to continue his therapy. 5. Resident #229 was admitted to the facility on 2/11/19, with multiple diagnoses including urinary tract infection, dementia, muscle weakness, and difficulty in walking. A social services note, dated 2/15/19, documented the SW explained to the family and Resident #229 there were changes regarding a possible transfer to a sister facility and offered for Resident #229 to stay in the facility. A family member said it did not matter to him and asked the SW to ask Resident #229 her choice. Resident #229 said she wanted to stay in the facility and finish her rehabilitation. No other progress notes were found regarding a possible transfer. On 2/19/19 at 3:25 PM, Resident #229's responsible party said the SW informed him on 2/13/19, Resident #229 needed to be transferred to a sister facility on 2/15/19, to continue her therapy and care. He said it did not matter to him where she was moved to. He said on 2/15/19, the SW told him about a new option to have her stay in the facility and he told the SW to ask Resident #229 what she wanted to do. Resident #229 said she wanted to stay. He said he was told by facility staff it was some sort of "Medicare mix-up." He said he thought he had signed discharge paperwork but could not be sure. On 2/19/19 at 4:15 PM, the SW said she spoke to Resident #229's responsible party on 2/13/19,	F 623		

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F 623	Continued From page 28 regarding the transfer due to the non-payment status. The SW said on 2/15/19, she was informed by the DON residents and families were now being allowed to stay in the facility as an option instead of transferring or discharging residents. She said she asked Resident #229 her preference and she said she wanted to remain in the facility and was not transferred to the sister facility. On 2/19/19 at 5:30 PM, the DON said Resident #229 was not ready to be discharged and the family was approached to transfer her due to their non-payment status or to stay in the facility and she stayed in the facility. 6. Resident #222 was admitted to the facility on 2/3/19, and was readmitted on 2/11/19, with multiple diagnoses which included fracture of right femur (thigh bone) and end stage renal disease (kidney failure). A social services note, dated 2/15/19 at 3:56 PM, documented the SW told Resident #222 and her family the facility was in a non-payment status due to the result of the facility's revisit survey combined with a complaint survey resulting in 2 minor tags. The progress note documented the SW spoke to Resident #222 and her family regarding the possibility of transferring her to a sister facility or a facility of their choice. The progress note documented Resident #222's representative considered an assisted living facility but because of the status of her wound, the assisted living facility was not going to accept Resident #222. The progress note documented Resident #222's representatives were called and told she could stay at the facility until she was	F 623		

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F 623	Continued From page 29 cleared to go to the assisted living facility. On 2/19/19 at 2:52 PM, during a telephone interview Resident #222's family representative said on 2/13/19, they were told by facility staff the facility was in a non-payment status due to the result of their revisit survey combined with complaint survey resulting to 2 minor tags and they were given the option of transferring Resident #222 to their sister facility or to another facility of their choice by 2/15/19. Resident #222's family representative said they asked the facility staff to give them more time until Monday, 2/18/19, to sort things out. The family representative said the facility staff apologized and said the corporate people were putting pressure on the staff to talk to the residents regarding transferring them to their sister facility, to a facility of their choice, or go home if they were able to. The family representative said they thought of moving Resident #222 to an assisted living facility instead of another nursing facility and started to make arrangements however, they found out the assisted living facility would not accept Resident #222 due to the status of her wound. The family of Resident #222 were advised to transfer her to their sister nursing facility which was next to the assisted living facility. Another family representative joined the telephone interview and said on 2/17/19, they received a call from the facility's Regional Nurse who apologized and said Resident #222 could stay in the facility as long as she needed.	F 623		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		3/20/19

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F 689	Continued From page 30 §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 record review, policy review, and staff interview, it was determined the facility failed to provide adequate supervision to meet resident needs. This was true for 1 of 5 residents (Resident #216) reviewed for supervision and accidents. This failed practice placed Resident #216 at risk of fracture and other injuries related to falls. Findings include: The facility's Fall Management policy and procedure, dated 12/13/18, documented the facility ensured residents' environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistive devices to prevent accidents. Adequate supervision was defined as an intervention and means of mitigating the risk of accident. Resident #216 was admitted to the facility on 12/6/18, with multiple diagnoses which included dementia and osteomyelitis (an infection of the bone) of the right ankle and foot. An admission MDS assessment, dated 12/13/18, documented Resident #216 had severe cognitive impairment, he was incontinent of bowel and bladder, and he required extensive assistance of 2 staff members for bed mobility, transfers, toileting, and walking in the room. The MDS	F 689	F 689 Corrective Action: 1. Resident #216 discharged from the facility on 1/22/2019. Identification: 1. All residents are identified as potentially being affected by this deficiency. 2. Incident documentation for residents that experienced a fall in the last 30 days (2/10/2019 □ 3/10/2019) has been audited by the DNS / Designee to ensure that the interventions implemented after the fall were appropriate, specific to the resident, updated on the resident□s Care Plan, and were in place. Areas identified during audit were corrected upon discovery. 3. The facility IDT will review any resident who has had more than two (2) falls in the last 90 days to ensure that the interventions are individualized and resident-centered, and were implemented to reduce the risk of future falls. Systemic Changes: Facility staff received education from the facility SDC / Designee on the following:	

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F 689	Continued From page 31 assessment documented Resident #216 was not steady with moving from a seated to standing position, walking, moving on and off the toilet, and surface to surface transfers (transfer between bed and chair or wheelchair), and he was only able to stabilize with human assistance. Resident #216's Fall Risk Evaluations, dated 12/6/18, 12/31/18, 1/2/19, 1/11/19, 1/13/19 and 1/14/19, documented he was at high risk for falls. Resident #216's Fall care plan, initiated on 12/6/18, documented he was at risk for falls related to his medication usage (quetiapine, an anti-psychotic) and his use of a Controlled Ankle Motion (CAM) boot on his right lower extremity due to amputation of his middle toe. Resident #216 had difficulty with balance per his physical therapy evaluation. The care plan interventions included the following: * Provide Resident #216 environmental adaptations such as placing his call light within his reach, glare free lighting, and keep his environment free of clutter. * Provide extensive assistance to Resident #216 when transferring from bed to chair and back. * Provide Resident #216 and his representatives safety measures to reduce his risk of fall and interventions if he fell. * Monitor Resident #216 for side effects of his medication. * Report Resident #216's falls to his physician and to his representatives. Resident #216's Incontinence care plan, initiated on 12/6/18, documented he had alteration in continence related to his restricted mobility due	F 689	a. At the time of a fall, a Fall Huddle will be conducted with the resident, CNA, LN, and any other caregivers (RNA, Activity staff, etc.) During the Huddle, the LN will interview the resident, caregiver staff, and other witnesses to event in an effort to determine possible contributing factors to the fall. Any interventions identified during the Huddle will be implemented as appropriate by the IDT and Core Care Team. b. During / After Grand Rounds an Administrative Fall Huddle will be conducted. Administrative staff and Core care Team will review the interventions put in place, consider conducting a return demonstration, encourage additional ideas and suggestions for fall prevention specific to the resident. Document any changes or information discussed and education provided in the Progress Notes, and update the resident□s Care Plan as appropriate. c. The IDT will meet weekly to review falls for the previous seven (7) days to ensure that interventions were still appropriate and no further changes to the resident□s Care Plan were needed. Monitor: 1.DNS / Designee to conduct audit of fall incident documentation to ensure interventions and resident Care Plans have been updated as appropriate, and that the IDT has reviewed the incidents weekly. 2.Audits to be conducted at the following frequencies:	

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F 689	Continued From page 32 to his CAM boot which severely limited his ability to transfer as needed to remain continent. The care plan interventions included the following: * Provide Resident #216 prompt peri-care as necessary for incontinent episodes between his regularly scheduled toileting times. * Observe Resident #216 for non-verbal signs of wanting to use the toilet. * Adjust Resident #216's toileting schedule as necessary if his elimination pattern changed, check with him frequently if he needed to use the toilet. A physician's progress note, dated 12/11/18, documented Resident #216 had severe dementia and he required interventions and assistance with activities of daily living. Resident #216 experienced 5 falls in his room which occurred on 12/30/18 at 10:45 PM, 1/7/19 at 4:20 PM, 1/11/19 at 11:35 PM, 1/13/19 at 4:30 PM and on 1/14/19 at 4:00 AM. An Incident and Accident (I&A) report, dated 12/30/18 at 10:45 PM, documented Resident #216 experienced an unwitnessed fall in his room when he attempted to get out of his bed to go to the toilet. He was observed lying on the floor and his incontinent brief was wet. The I&A report documented Resident #216 was alert and confused and said, "I was trying to go to the bathroom." Immediate actions taken were providing Resident #216 with frequent checks, prompting him every 2 hours to use the bathroom, placing fall mats at his bedside, and he was reminded to use his call light.	F 689	a. Weekly for four (4) weeks b. Monthly for three (3) months 3. Findings to be reviewed by Administrator and reported to QA Committee	

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F 689	Continued From page 33 A nurse's note, dated 12/31/18 at 10:50 AM, documented the Interdisciplinary Team (IDT) reviewed Resident #216's fall. The note documented Resident #216 had recently finished his antibiotics and staff reported he had loose stools. The IDT placed Resident #216 on prompt toileting every 2 hours. Resident #216's care plan was updated on 12/31/18 to include prompt toileting every 2 hours, and continued education was provided to him to use his call light because he was forgetful. An I&A report, dated 1/7/19 at 4:20 PM, documented Resident #216 experienced an unwitnessed fall in his bathroom when he attempted to stand after he used the toilet. He was observed sitting on the floor with his head up against the wall and his incontinent brief was wet. The I&A report documented Resident #216 said "I went to the bathroom." The I&A report also documented Resident #216 was impulsive and was placed on a Falling Leaf Program, and he was provided with the "4 P's" every hour, a 2-hour toileting schedule, and mats at his bedside. Resident #216 was on a toileting schedule every 2 hours and had mats at his bedside after his fall on 12/30/18. A nurse's note, dated 1/8/19 at 11:39 AM, documented a late entry for 1/7/19. The note stated Resident #216 was found lying on the floor in his room with his pants pulled down to his mid-thigh and he had a 6 centimeter abrasion on his right buttock. A nurse practitioner's progress note, dated 1/9/19, documented Resident #216 was	F 689		

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F 689	Continued From page 34 somewhat confused and he did not know what the call light was. Resident #216's care plan was updated on 1/10/19 and documented he was placed on the Falling Leaf Program. The care plan did not include the "4 P's" and mats which were placed at Resident #216's bedside. An I&A report, dated 1/11/19 at 11:35 PM, documented Resident #216 experienced an unwitnessed fall in his room when he tried to get to the restroom. The recommendations were to change Resident #216's bed from the low position, replace his mat at the beside with a non-skid rug, put a recliner in his room, and place him in the Falling Leaf Program. Resident #216 was placed in the Falling Leaf Program after he fell on 1/7/19. Resident #216's care plan was not updated after the fall on 1/11/19, to include the recommendation of putting a recliner in his room and to replace his mat with a non-skid rug. A nurse's note, dated 1/12/19, documented Resident #216 continued to be confused and needed assistance with bed mobility and transfers. He was incontinent of his bowel and bladder. A nurse's note, dated 1/13/19, documented Resident #216 continued to work with the physical therapist and cautioned Resident #216 was not to ambulate and staff were to use pivot transfers (have the resident stand, turn, and then sit down on the new surface).	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
	135038		R 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BOISE	808 NORTH CURTIS ROAD BOISE, ID 83706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 35 Resident #216's Fall care plan was updated on 1/14/19, directing staff to put rugs at his bedside and a recliner in his room. An I&A report, dated 1/13/19 at 7:30 PM, documented Resident #216 experienced an unwitnessed fall in his room when he attempted to self-transfer and he slid to the floor. He was observed sitting on the floor with his back against his chair. Review of Resident #216's fall documented he was confused and staff were directed to keep him in the hallway within line of sight when he was up in his wheelchair. An I&A report, dated 1/14/19 at 4:00 AM, documented Resident #216 experienced an unwitnessed fall in his room and he sustained a small skin tear on his left elbow. Resident #216 was observed on the floor next to his bed. The I&A report documented Resident #216 said "I had to pee. I couldn't wait." The report documented Resident #216 was impulsive, forgetful, and he had severe dementia. Recommendations were to provide Resident #216 with prompt toileting every 2 hours and as necessary. This was the same recommendation after Resident #216 fell on 12/30/18, which was documented on his care plan. A nurse's note, dated 1/14/19 at 10:24 AM, documented the IDT reviewed Resident #216's fall and discontinued his low bed and mats. Staff were directed to place non-skid rugs at the bedside and next to his recliner. Resident #216's care plan was updated on 1/15/19, to keep him within eyesight in the hallway while he was up in his wheelchair.	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
	135038		R 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BOISE	808 NORTH CURTIS ROAD BOISE, ID 83706

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F 689	Continued From page 36 On 2/11/19 at 3:20 PM, the DON with the Regional Director of Clinical Services (RDCS) was asked what the meaning of "4 P's" was and what was their Falling Leaf Program. The DON said the 4 P's meant assessing for personal items, potty, pain, and positioning need. The DON said when a resident was on the Falling Leaf Program, a leaf was placed outside the resident's door to alert the staff the resident was a frequent faller, and staff should check the resident whenever they pass by the door and ask about the "4P's." The DON said Resident #216 was very impulsive and he was educated several times to use his call light, and Resident #216 was able to demonstrate how to use his call light. The DON said they moved Resident #216 to be nearer to the nurse's station and he was opposite the Unit Manager's office for increased supervision. When asked what new interventions were implemented when Resident #216 experienced three more falls in his room after he was placed in the Falling Leaf Program and if there was documentation of the frequent checks done on Resident #216. The DON said they did not document the frequent checks. The DON said the frequent checks could be anywhere from every 15 minutes to every 30 minutes. The DON also stated she believed the facility had done everything they could to prevent Resident #216's falls and even a one-on-one sitter would not prevent Resident #216's falls because he was so impulsive. The facility failed to provide adequate supervision to Resident #216 from experiencing multiple falls in his room.	F 689		

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
	MDS001380		R **02/19/2019**

NAME OF PROVIDER OR SUPPLIER

LIFE CARE CENTER OF BOISE

STREET ADDRESS, CITY, STATE, ZIP CODE

808 NORTH CURTIS ROAD
BOISE, ID 83706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS	{C 000}		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/17/19

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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July 9, 2019

Mikael Pickrell, Administrator
Life Care Center of Boise
808 North Curtis Road
Boise, ID 83706-1306

Provider #: 135038

Dear Ms. Pickrell:

On February 11 through **February 19, 2019**, an unannounced on-site complaint survey was conducted at Life Care Center of Boise. The complaint was investigated in conjunction with the annual recertification survey. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008020

ALLEGATION #1:

The facility did not provide adequate supervision to prevent residents from falls and resident families were not notified of the falls.

FINDINGS #1:

During the investigation 9 residents were observed and their records were reviewed for quality of care and quality of life issues. Two discharged resident's medical record were also reviewed. The facility's Incident and Accident (I&A) reports, Grievance file and Resident Council minutes were also reviewed.

The facility's I&A reports documented one resident had experienced 5 unwitnessed falls in his room which occurred on 12/30/18, 1/7/19, 1/11/19, 1/13/19, and 1/14/19. The I&A reorts documented the facility notified the resident's family member each time the resident fell.

The I&A reports and the resident's record documented actions which were to be taken in response to his falls. However, the resident's care plan was not consistently updated to include the additional interventions to prevent the resident from falling.

On 2/11/19, the Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS) were interviewed about the resident. The DON stated she believed the facility had done everything they could to prevent the resident's falls.

The facility did not provide adequate supervision to the resident to prevent multiple falls in his room.

While it could not be determined the facility failed to notify family members of resident falls, it was determined the facility failed to provide adequate supervision to the resident. Therefore, the allegation was substantiated and a deficiency was cited at F689, relating to residents being free from accident hazards and supervision.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility did not provide adequate hydration and nutritional support to prevent resident weight loss.

FINDINGS #2:

During the investigation, residents were observed during meal time. One resident's clinical record was reviewed, and residents and staff interviews were conducted.

One resident's weight upon admission to the facility was 190 pounds and his weight upon discharge was 169 pounds. While at the facility the resident was prescribed hydrochlorothiazide (a medication to help the body get rid of extra water). The resident's record documented he was being followed by the facility's dietitian and was provided with a regular diet and fluids 3 times a day between meals, Medpass (a nutritional supplement), 3 imes a day between meals and Juven (a protein drink), was also prescribed. The resident's meal record for 1/2019 documented he was consuming 50 -100% of his meals in 49 out of 66 opportunities. The resident's record also documented he refused most of the snacks offered to him.

During meal observation, 6 residents were observed being assisted to eat by three Certified Nursing Assistants. Residents' rooms were observed with water at the bedside.

Staff were observed setting up meal trays for residents eating in their rooms who needed assistance. Water sources/containers were also observed at the facility entrance. Residents were interviewed and observed for signs of dehydration, and no concerns were voiced or observed.

Based on investigative findings the resident had lost weight while in the facility but no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility did not provide a care conference with resident representatives, and did not provide discharge information to other facilities for transfer.
Allegation #4:

The facility did not provide the name or phone number of residents' physicians to residents' representatives when asked.

FINDINGS #3:

During the investigation, one resident's clinical record was reviewed and the Social Worker was interviewed.

One resident's record documented he was admitted to the facility in December 2018, and a care conference was held on 6 days later attended by the resident's family member, two of the resident's family friends, the Dietary Manager, the Social Worker, a Pastor, and a representative from the Nursing department.

In an interview with the Social Worker, she said the resident's representative requested the resident's record be sent to 2 different facilities, and another resident representative requested the resident record be sent to another facility. The Social Worker said she sent the resident's records to the other facilities as requested. The Social Worker said she was then told one of the other resident's representatives made a down payment to the facility near the resident's home. The Social Worker found out the facility would not accept the resident until the resident's wound was healed and he was off of his antibiotic. A Social Worker progress note documeted the Social Worker talked to the resident's representative regarding the facility they made the down payment on was not able to accept the resident until the resident's wound was healed and he was off of his antibiotic. In January, 2019 the resident was discharged to community home.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

FINDINGS #4:

During the investigation one resident's record was reviewed. Staff members and residents were interviewed.

Residents interviewed said they knew their physicians.
A nurse was interviewed and said upon admission to the facility the resident and their representatives were informed who would be their physician, and if the resident or their representative asked for the physician's phone number they would provide the physician's office number. The nurse also said the physician's phone number was written on the resident's face sheet which was being provided to the residents.

Based on investigative findings, the allegation was unsubstantiated, and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

Belinda Day, RN, Supervisor
Long Term Care Program