

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

PRINTED: 03/20/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/12/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF POST FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	<p>INITIAL COMMENTS</p> <p>On March 11, 2019 through March 12, 2019, an onsite revisit and complaint investigation survey was conducted to verify correction of deficiencies noted during the survey December 14, 2018. Life Care Center of Post Falls it was found to be in substantial compliance with federal health care regulations as of January 23, 2109.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Wendi Gonzales, RN Presie Billington, RN</p>	{F 000}			

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

TITLE

(X6) DATE

Electronically Signed

03/18/2019

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.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001415	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/12/2019
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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/18/19
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F 000	<p>INITIAL COMMENTS</p> <p>On March 11, 2019 through March 12, 2019, an onsite revisit survey and complaint investigation was conducted.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Wendi Gonzales, RN Presie C. Billington, RN</p>	F 000			

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

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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

June 24, 2019

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

Provider #: 135135

Dear Mr. Kautz:

On **March 12, 2019**, an unannounced on-site complaint survey was conducted at Life Care Center of Post Falls. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00008013

ALLEGATION #1:

A resident did not receive assistance with a meal and there were no cutlery and beverages on the resident's tray.

FINDINGS #1:

An unannounced complaint survey was completed in conjunction with the facility's follow-up survey on March 11, 2019 through March 12, 2019.

During the investigation, ten residents were observed for quality of care issues. Dinner meals were observed. The records of twelve residents, including two closed records, were reviewed. The facility's Incident and Accident reports and grievance files were also reviewed. Eight residents and several staff, including the Director of Nursing, were interviewed regarding various

issues.

One resident was observed being assisted by a CNA (Certified Nursing Assistant) to sit at the edge of her bed. The CNA was observed to set-up the resident's meal on the over-bed table and place the table within the resident's reach. The cutlery was observed on the tray. The resident was able to feed herself. After the resident finished her meal, she said she did not have any concerns with the staff. The resident said she was always assisted with meals and with all her activities of daily living.

Another resident was observed being assisted to eat in his room and there was no concern noted. Two other residents were in their room and their meals were set-up for them by a staff member. There were no concerns noted.

Eight residents were interviewed and said they were assisted in their activities of daily living.

The facility's grievance file was reviewed. No concerns were documented related to residents not receiving assistance during meals.

CONCLUSIONS:

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

ALLEGATION #2:

A resident was admitted with pressure ulcers and developed new wounds while in the facility.

FINDINGS #2:

The records of seven residents were reviewed. An observation regarding wound care was done and a resident interview was conducted.

One resident's hospital record documented he was admitted to the hospital with bilateral (both sides) diabetic foot ulcers and was treated for severe sepsis (infection in the blood). The hospital record documented the resident would likely require a below the knee amputation and dialysis. However, the resident was not interested in surgery or dialysis and he desired conservative treatment. He was discharged from the hospital and was admitted to the facility in October of 2018, with diagnoses of congestive heart failure, with chronic advanced kidney damage, osteomyelitis (infection of the bone), chronic obstructive pulmonary disease, and diabetes mellitus.

The resident's record documented he was discharged from his physical and occupational therapy (PT/OT) services due to his refusal to participate. The resident's wound record documented he was admitted to the facility with bilateral heel ulcers. The treatment administration record (TAR) documented wound treatment was provided to the resident as ordered. The record documented the resident preferred to sleep in his recliner and was educated several times to elevate his legs, but the resident was often found with his heels directly on the floor. The record included documentation of his refusals to elevate his legs and not allowing the staff to put a pillow or padding under his legs resting against the recliner footrest. The record documented the resident said, "I know I shouldn't have them on the ground like that but that's how I sit." The record documented his physician was notified when the facility noted his bilateral heel ulcers worsened and the physician resumed his antibiotic. The wound record also documented the resident had a reddened area on the left side of his stomach with the skin shedding and he had incontinence dermatitis. The resident's nursing notes documented the he had a tendency to lean on the left side of his recliner. The nursing notes also documented the Resident's refusal to be repositioned.

The records of six other residents with wounds were reviewed. No concerns were identified.

One resident was observed during wound treatment, and the resident did not have a concern. The resident said she was unable to reposition herself, but the staff were repositioning her at least 4-5 times a day. Another resident was observed during a wound dressing change by staff and no concern was noted.

CONCLUSIONS:

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

ALLEGATION #3:

A resident was not provided with pericare.

FINDINGS #3:

The records of twelve residents, including two closed records, were reviewed. Facility grievance files were also reviewed. Observations were conducted, including observations of staff providing peri-care to residents. Residents were also interviewed.

During a tour of the facility no foul odors were noted. Residents' rooms were observed and there were no unpleasant smells noted.

The facility's grievance files were reviewed and there were no concerns related to staff not

Peter Kautz, Administrator
June 24, 2019
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providing peri-care for residents.

Two residents who were incontinent said they were provided with peri-care as needed. Staff were observed providing incontinence care to residents and changing incontinence briefs as necessary.

CONCLUSIONS:

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,



LAURA THOMPSON, RN, Supervisor
Long Term Care Program

LT/slj



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Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

July 9, 2019

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

Provider #: 135135

Dear Mr. Kautz:

On **March 11, 2019** through **March 12, 2019**, an unannounced on-site complaint survey was conducted at Life Care Center of Post Falls. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008012

ALLEGATION #1:

The facility was not providing appropriate wound care.

FINDINGS #1:

During the investigation, residents were observed, staff and residents were interviewed, and records were reviewed.

Two nurses and the Director of Nursing were observed providing wound care to two residents. There were no concerns for wound and skin care during the observation and the pressure ulcers appeared to have been improving.

Peter Kautz, Administrator
July 9, 2019
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Four residents' records were reviewed, including two closed resident records for wound management and there were no concerns with the documentation.

One resident was admitted to the facility in June 2018 and developed a stasis ulcer to her right calf on 12/30/18. The resident's record documented the resident was receiving wound care management and was having other medical concerns that caused the wound to increase in size.

It could not be established that the facility failed to provide wound care management to the resident. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj