



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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E-mail: fsb@dhw.idaho.gov

March 6, 2020

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

Provider #: 135038

Dear Ms. Pickrell:

On **February 21, 2020**, a survey was conducted at Life Care Center of Boise by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 16, 2020**. Failure to submit an acceptable PoC by **March 16, 2020**, may result in the imposition of penalties by **April 8, 2020**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 27, 2020 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 21, 2020**. A change in the seriousness of the deficiencies on **April 6, 2020**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **May 21, 2020** includes the following:

Denial of payment for new admissions effective **May 21, 2020**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 21, 2020**, 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 Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 21, 2020** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **March 16, 2020**. If your request for informal dispute resolution is received after **March 16, 2020**, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

bd/lj

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

PRINTED: 03/23/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/21/2020
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from February 18, 2020 to February 21, 2020.</p> <p>The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Michael Brunson, RN Susan Finnell, RN Gay Thomas, RN</p> <p>Survey Abbreviations: ADL = Activities of Daily Living CNA = Certified Nursing Assistant ICP = Infection Control Preventionist IDON = Interim Director of Nursing LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = Milligram PRN = As Needed RDCS = Regional Director of Clinical Services UM = Unit Manager</p>	F 000			
F 578 SS=E	<p>Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)</p> <p>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.</p>	F 578		4/1/20	

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

TITLE

(X6) DATE

Electronically Signed

03/13/2020

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 578	Continued From page 1 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents records included an Advance Directive or documentation an Advance Directive was discussed or offered. This was true for 3 of 9 residents (#36, #37, and #40) whose records were reviewed for an Advance Directive. This	F 578	Individual Residents: #36, #37 advanced directives reviewed and care plans updated, #40 is no longer in the building. Other Resident in Similar Situations: all residents medical records were reviewed to ensure advanced directives are		

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F 578	<p>Continued From page 2</p> <p>failed practice created the potential for harm if residents' wishes regarding end of life or emergent care were not honored if they became incapacitated. Findings include:</p> <p>The State Operations Manual, Appendix PP, defines an Advance Directive as "...a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." The State Operations Manual also states a Physician Orders for Life-Sustaining Treatment (POLST) is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an Advance Directive.</p> <p>The facility's Advance Directive policy, dated 8/21/19, documented the following:</p> <ul style="list-style-type: none"> * The social worker requested a copy of the Advance Directive so that it became a part of the medical record. * Copies of the Advance Directive remained in the resident's record, even if the chart was thinned. * Each time the resident was admitted, had a significant change, quarterly or as needed, Social Services reviewed the Advance Directive for accuracy. 	F 578	<p>current and in place. Care plans updated to match. Any resident that didn't have advanced directives were offered assistance with developing if desired.</p> <p>Measure to Prevent Reoccurrence: Staff Development Coordinator provided education on policy and procedure / requirements on Advance Directives to IDT.</p> <p>Ongoing Monitoring: DON/Designee will audit documentation for 10 resident preferences /Advanced Directive weekly x4 then monthly x3, and report findings to QAPI Committee monthly.</p> <p>Individual to Ensure Ongoing Compliance: DON/Designee</p> <p>Compliance date: 4-1-20</p>		

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F 578	<p>Continued From page 3 This policy was not followed.</p> <p>1. Resident #36 was admitted to the facility on 6/16/17, with multiple diagnoses which included atrial fibrillation (an irregular and often faster heartbeat), heart failure, kidney disease, and cognitive communication deficit.</p> <p>Resident #36's physician orders, dated 3/1/19, documented her status was do not resuscitate.</p> <p>Resident #36's care plan conference, dated 3/5/19, documented Resident #36's daughter would bring in a copy of her living will. The most recent care plan conference, dated 11/26/19, documented Resident #36 had no living will.</p> <p>Resident #36's record did not include an Advance Directive or documentation that one was offered or discussed with her.</p> <p>On 2/19/20 at 1:47 PM, the MDS Coordinator and the Social Worker were interviewed. The MDS Coordinator stated she facilitated the care conferences for residents. She stated there was no documentation an Advance Directive was discussed or offered to Resident #36. The Social Worker stated there was no documentation of an Advance Directive in Resident #36's chart.</p> <p>2. Resident #37 was readmitted to the facility on 12/23/19, with multiple diagnoses including chronic kidney disease.</p> <p>Resident #37's care plan conferences dated, 8/23/18, 12/24/18, 3/14/19, and 1/18/20 documented "none" for Advance Directive.</p>	F 578			

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F 578	Continued From page 4 Resident #37's record did not include an Advance Directive, or documentation that one was offered or discussed with her. On 2/19/20 at 12:46 PM, UM #1 stated there was an Idaho POST, but no Advance Directive in Resident #37's chart. 3. Resident #40 was readmitted to the facility on 9/4/18, with multiple diagnoses including diabetes, kidney disease, and heart failure. Resident #40's care plan conference, dated 4/7/19, documented he had no Advance Directive. Resident #40's record did not include an Advance Directive or documentation that one was offered or discussed with him. On 2/19/20 at 12:48 PM, UM #1 stated Resident #40's record did not include documentation about an Advance Directive. On 2/19/20 at 1:47 PM, the MDS Coordinator stated she facilitated the care conferences for residents. She stated there was no documentation that an Advance Directive was discussed or offered to Resident #40.	F 578			
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		4/1/20	

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F 584	<p>Continued From page 5</p> <p>The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and resident and staff interview, it was determined the facility failed to ensure a resident's room was</p>	F 584	<p>Individual Residents: Resident #45 window was repaired on 2-25-20.</p>		

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F 584	<p>Continued From page 6</p> <p>homelike. This was true for 1 of 16 residents (Resident #45) whose environment was observed. This failure created the potential for diminished quality of life and psychosocial harm due to living with a damaged window. Findings include:</p> <p>The facility's Environment Services policy, dated 8/9/19, directed staff to create a homelike environment and to maintain a sanitary, orderly, and comfortable interior.</p> <p>This policy was not followed.</p> <p>On 2/20/20 at 8:05 AM, the window in Resident #45's room had a three-inch diameter chip in it with an 11-inch crack running through the chip. The chip was covered by a piece of clear tape. Resident #45 said the chip had been there a long time, when a lawnmower flicked a rock into the window. She said she could not see out of that portion of the window.</p> <p>On 2/20/20 at 10:33 AM, the Director of Maintenance observed the window and said the window was broken two-weeks ago when a lawnmower flicked a rock into the window. He said he called a local glass company and had not received a call back.</p>	F 584	<p>Other Resident in Similar Situations: facility wide room to room inspection of windows was conducted to check for necessary or needed repairs.</p> <p>Measure to Prevent Reoccurrence: Education provided to all associates on homelike environment and reporting issues/concerns to maintenance or IDT team.</p> <p>Ongoing Monitoring: Maintenance Director or designee to audit 10 rooms a week x4 weeks then 10 rooms monthly x3. Report finding to QAPI committee monthly.</p> <p>Individual to Ensure Ongoing Compliance: Maintenance Director /Designee</p> <p>Compliance date: 4-1-20</p>		
F 656 SS=D	<p>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)</p> <p>§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</p>	F 656		4/1/20	

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F 656	<p>Continued From page 7</p> <p>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 -</p> <p>(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</p> <p>(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).</p> <p>(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.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for 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.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, policy review, record review, and resident and staff interview, it was</p>	F 656	Individual Residents: Resident #1 care plan was updated to include his vision		

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F 656	<p>Continued From page 8</p> <p>determined the facility failed to ensure vision was addressed on a resident's comprehensive care plan for 1 of 16 residents (Resident #1) reviewed for comprehensive care plans. This deficient practiced created the potential for harm if a resident's vision worsened. Findings include:</p> <p>The facility's Resident Assessment and Care Plan policy, dated 1/28/16, documented information identified using the MDS and Care Area Assessment process was used to develop an individualized person-centered care plan to assist residents to attain and/or maintain their highest practicable level of well-being.</p> <p>This policy was not followed.</p> <p>Resident #1 was admitted to the facility on 7/24/19, with multiple diagnoses including glaucoma (a group of eye conditions that damage the optic nerve).</p> <p>Resident #1's admission MDS, dated 8/5/19, documented he had glaucoma and impaired vision that required corrective lenses to see. The Care Area Assessment (CAA) worksheet documented he had glaucoma and required large print in order to see. The CAA was triggered to include vision on his care plan.</p> <p>Resident #1's care plan did not include his vision problem and that he required large print in order to see and read.</p> <p>On 2/18/20 at 11:17 AM, Resident #1 was in his room with a pair of glasses on. He said he could not see the print to read.</p>	F 656	<p>problems on the care plan.</p> <p>Other Residents in similar situations: All Residents have the potential to be affected by this practice. Current residents with CAA triggering vision have been audited to ensure care plans match.</p> <p>Measures to prevent reoccurrence: MDS or designee to provide education to IDT and LN staff on maintaining and updating care plans to reflect the residents current care needs.</p> <p>Ongoing Monitoring: DON / MDS/Designee to audit 5 care plans a week x4 weeks then monthly x3 to ensure CAA matches care plan. Negative findings of these audits will be reviewed through QAPI x3 months.</p> <p>Individual to ensure compliance: MDS Coordinator will ensure ongoing compliance.</p> <p>Compliance date: 4-1-20</p>		

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
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F 656	Continued From page 9 On 2/21/20 at 10:10 AM, the MDS Coordinator said Resident #1's vision should have been addressed on his comprehensive care plan.	F 656			
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure residents' care plans were	F 657	Individual Residents: Resident #36 care plan was updated with current oxygen order.	4/1/20	

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F 657	<p>Continued From page 10 revised and updated to maintain accuracy. This was true for 3 of 16 residents (#1, #36, and #45) whose care plans were reviewed. This failure created the potential for harm if care was based on inaccurate care plan information. Findings include:</p> <p>The facility's policy for Care Planning and Interventions dated 7/23/09, documented the care plan is updated as needed and not less than quarterly as conditions change or interventions are determined to be ineffective or need to be revised.</p> <p>This policy was not followed.</p> <p>1. Resident #36 was admitted to the facility on 6/16/17, with multiple diagnoses which included atrial fibrillation (an irregular and often fast heart rate), heart failure, and kidney disease.</p> <p>Resident #36's care plan initiated on 7/11/19, documented she was to receive oxygen continuously at 2 liters per minute (LPM) by nasal cannula, related to her congestive heart failure (weakness of the heart leading to a buildup of fluid in the body).</p> <p>Resident #36's physician orders, updated 12/19/19, documented her oxygen was changed from 2 LPM continuously, to 0-2 LPM as needed to keep her oxygen saturation levels above 88%.</p> <p>On 2/18/20 at 11:13 AM, Resident #36 was asleep in her room and oxygen was being delivered to her by an oxygen concentration unit set at 2 LPM.</p>	F 657	<p>Resident #1 Care plan was updated with current fall interventions. Resident #45 care plan was updated related to hearing</p> <p>Other Residents in similar situations: All residents have the potential to be affected by this practice. Resident Care plans for falls, communication and vision were reviewed and updated as needed Residents had their care plans reviewed and updated as needed.</p> <p>Measures to prevent reoccurrence: DON or designee educated IDT/LNs on care plan revisions.</p> <p>Ongoing Monitoring: Care plans will be reviewed in conjunction with the residents MDS schedule. DON or designee will audit 5 care plans a week x 4 weeks then monthly x3 to ensure that care plans are being updated with changes. Findings of these audits will be reviewed through monthly QAPI x3 months for trends and additional education.</p> <p>Individual to ensure compliance: The Director of Nursing will ensure ongoing compliance</p> <p>Compliance date: 4-1-20</p>		

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F 657	<p>Continued From page 11</p> <p>On 2/20/20 at 8:11 AM, UM #1 stated there was a change in Resident #36's oxygen order from continuous to as needed and the care plan was not changed.</p> <p>2. Resident #1 was admitted to the facility on 7/24/19, with multiple diagnoses including glaucoma (a group of eye conditions that damage the optic nerve).</p> <p>An Incident report, dated 12/13/19, documented Resident #1 had an unwitnessed fall at 11:18 PM.</p> <p>A progress note, dated 12/13/19 at 11:56 PM, documented Resident #1 was found on the floor in his room and did not sustain an injury.</p> <p>A Fall Summary, dated 12/13/19, documented fall interventions were to instruct Resident #1 to call for assistance with transfers and keep his bed in the low position.</p> <p>A Nurse Practitioner note, dated 12/16/19, documented Resident #1 slipped off the side of his bed without injury and was assessed for bed modifications.</p> <p>Resident #1's care plan, dated 2/4/20, documented he was at risk for falls. The care plan was not revised with the fall interventions for him to call for assistance with transfers and for his bed to kept in the low position, as documented on the 12/13/19 Fall Summary.</p> <p>On 2/18/20 at 11:19 AM, Resident #1 said he fell about a month ago while trying to transfer from his bed to a chair and was not hurt.</p>	F 657			

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F 657	<p>Continued From page 12</p> <p>On 2/21/20 at 9:19 AM, the MDS Coordinator said Resident #1's care plan was not revised after he fell on 12/13/19.</p> <p>On 2/21/20 at 10:17 AM, the IDON said she expected staff to revise Resident #1's care plan regarding fall prevention interventions.</p> <p>3. Resident #45 was admitted to the facility on 6/1/17, with multiple diagnoses including hearing loss.</p> <p>Resident #45's care plan, dated 4/30/19, directed staff to assist her with wearing a pocket talker (a hearing device with a small microphone and headphones).</p> <p>On 2/19/20 at 3:00 PM, Resident #45 said she was hard of hearing and had tried different hearing devices and chose not to wear them. She said she had not used the pocket talker for a long time because she did not like the way it fit on her head.</p> <p>On 2/20/20 at 8:52 AM, CNA #3 said Resident #45 did not use a hearing device.</p> <p>On 2/20/20 at 9:12 AM, RN #2 said Resident #45 was able to hear "good enough" as long as staff looked at her when they spoke. RN #2 said Resident #45 did not use a hearing device.</p> <p>On 2/20/20 at 11:11 AM, UM #1 said Resident #45 did not use a pocket talker and said the care plan was not revised regarding the hearing device.</p>	F 657			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		4/1/20	

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F 677	<p>Continued From page 13</p> <p>§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:</p> <p>Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure bathing and dressing was provided to meet a resident's needs. This was true for 1 of 16 residents (Resident #45) reviewed for ADL care. This created the potential for residents to experience skin breakdown and a negative effect to their psychosocial well-being when care was not provided as needed. Findings include:</p> <p>The facility's ADL policy, dated 4/22/19, directed staff to provide residents with bathing and dressing needs in accordance with residents' preferences, goals for care, and professional standards of practice.</p> <p>This policy was not followed.</p> <p>Resident #45 was admitted to the facility on 6/1/17, with multiple diagnoses including muscle weakness and osteoporosis.</p> <p>Resident #45's annual MDS assessment, dated 1/16/20, documented she was cognitively intact and required extensive, two-person assistance for dressing and one-person assistance for bathing.</p> <p>Resident #45's care plan, dated 4/30/19, documented she was dependent on staff for</p>	F 677	<p>Individual Residents Resident #45 was showered on 2/21/2020 and assisted with changing her clothing.</p> <p>Other Residents in similar situations: All residents have the potential to be affected.</p> <p>Measures to prevent reoccurrence: SDC or designee to provide education to Nursing staff on Assisting Dependent Residents with Activities of Daily Living including showers and assistance with dressing.</p> <p>Ongoing Monitoring: DON or designee to audit 5 resident a week x4 then monthly x 3 to ensure that residents are receiving assistance with showers and dressing per care plan. Findings of these audits will be reviewed through monthly QAPI x3 months for trends and additional education.</p> <p>Individual to Ensure Ongoing Compliance: DON/Designee</p> <p>Compliance date: 4-1-20</p>		

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F 677	<p>Continued From page 14</p> <p>dressing and bathing. The care plan directed staff to bathe her twice a week, as needed, or provide a sponge bath when a full bath or shower was not tolerated.</p> <p>ADL Reports from 12/1/19 through 2/20/20, documented Resident #45's bathing days were Tuesday and Thursday. The ADL Reports documented the following:</p> <ul style="list-style-type: none"> - Resident #45 was not bathed from 12/1/19 to 12/30/19 (29 days). The report documented showers were not applicable on 12/3/19, 12/10/19, 12/17/19, and 12/24/19. - Resident #45 was not bathed from 12/31/19 to 1/15/20 (16 days). The report documented she refused her showers on 1/1/20, 1/6/20, and 1/8/20. - Resident #45 was not bathed from 1/27/20 to 2/21/20 (25 days). The report documented she refused her showers on 1/29/20, 2/3/20, 2/10/20, 2/12/20, and 2/17/20 and was not available on 2/19/20. <p>Progress notes for Resident #45 documented the following:</p> <ul style="list-style-type: none"> - A progress note, dated 12/25/19 at 12:20 PM, documented she refused her shower. - A Progress note, dated 1/28/20 at 11:09 AM, documented she was not showered that day. - Progress notes, dated 1/30/20 and 1/31/20, documented she was not on the shower schedule and did not receive a shower. 	F 677			

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F 677	<p>Continued From page 15</p> <p>- A progress note, dated 2/12/20, documented she refused her shower and was reapproached by staff and she declined again.</p> <p>On 2/18/20 at 10:46 AM, Resident #45 was in her bed in her room. She wore a pink and white shirt with food stains on it. She said she was not receiving showers like she should.</p> <p>On 2/19/20 at 12:40 PM, Resident #45 was in her bed in her room. She wore the same shirt as the previous day and her hair appeared unkempt with visible dandruff flakes in her hair. She said the only reason she declined showers was when staff wanted to give her a shower before lunch because she did not want to miss her lunch. She said staff did not always come back to offer her a shower at a different time when she declined. She said she would like more than two showers a week.</p> <p>On 2/19/20 at 3:02 PM, Resident #45 was in her bed in her room. She wore the same shirt as the previous time and her hair appeared unkempt with visible dandruff flakes in her hair. RN #1 came into Resident #45's room and gave her a medication. RN #1 did not appear to notice the stained shirt and did not offer her a shower or to change her shirt.</p> <p>On 2/20/20 at 8:05 AM, Resident #45 was in her bed in her room. She wore the same shirt as the previous two days and her hair appeared unkempt with visible dandruff flakes in her hair. She said she would have staff change her shirt when she received her shower that day.</p>	F 677			

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F 677	<p>Continued From page 16</p> <p>On 2/20/20 at 8:43 AM, Shower Aide #1 said she generally offered showers to Resident #45 from mid-morning to early afternoon. She said when Resident #45 refused her showers, she let the nurse know and offered the shower again or a bed bath at a later time.</p> <p>On 2/20/20 at 8:52 AM, CNA #3 said staff were to change Resident #45's shirts in the morning and on shower days.</p> <p>On 2/20/20 at 11:11 AM, UM #1 observed Resident #45's shirt, hair, and clothes in her closet. She said Resident #45 needed hygiene attention. She said her hair had dandruff, her shirt was soiled, and she had clothes in her closet that staff could change her into. UM #1 said she expected staff to bathe and dress residents. She said she expected staff to reapproach residents when they declined and to document it. She said the last time Resident #45 had been bathed was on 1/27/20.</p> <p>On 2/20/20 at 4:25 PM, the IDON said Resident #45 refused showers and she expected staff to reapproach and/or offer her a bed bath. She said she expected staff to offer her clean clothes everyday.</p> <p>On 2/21/20 at 10:00 AM, Resident #45 was in her bed in her room. She wore the same shirt as the previous day and her hair appeared unkempt with visible dandruff flakes in her hair. She grabbed at her shirt and said staff did not give her a bath or change her shirt.</p>	F 677			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	F 757		4/1/20	

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F 757	<p>Continued From page 17</p> <p>§483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or</p> <p>§483.45(d)(2) For excessive duration; or</p> <p>§483.45(d)(3) Without adequate monitoring; or</p> <p>§483.45(d)(4) Without adequate indications for its use; or</p> <p>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure a resident was free from unnecessary medications when a resident was continually prescribed an antibiotic without clinical rationale. This was true for 1 of 6 residents (Resident #47) reviewed for unnecessary medications. This deficient practice had the potential for harm due to adverse drug reactions. Findings include:</p> <p>The facility's Antibiotic Stewardship policy, dated 4/15/19, documented the facility must implement an antibiotic stewardship program that includes</p>	F 757	<p>Individual Residents: Resident #47 was evaluated by medical professional on 2-26-20 concerning Macrobid order and rationale was placed in chart.</p> <p>Other Resident in Similar Situations: Audit completed of all residents on continuous antibiotics to ensure that rationale for use is in place.</p> <p>Measure to Prevent Reoccurrence: Don or designee will educate the LN staff on Unnecessary Drugs and the need for</p>		

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F 757	<p>Continued From page 18</p> <p>antibiotic use protocols and a system to monitor antibiotic use.</p> <p>Resident #47 was admitted to the facility on 7/8/19, with multiple diagnoses including a history of Urinary Tract Infection (UTI).</p> <p>Resident #47's MDS assessments, dated 7/18/19, 10/18/19, and 1/18/20, documented she was on an antibiotic and had no infections.</p> <p>Resident #47's care plan, dated 7/23/19, documented she was on the antibiotic Macrobid for long term recurrent UTI's. The care plan directed staff to administer antibiotic medications as ordered by the physician, and observe for and report adverse reactions related to antibiotic therapy.</p> <p>Resident #47's urinalysis and culture, dated 12/17/19, documented the urinalysis result was negative for a UTI and the culture results documented there was "no significant growth."</p> <p>Resident #47's February 2020 MAR included a physician's order, dated 1/10/20, for 100 mg of Macrobid at bedtime for "urinary prevention." The MAR documented the medication was administered from 2/1/20 to 2/20/20.</p> <p>On 2/18/20 at 9:27 AM, Resident #47 said she did not have a UTI.</p> <p>On 2/21/20 at 9:10 AM, the Infection Control Preventionist said Resident #47 was on Macrobid since she was admitted to the facility. She said she could not find a clinical rationale for Resident #47's continued use of the maintenance dose of</p>	F 757	<p>rationale on continuous antibiotic use.</p> <p>Ongoing Monitoring: DON or designee will audit all residents on new continuous antibiotics weekly x 4 and monthly x3 to ensure that rationale is in chart. Findings of these audits will be reviewed through monthly QAPI x3 months for trends and additional education. Individual to Ensure Ongoing Compliance: DON/Designee</p> <p>Compliance date: 4-1-20</p>		

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F 757	Continued From page 19 Macrobid.	F 757			
F 758 SS=E	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 are limited to 14 days. Except as provided in	F 758		4/1/20	

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F 758	<p>Continued From page 20</p> <p>§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.</p> <p>§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 record review, policy review, and staff interview, it was determined the facility failed to ensure psychotropic medications were limited to 14 days for PRN medications and behaviors were adequately monitored. This was true for 3 of 6 residents (#13, #21, and #57) reviewed for unnecessary medications. This deficient practice created the potential for harm if residents experienced adverse effects from unnecessary psychotropic medications. Findings include:</p> <p>The facility's Psychotropic Medication Use policy, dated 11/28/16, documented PRN psychotropic medications were limited to 14 days. If the practitioner believed it was appropriate to extend beyond 14 days, the practitioner was to document the rationale and indicate a duration for the use of the PRN medication in the resident's medical record.</p> <p>This policy was not followed.</p> <p>1. Resident #21 was readmitted on 7/26/19, with multiple diagnoses including anxiety.</p>	F 758	<p>Individual Residents: Resident #21 was evaluated by MD on 2-26-20 to address Lorazepam. Resident #13 was evaluated by the MD on 2-26-20 to address Xanax rationale for continuing medication. Resident #57 Behavior monitoring sheets were updated by LSW on 3-1-20.</p> <p>Other Resident in Similar Situations: Review was conducted of residents with orders for psychotropic medications to ensure a stop date is included, rationale included for orders with discontinue date longer than 14 days and behavior sheets in place. Corrections made as needed.</p> <p>Measure to Prevent Reoccurrence: DON/SDC will educate LN and LSW on Psychotropic medication stop date, rationale and discontinuation, including education of implementing behavior sheets for psychotropic medications</p>		

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F 758	<p>Continued From page 21</p> <p>Resident #21's physician's order documented to administer lorazepam (a psychotropic drug used to treat anxiety) 0.5 mg, one tablet by mouth daily PRN for anxiety, dated 9/26/19 with an end date of 2/14/20.</p> <p>A Pharmacy Consultation report for Resident #21, dated 9/26/19, documented to discontinue PRN lorazepam unless the prescriber documented the indication for use, the intended duration of therapy, and the rationale for the extended time period. The nurse practitioner's response was to add a six month stop date and "See the original order."</p> <p>Resident #21's MAR for December 2019 and January 2020, documented to administer lorazepam 0.5 mg, one tablet by mouth daily PRN for anxiety. The medication was administered 23 times in December and 19 times in January.</p> <p>Resident #21's February 2020 MAR documented to administer lorazepam 0.5 mg, one tablet by mouth daily PRN for anxiety. The medication was administered 11 times from 2/1/20 to 2/11/20.</p> <p>A Pharmacy Consultation report for Resident #21, dated 2/3/20, documented PRN orders for psychotropic drugs were limited to 14 days unless the prescriber documented the diagnosed specific condition being treated, the rationale for the extended time period, and duration for the PRN order.</p> <p>Resident #21's physician's order, dated 2/17/20, with an undetermined stop date, documented to</p>	F 758	<p>lasting longer than 14 days.</p> <p>Ongoing Monitoring: Don or designee will audit 5 residents a week to ensure that psychotropic medications include a stop date, rationale if needed and behavior sheets in place x4 weeks then monthly x3 months. Findings of these audits will be reviewed through monthly QAPI x3 months for trends and additional education.</p> <p>Individual to Ensure Ongoing Compliance: Director of Nursing</p> <p>Compliance date: 4-1-20</p>		

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F 758	<p>Continued From page 22</p> <p>administer lorazepam 0.5 mg, one tablet every 12 hours PRN for anxiety.</p> <p>Resident #21's February 2020 MAR documented to administer lorazepam 0.5 mg, one tablet by mouth daily PRN for anxiety. The medication was administered 2 times from 2/17/20 to 2/20/20.</p> <p>On 2/20/20 at 2:45 PM, UM #1 said the comment by the nurse practitioner on the pharmacy notice to "See the original order" was not a justification to extend the stop date for Resident #21's lorazepam.</p> <p>On 2/21/20 at 1:15 PM, the IDON said the medical record for Resident #21 lacked documented evidence of a rationale to extend the PRN psychotropic medication for longer than 14 days.</p> <p>2. Resident #13 was readmitted to the facility on 1/22/20, with multiple diagnoses including Alzheimer's Disease and anxiety.</p> <p>Resident #13's physician's order, documented to administer Xanax (a psychotropic drug used to treat anxiety) 0.5 mg, one tablet by mouth every 8 hours PRN for anxiety, dated 1/25/20 with an end date of 7/24/20.</p> <p>Resident #13's January 2020 and February 2020 MAR documented she received the PRN Xanax 16 times from 1/25/20 to 2/20/20.</p> <p>Resident #13's record did not document a clinical rationale for continuing the PRN medication beyond 14 days.</p>	F 758			

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F 758	<p>Continued From page 23</p> <p>On 2/21/20 at 9:19 AM, UM #1 said there was not a documented rationale for Resident #13's Xanax to extend the PRN psychotropic medication beyond 14 days.</p> <p>On 2/21/20 at 1:15 PM, the IDON said the medical record for Resident #13 lacked documented evidence of a rationale to extend the PRN psychotropic medication for longer than 14 days.</p> <p>3. The facility's Psychotropic Medication Use policy, dated 11/28/16, directed staff to monitor and document a resident's behaviors using a behavioral monitoring chart, and to document the number of symptoms and the resident's response to staff interventions.</p> <p>Resident #57 was readmitted to the facility on 2/14/17, with multiple diagnoses including major depression, cognitive social or emotional deficit following cerebrovasuclar disease (a group of conditions, diseases, and disorders that affect the blood vessels and blood supply to the brain), anxiety, and dementia with behavioral disturbance.</p> <p>Resident #57's physician orders documented to administer Sertraline (an antidepressant) 37.5 mg once a day Monday through Saturday related to major depressive disorder, Sertraline 25 mg once a day every Sunday related to anxiety, and Zyprexa (an antipsychotic) 7.5 mg once a day related to cognitive social or emotional deficit following cerebrovasuclar disease. All three orders started on 11/17/19.</p> <p>Resident #57's MARs for December 2019,</p>	F 758			

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F 758	<p>Continued From page 24</p> <p>January 2020, and February 2020 documented the Sertraline and Zyprexa were administered as ordered.</p> <p>Resident #57's care plan documented the following:</p> <ul style="list-style-type: none"> * Staff were directed to administer antidepressant medications and observe efficacy every shift. The intervention was initiated on 5/14/19. * Staff were directed to engage Resident #57 in conversations related to anxiety. The intervention was initiated on 9/14/19. * Staff were directed to document wandering behaviors, what diversion interventions were attempted in Resident #57's behavior log, and to encourage him to participate in activities to divert him from exit seeking behavior related to risk of elopement. The intervention was initiated on 1/28/20. * Resident #57's triggers for wandering and eloping were when he believed he needed to leave for work. His behaviors were deescalated through diversion discussion with him. The intervention was initiated on 1/28/20. <p>There was no documentation in Resident #57's record of resident specific behavior monitoring related to his depression and anxiety.</p> <p>Resident #57's December 2019 and January 2020 behavior monitoring documented a behavior of "Perseveration on past events" with interventions of "allow conversation" and "don't argue." The behavior monitoring did not</p>	F 758			

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F 758	Continued From page 25 document what past events were considered harmful to him and what diagnosis and/or medication was related to this behavior. Resident #57's February 2020 behavior monitoring documented a behavior of "delusions that he is working" with an intervention of "validation therapy." The behavior monitoring did not document what work delusions were considered harmful to him and what diagnosis and/or medication was related to this behavior. On 2/20/20 at 3:02 PM, the Social Worker (SW) said Resident #57's depression was not monitored. She said he sometimes wandered into other residents' rooms and was also at risk for elopement. The SW said these behaviors were not documented on the behavior monitoring and should have been. The SW said the Zyprexa was for his wandering and elopement behaviors. On 2/21/20 at 9:13 AM, the IDON said the "Perseveration on past events" and "Delusions that he is working" were related to Resident #57's wandering and elopement behaviors where he thought he was going through doors at work. The IDON said she expected the behavior monitoring to be more clear on what behaviors were monitored and what medications were used to treat the behaviors. She said she expected staff to document Resident #57's behaviors to make sure he still needed the medications.	F 758			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		4/1/20	

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F 761	<p>Continued From page 26</p> <p>professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure two opened vials of Tuberculin Purified Protein Derivative (a diagnostic solution administered for the detection of tuberculosis) was labeled with the date the vials were opened. This was true for 1 of 2 medication storage rooms reviewed for expired medications. This deficient practice had the potential for harm if residents received a decreased potency resulting in false Tuberculosis (TB) test readings. Findings include:</p> <p>The facility's Storage and Expiration Dating of</p>	F 761	<p>Individual Residents: 2 TB bottles were removed from the medication room on 2/26/2020.</p> <p>Other Resident in Similar Situations: All residents have the potential to be affected.</p> <p>Measure to Prevent Reoccurrence: SDC or designee to provide education to LN staff on dating TB solution when opened and discarding after 30 days.</p> <p>Ongoing Monitoring:</p>		

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F 761	Continued From page 27 Medications policy, revised 12/13/17, documented once any medication or biological package was opened, the facility followed manufacture/supplier guidelines with respect to expiration dates for opened medications. Facility staff recorded the date the medication was opened on the container when the medication had a shortened expiration date once it was opened. This was not followed. The manufacturer instructions for the Tuberculin Purified Protein Derivative, undated, documented vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. This was not followed. On 2/19/20 at 2:45 PM, the Hall 1 medication room was observed with the RDCS. In the medication refrigerator, two opened vials of Tuberculin Purified Protein Derivative were observed without an opened date. More than one half of the TB derivative was used out of both vials. On 2/19/20 at 3:00 PM, the RDCS said the TB vials were used for staff and residents. She said the vials should have been labeled with an opened date. On 2/20/20 at 4:00 PM, the IDON said the TB vials should have been dated when opened and discarded after 30 days from the opened date.	F 761	DON or designee to Audit Medication refrigerators to ensure that TB solutions are dated when opened weekly x4 then monthly x3. Findings of these audits will be reviewed through monthly QAPI x3 months for trends and additional education. Individual to ensure ongoing compliance: DON/Designee Compliance Date: 4-1-2020		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining	F 791		4/1/20	

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F 791	<p>Continued From page 28 routine and 24-hour emergency dental care.</p> <p>§483.55(b) Nursing Facilities. The facility-</p> <p>§483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;</p> <p>§483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;</p> <p>§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;</p> <p>§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and</p> <p>§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred</p>	F 791			

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F 791	<p>Continued From page 29</p> <p>medical expense under the State plan. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, resident and staff interview, it was determined the facility failed to provide dental services for 1 of 2 residents (Resident #7) reviewed for dental services. The deficient practice had the potential to harm residents if residents experienced pain or decay in teeth due to lack of care for dental needs. Findings include:</p> <p>The facility's Dental Services policy, dated 4/15/19, documented the facility was responsible for assisting residents in obtaining needed dental services, including routine dental services. On admission, the facility obtained the name of the resident's dentist and if none was provided, they selected a dentist to provide dental services as needed. The policy also documented arrangements were made promptly for routine and emergency dental services. This policy was not followed.</p> <p>Resident #7 was admitted to the facility on 11/8/19, with multiple diagnoses including diabetes mellitus.</p> <p>Resident #7's care plan, initiated on 11/8/19 and revised on 2/7/20, directed staff to assist him as needed to clean gums with toothpaste and report open areas or complaints of pain to the nurse.</p> <p>On 2/18/20 at 12:37 PM, Resident #7's mouth was observed and he said his teeth were corroded and he needed to see a dentist. He said there was food he could not eat with his teeth. Resident #7 said he told a staff person when he</p>	F 791	<p>Individual Residents: Resident #7 scheduled to see dentist on 3/17/2020</p> <p>Other Resident in Similar Situations: All Residents have the potential to be affected by this practice. Social Worker /Designee to review in resident council or 1:1 what to do if they would like a dental appointment and/or they have pain in mouth or difficulty chewing.</p> <p>Measure to Prevent Reoccurrence: SDC or designee to provide education to all staff on the Dental Services Policy, notifying nursing when residents request dental services or complain of mouth pain and the protocol for adding residents to the dentist list to be seen.</p> <p>Ongoing Monitoring: DON/Social Services or designee to interview residents for need for dental appointments. 5 residents a week x4 then monthly x 3 Findings of these audits will be reviewed through monthly QAPI x3 months for trends and additional education.</p> <p>Individual to Ensure Ongoing Compliance: DON/Social Services/Designee</p> <p>Compliance Date: 4-1-20</p>		

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F 791	Continued From page 30 was admitted about his corroded teeth. On 2/20/20 at 9:00 AM, the Social Worker said Resident #7 never said anything to her about his teeth. On 2/20/20 at 2:44 PM, CNA #2 said she thought Resident #7's teeth were so worn down that the roots to the teeth were dead. CNA #2 said she asked him if they hurt and he told her they did not hurt. On 2/20/20 at 3:20 PM, LPN #1 said she knew Resident #7 had terrible teeth and that was why he ate a lot of soft food. She said she did not think he saw a dentist since being admitted to the facility. On 2/20/20 at 3:30 PM, the Medical Records representative said Resident #7's name was never placed on the dentist's list. On 2/20/20 at 3:57 PM, the IDON said Resident #7 never complained until the previous day when he ate a burger and fries that bothered his teeth.	F 791			
F 880 SS=F	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.	F 880		4/1/20	

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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	<p>Continued From page 31</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct</p>	F 880			

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F 880	<p>Continued From page 32</p> <p>contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on review of facility documents, policy review, and staff interview, it was determined the facility failed to ensure the Infection Control policies and Infection Control Surveillance plan were reviewed annually by the Infection Control Committee, which had the potential to affect the 63 residents in the facility. This deficient practice had the potential of placing residents and staff at risk for infectious diseases. Findings include:</p> <p>The facility's Infection Control Plan, revised 3/2017, documented the Infection Control Surveillance Plan was reviewed at least annually and whenever significant changes occurred.</p> <p>The facility's Infection Control Policy Manual was reviewed. An Annual Review sheet located in the front of the manual was not dated or signed, it was left blank.</p>	F 880	<p>Individual Residents: Infection control manual reviewed and signed on 3-10-20. Other Resident in Similar Situations: All residents have the potential to be affected.</p> <p>Measure to Prevent Reoccurrence: Regional staff to provide education to IDT team on reviewing the infection control manual annually</p> <p>Ongoing Monitoring: ED or designee to add to QAPI Calendar for monthly review as a reminder for annual signature.</p>		

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F 880	Continued From page 33 On 2/20/20 at 4:00 PM and on 2/21/20 at 10:16 AM, the ICP said the annual review sheet was not signed. The ICP said the Quality Assessment and Assurance (QAA) meeting minutes should have also documented when the Infection Control policies were reviewed and they were not. On 2/21/20 at 12:56 PM, the RDCS said the QAA minutes lacked documented evidence the Infection Control Policies and Plan were reviewed annually.	F 880	Individual to Ensure Ongoing Compliance: ED/SDC Compliance Date: 4-1-20		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 883		4/1/20	

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F 883	<p>Continued From page 34</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure consent, education of side effects, and risks for receiving an influenza vaccine were obtained before the vaccine was administered for 1 of 5 residents (Resident #8) reviewed for</p>	F 883	<p>Individual Residents: Resident #8 gave verbal consent prior to being given influenza vaccine.</p> <p>Other Resident in Similar Situations: All Residents have the potential to be</p>		

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F 883	<p>Continued From page 35</p> <p>influenza immunizations. This deficient practice had the potential for harm if medication side effects and risks if the medication was administered without the resident and/or resident's representative being informed. Findings include:</p> <p>The facility's Influenza Vaccine policy, dated 3/2017, documented the facility must ensure that before offering the influenza immunization each resident or resident representative received education regarding the benefits and potential side effects of the immunization. This policy was not followed.</p> <p>Resident #8 was readmitted to the facility on 2/26/18, with multiple diagnoses including chronic kidney disease.</p> <p>Resident #8's physician's standing orders upon admission for all residents documented "... the resident may receive the flu vaccine."</p> <p>Resident #8's October 2019 MAR documented Afluria Quadrivalent suspension for flu vaccine for prophylaxis. The medication was administered on 10/10/19.</p> <p>Resident #8's Informed Consent for Influenza Vaccination documented the consent was signed on 10/11/19 (after the vaccine was administered).</p> <p>On 2/21/20, the ICP said the influenza vaccination for Resident #8 was administered on 10/10/19 and the consent documenting the side effects and risks of the vaccine was signed after he received it on 10/11/19. The ICP said the consent should have been signed before the</p>	F 883	<p>affected by this practice.</p> <p>Measure to Prevent Reoccurrence: SDC or designee to educate Licensed Nurses on the Influenza vaccine policy.</p> <p>Ongoing Monitoring: DON or designee to Audit 5 resident charts a week to ensure that consents have been signed prior to giving vaccine weekly x4 then monthly x 3 Findings of these audits will be reviewed through monthly QAPI x3 months for trends and additional education.</p> <p>Individual to Ensure Ongoing Compliance: SDC/DON</p> <p>Compliance Date: 4-1-20</p>		

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F 883	Continued From page 36 vaccine was administered.	F 883			