



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
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June 7, 2019

Briar Rose Fenn, Administrator
Life Care Center of Idaho Falls
2725 East 17th Street
Idaho Falls, ID 83406-6601

Provider #: 135091

Dear Ms. Fenn:

On **May 24, 2019**, a survey was conducted at Life Care Center Of Idaho Falls by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern 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.

Briar Rose Fenn, Administrator
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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 **June 17, 2019**. Failure to submit an acceptable PoC by **June 17, 2019**, may result in the imposition of penalties by **July 10, 2019**.

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

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

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

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

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

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 **June 28, 2019 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **August 24, 2019**. A change in the seriousness of the deficiencies on **July 8, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by

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August 24, 2019 includes the following:

Denial of payment for new admissions effective **August 24, 2019**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 24, 2019**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **August 24, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

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- 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 **June 17, 2019**. If your request for informal dispute resolution is received after **June 17, 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 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: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/24/2019
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF IDAHO FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 2725 EAST 17TH STREET IDAHO FALLS, ID 83406
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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
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from May 20, 2019 through May 24, 2019.</p> <p>The surveyors conducting the survey were: Edith Cecil, RN, Team Coordinator Presie Billington, RN Karen Gray, RD</p> <p>Survey Abbreviations:</p> <p>CDM = Certified Dietary Manager CNA = Certified Nursing Assistant DM = Director of Maintenance DON = Director of Nursing F = fahrenheit GM = grams MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = milligrams mls = milliliters</p>	F 000		
F 550 SS=D	<p>Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's</p>	F 550		6/27/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 06/12/2019
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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 550	<p>Continued From page 1</p> <p>individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to maintain or enhance residents' dignity during dining when residents seated at the same table were served their meals at different times. This was true for 1 of 18 residents (#57) observed dining in the facility. This failure had the potential to cause a decrease in residents' sense of self-worth and psycho-social well-being. Findings include:</p>	F 550	<p>Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts or conclusions set forth in the statement of deficiencies.</p> <p>Specific Resident: Resident #57 will receive his/her tray by staff member(s) utilizing consecutive serving process as</p>		

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F 550	<p>Continued From page 2</p> <p>On 5/20/19 at 5:51 PM, Resident #57 was seated at a table in the main dining room with a male resident and a female resident.</p> <p>On 5/20/19 at 5:55 PM, two meal trays were brought to Resident #57's table. The trays were for the male and female residents. The Housekeeping Director sat next to the male resident and assisted the male resident with his meal. Another staff sat next to the female resident and assisted her with her meal. Resident #57 did not receive her meal.</p> <p>On 5/20/19 at 5:59 PM, the male resident asked the Housekeeping Director why Resident #57 had not received her meal. The Housekeeping Director said Resident #57's tray would arrive soon.</p> <p>On 5/20/19 at 6:01 PM, the Housekeeping Director asked another staff to check on the food of Resident #57 and the Housekeeping Director was told it would be served in a minute.</p> <p>On 5/20/19 at 6:07 PM, Resident #57's meal tray arrived at the table. Resident #57 received her meal 12 minutes (5:55 PM - 6:07 PM) after her tablemates received their meals.</p> <p>On 5/20/19 at 6:27 PM, the CDM said they usually served meals to all residents at a table at the same time so they could all eat together. The CDM said the CNAs asked the residents what they would like to eat as soon as they arrived in the dining room. The CDM stated they had been busy in the kitchen and Resident #57's meal ticket might have been mixed with other meal</p>	F 550	<p>his/her tablemates during dining services.</p> <p>Other Residents: Facility residents who attend meals in the dining room(s) will have trays served with consecutive serving process as their tablemates.</p> <p>Systemic Changes: 1) Facility audit completed to determine serving is consecutive with residents dining at the same table to ensure tablemates are served during the same period. 2) Consecutive serving process to begin with the first resident seated at the table and will continue until the last resident seated at the table is served prior to server obtaining meals for another table. 3) Tablemates will have obtained their trays prior to staff providing assistance. 4) Training/Education conducted with staff members who participate in the dining service on dignity/serving guidelines to include consecutive meal delivery to minimize potential of decreasing residents' feelings of self-worth and psychosocial well-being with extended waiting period different from their tablemates.</p> <p>Monitoring: Dining room meal supervisor and/or designee to audit dining rooms for compliance with consecutive serving process for residents dining at the same table. Audits to be completed 3x weekly for 4 weeks followed by 2x weekly for 4 weeks followed by weekly for 4 weeks.</p> <p>Results of monitoring will be reviewed at</p>		

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F 550	Continued From page 3 tickets.	F 550	QAPI for trending, ongoing education and compliance.	6/27/19	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, it was determined the facility failed to ensure residents' preferences for bathing	F 561			
			Specific Resident(s): 1) Resident #50 has discharged from the facility. 2) Resident #122 interviewed to establish		

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F 561	<p>Continued From page 4</p> <p>schedules were honored. This was true for 2 of 10 residents (#50 and #122) reviewed for choices. This deficient practice had the potential for residents to experience a decreased sense of wellbeing, lack of self-worth, and frustration when their preferences for bathing were not accommodated. Findings include:</p> <p>Residents were not provided baths/showers consistent with their preferences, as follows:</p> <p>a. Resident #50 was admitted to the facility on 4/19/19 for skilled therapy services following a cerebrovascular accident (stroke) with left side hemiplegia (paralysis on one side of the body).</p> <p>A 30-day MDS assessment, dated 5/17/19, documented Resident #50 was cognitively intact and able to make daily decisions. Resident #50 required extensive assistance of one person for dressing, toilet use, transfers, and personal hygiene. She required physical assistance with bathing.</p> <p>On 5/20/19 at 1:56 PM, Resident #50 stated showers were only given twice a week and residents could not get a shower on another day, even if a resident felt a shower was needed. Resident #50 said if she asked for a shower on another day the CNAs told her it was not her shower day and she could not have one. Resident #50 stated she had a problem with diarrhea and the CNAs cleaned her with wipes. Resident #50 said she did not feel the CNAs got her clean and they would not give her a shower.</p> <p>The shower schedule for Resident #50 directed staff to provide her showers on Saturdays</p>	F 561	<p>specific preferences for bathing/showering schedule. Facility will honor preferences established.</p> <p>Other Residents: Facility residents that require bathing/showering assistance will have bathing/showering preferences established and honored by the facility.</p> <p>Systemic Changes: 1) Facility wide audit completed to determine resident specific preferences for showering/bathing schedule. 2) Residents' bathing/showering preferences ongoing will be established in the 48 hour care planning process when admitted to the facility. 3) Resident preferences to be accurately reflected on facility's working tool (shower schedule listing). 4) Resident variation requests, from the established preferences related to bathing/showering, will be accommodated as needed. 5) Direct care staff, Certified Nursing Assistants (CNA) and Licensed Nursing Staff (LN), provided training/education related to residents' preferences for bathing/showering including variation requests to be honored upon request to minimize potential for residents to experience a decreased sense of wellbeing, lack of self-worth and frustration when preferences are not accommodated.</p> <p>Monitoring: Director of Nursing (DON) and/or designee to audit 20% of facility residents to monitor facility honoring residents' preferences for</p>		

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F 561	<p>Continued From page 5</p> <p>between 6:00 AM and 2:00 PM on the day shift and on Tuesdays from 2:00 PM to 10:00 PM on the evening shift. The showers were scheduled by room numbers on Hall 1. The schedule stated, "Do not change shower days without talking to hall manager first."</p> <p>b. Resident #122 was admitted to the facility on 5/8/19 for skilled therapy services following a fall at home with fractures to the left femur (thigh bone), and shaft of humerus (long bone in the upper arm) left arm.</p> <p>A 5-day MDS assessment, dated 5/15/19, documented Resident #122 was cognitively intact and able to make daily decisions. Resident #122 required extensive assistance of one person for dressing, toilet use, transfers, and personal hygiene. She required physical help in part of bathing.</p> <p>On 5/21/19 at 11:55 AM, Resident #122 stated she did not have choices about showers. She stated the facility scheduled them. Resident #122 said on Sunday morning she wanted a shower before she went to church. She said she told the CNA she would not get dressed, that she wanted to take a shower. Resident #122 said the CNA told her repeatedly that it was not her shower day and the CNA got harsher every time she said it. Resident #122 said she told the CNA "I am taking a shower!" and the CNA finally took her to the shower.</p> <p>The shower schedule for Resident #122 directed staff to provide a shower on Tuesdays between 6:00 AM and 2:00 PM on the day shift and on Fridays between 2:00 PM and 10:00 PM on the</p>	F 561	<p>bathing/showering. Monitoring to be conducted 3x weekly for 4 weeks followed by 2x weekly for 4 weeks and then weekly for 4 weeks.</p> <p>Results of monitoring will be reviewed at QAPI for trending, ongoing education and compliance.</p>		

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F 561	Continued From page 6 evening shift.	F 561			
F 584 SS=E	<p>On 5/23/19 at 3:00 PM, the Regional Director of Clinical Services (RDCS), with the Administrator present, stated the facility did not have a specific policy related to resident choice. The Administrator and RDCS confirmed the facility had set schedules for showers on all four halls.</p> <p>Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)</p> <p>§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.</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</p>	F 584		6/27/19	

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F 584	<p>Continued From page 7</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, review of the Maintenance Log Book, and resident and staff interview, it was determined the facility failed to ensure comfortable water temperatures were maintained for residents during showers. This was true for 4 of 10 residents (#33, #34, #50, and #67) reviewed for a comfortable environment, and had the potential to adversely affect all residents that utilized the showers on 2 of 4 halls (Hall 1 and Hall 2). This created the potential for residents to avoid showers and/or negatively impact their sense of self-worth due a loss of control over their environment. Findings include:</p> <p>On 5/20/19 at 1:56 PM, Resident #50 stated the water temperatures in the Hall 1 shower room fluctuated. "Sometimes you get a blast of hot water then a blast of freezing water."</p> <p>On 5/21/19 at 2:50 PM, Resident #33 stated she preferred a nice warm shower, but sometimes the water was not very warm, it fluctuated during showers. Resident #33 resided on Hall 1.</p>	F 584	<p>Specific Resident(s): 1) Resident #50 has been discharged from the facility. 2) Residents #33, #34, #67 interviewed to establish comfortable water temperatures to maintain during showers.</p> <p>Other Residents: Facility residents utilizing the shower rooms on Hall 1/Hall 2 will have comfortable water temperatures maintained during showers to the highest extent possible. Fluctuation in water temperatures will remain within regulated range throughout the shower and facility staff providing assistance will alter the water temperature for comfort per resident specific preferences.</p> <p>Systemic Changes: 1) Facility audit completed for residents on Hall 1/Hall 2 to establish comfortable water temperatures during showers. 2) Facility replaced 2 water heaters, in the affected areas, to minimize potential for avoidable water fluctuations. 3) Education provided to</p>		

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F 584	<p>Continued From page 8</p> <p>On 5/24/19 at 10:25 AM, Resident #34, who resided on Hall 2, stated the water temperature in the shower was up and down. He stated he liked hot showers and showers at the facility, "are not comfortable".</p> <p>On 5/24/19 at 10:27 AM, Resident #67, who resided on Hall 2, stated, "Sometimes the water is comfortable in the shower, but most of the time the temperature fluctuates."</p> <p>On 5/22/19 at 8:45 AM, the hot water temperature in the Hall 1 shower room measured 116.2 degrees Fahrenheit (F).</p> <p>On 5/23/19 at 10:00 AM, the Maintenance Director (MD) checked the hot water temperature of the Hall 1 shower. After letting the hot water run for approximately four minutes, the temperature measured 107.6 degrees F. He stated, "Even though the temperatures are in the proper temperature ranges, we cannot maintain a consistent water temperature. When the supply of hot water runs low it gets too cool. Our water heaters cannot keep up with the demand. We had regulators installed, but it has not helped."</p> <p>The Maintenance Log Book included documentation on 1/24/19 and 4/25/19, stating the water heaters on Hall 1 and Hall 2 needed to be replaced.</p>	F 584	<p>maintenance staff concerning follow up with identified concerns for resolution; including water temperature variations detected and documented in the facility's monitoring log book. 4) Direct care staff providing showers will alter the water temperature during shower if the resident voices concern(s) with uncomfortable temperatures. 5) CNA and LN staff education/training provided on what to do to ensure comfortable water temperatures are maintained, changing the water temperature when a resident voices concerns, and reporting fluctuations to facility maintenance staff to minimize potential for residents to avoid showers and/or negatively impact their sense of self-worth due to a loss over their environment.</p> <p>Monitoring: Director of Nursing (DON) and/or designee to audit 20% of the resident population on Hall 1/Hall 2 for water temperature comfort while receiving shower(s). Monitoring will be conducted 3x weekly for 4 weeks followed by 2x weekly for 4 weeks followed by weekly for 4 weeks.</p> <p>Results of monitoring will be reviewed at QAPI for trending, ongoing education and compliance.</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</p>	F 656		6/27/19	

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F 656	Continued From page 9 care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced	F 656			

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F 656	<p>Continued From page 10</p> <p>by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure comprehensive resident-centered care plans included the use of oxygen and the bathing needs of the resident. This was true for 1 of 18 (#29) residents whose comprehensive care plans were reviewed. This deficient practice created the potential for Resident #29 to receive inadequate or inappropriate care due to missing information in his care plan. Findings include:</p> <p>Resident #29 was admitted to the facility on 4/2/19 with multiple diagnoses including diabetes mellitus, peripheral neuropathy, muscle weakness, and difficulty walking.</p> <p>An admission MDS assessment, dated 4/9/19, documented Resident #29 was cognitively intact and required extensive assistance from one person for most activities of daily living (ADLs). Resident #29's care plan did not address his oxygen and bathing needs, as follows:</p> <p>a. A physician's order dated 5/19/19, directed staff to titrate Resident #29's oxygen flow rate to four liters via nasal cannula to keep his oxygen saturation level greater than 90%, and to check his oxygen saturation twice per shift, and as needed, for signs and symptoms of respiratory distress.</p> <p>Resident #29's care plan did not document his use of oxygen or monitoring his oxygen saturation levels.</p> <p>On 5/20/19 at 12:58 PM and 5:20 PM, 5/21/19 at 11:01 AM and 6:12 PM, Resident #29 was</p>	F 656	<p>Specific Resident: Resident #29's plan of care updated to accurately reflect supplemental oxygen administration need(s) and bathing need(s).</p> <p>Other Residents: 1) Facility residents requiring administration of supplemental oxygen will have need(s) accurately reflected in his/her care plan. 2) Facility residents will have bathing need(s) accurately reflected in his/her care plan.</p> <p>Systemic Changes: 1) Facility wide audit completed to established residents have bathing need(s) accurately reflected in their plan of care. 2) Facility audit completed for residents requiring administration of Medical Doctor (MD) ordered supplemental oxygen to establish accurate reflection in their plan of care. 3) Residents bathing and/or supplemental oxygen need(s) will be reflected on residents' individualized comprehensive plan of care. 4) Plan of care development for administration of supplemental oxygen need(s) will include but not limited to the following: reason for oxygen use, MD direction for monitoring oxygen saturation and specific MD order(s). 5) Plan of care development for bathing need(s) will include but not limited to the following: frequency, number of staff needed to assist and any special instruction for staff members. 6) Education provided to LN staff on accurate reflection of resident need(s) related to bathing/supplemental</p>		

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F 656	Continued From page 11 observed in bed sleeping, receiving oxygen by nasal cannula. On 5/22/19 at 9:57 AM, LPN #1 said Resident #29's care plan did not address his use of oxygen. b. Resident #29's care plan did not address his bathing needs, such as the frequency of his baths/showers, the number of staff needed to safely assist him with baths/showers, and any special instructions for staff. On 5/22/19 at 10:16 AM, LPN #1 said Resident #29 was scheduled to have his shower/bath two times a week on Sundays and Wednesdays. On 5/23/19 at 5:19 PM, the Administrator said Resident #29's care plan did not include his bathing needs.	F 656	oxygen use on resident's plan of care to minimize potential to receive inadequate or inappropriate care due to missing information on his/her care plan. Monitoring: 1) Resident Care Manager and/or designee to audit residents receiving supplemental oxygen for accurate reflection of need(s) in his/her care plan 3x weekly for 4 weeks followed by 2x weekly for 4 weeks followed by weekly for 4 weeks. 2) Resident Care Manager and/or designee to audit 20% of resident population for accurate reflection of bathing need(s) in care plan 3x weekly for 4 weeks followed by 2x weekly for 4 weeks followed by weekly for 4 weeks. Results of monitoring will be reviewed at QAPI for trending, ongoing education and compliance.		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents received bathing assistance consistent with their needs. This was true for 1 of 2 (#29) residents reviewed for bathing. This failure created the potential for residents to experience embarrassment, isolation, and decreased sense of self-worth, due to a lack of cleanliness.	F 677	Specific Resident: Resident #29 will receive bathing assistance consistent with his/her need(s). Any refusals of bathing/bathing assistance will be reflected in his/her clinical record. Other Residents: Facility residents requiring bathing assistance will receive	6/27/19	

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F 677	<p>Continued From page 12</p> <p>Findings include:</p> <p>Resident #29 was admitted to the facility on 4/2/19 with multiple diagnoses, including diabetes mellitus, muscle weakness and difficulty in walking.</p> <p>An admission MDS assessment, dated 4/9/19, documented he was cognitively intact and he required extensive assistance from one person for most activities of daily living.</p> <p>Resident #29's April 2019 bathing/shower flowsheet documented he received a shower/bath on 4/3/19, 4/5/19, 4/18/19, and 4/22/19. A Nursing Note, dated 4/4/19 at 6:51 PM, documented Resident #29 refused his shower/bath. Resident #29's record did not include documentation to explain the reason(s) he did not receive additional showers/baths in April.</p> <p>Resident #29 did not receive a shower/bath between 4/6/19 and 4/17/19, 12 days, and he did not receive a shower between 4/23/19 and 4/28/19, 6 days.</p> <p>On 5/22/19 at 10:16 AM, LPN #1 said Resident #29 was scheduled to have his shower/bath two times a week on Sundays and Wednesdays. LPN #1 said she was not sure why Resident #29 did not consistently receive showers/baths on his scheduled shower/bath days in April.</p> <p>On 5/22/19 at 10:52 AM, CNA #1 said the CNAs provided bath/showers to residents. CNA #1 said when a resident refused a shower/bath, he would approach the resident at least two times, and if</p>	F 677	<p>bathing/bathing assistance consistent with his/her individualized need(s). Any refusals of bathing/bathing assistance will be reflected in his/her clinical record.</p> <p>Systemic Changes: 1) Facility wide audit completed to insure current residents are receiving bathing/bathing assistance consistent with their individualized need(s). 2) Bathing/bathing assistance to be completed and accurately documented in the residents' clinical record. Variation(s) in receiving bathing/bathing assistance which may include, but not limited to, resident refusal and/or out of the facility, etc. will be acutely documented to explain the reason(s) he/she did not receive additional shower/baths. 3) CNA/LN staff provided education/training in regards to providing bathing/bathing assistance consistent with residents' individualized need(s) with accurate reflection in the documentation, including documenting variation(s), to minimize potential for residents to experience embarrassment, isolation, and decreased sense of self-worth, due to lack of cleanliness.</p> <p>Monitoring: Resident Care Manager and/or designee to audit 20% of resident population to insure residents are receiving bathing/bathing assistance consistent with his/her need(s) 3x weekly for 4 weeks followed by 2x weekly for 4 weeks followed by weekly for 4 weeks.</p> <p>Results of monitoring will be reviewed at</p>		

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F 677	Continued From page 13 the resident continued to refuse he would report the refusal to the nurse. On 5/23/19 at 5:19 PM, the RDCS said she did not find documentation to explain the reason Resident #29 did not consistently receive a shower/bath on his scheduled shower/bath days in April.	F 677	QAPI for trending, ongoing education and compliance.		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure professional standards of practice were followed for medication administration. This was true for 3 of 9 residents (#29, #36, and #37) reviewed for bowel care. This failed practice created the potential for residents to experience complications related to constipation. Findings include: 1. Resident #36 was readmitted to the facility on 9/5/18 with multiple diagnoses which included morbid obesity and constipation. A quarterly MDS, dated 4/15/19, documented Resident #36 was cognitively intact and required	F 684	Specific Resident(s): 1) Resident #37 has discharged from the facility. 2) Residents, #29 and #36, current plan of treatment, related to constipation, reviewed for appropriateness with required alterations per Medical Doctor (MD) order if relevant to minimize possible potential complications related to constipation. Other Residents: Facility residents with a diagnosis of constipation will have MD bowel management orders followed to insure standards of practice are completed for medication administration to minimize potential complications	6/27/19	

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F 684	<p>Continued From page 14 extensive one person assistance for toileting.</p> <p>Resident #36's physician orders, dated 1/12/19, included the following:</p> <ul style="list-style-type: none"> * Senna tablet 8.6 milligrams (mg), two tablets by mouth daily as needed for constipation-no bowel movement for 3 days. * Bisacodyl suppository, insert 10 mg rectally as needed for no bowel movement on day 4. If no results, see Fleet enema order. * Fleet enema, 7-19 grams (gm)/118 milliliters (mls) insert one application rectally as needed for constipation if there are no results within 2 hours of suppository administration. <p>Resident #36's MARs from 5/1/19 to 5/22/19, did not include documentation bowel care medications were provided as ordered by the MD, as follows:</p> <ul style="list-style-type: none"> * From 5/16/19 through 5/21/19, Resident #36 did not have a bowel movement (6 days). Resident #36's MAR did not include documentation the Senna tablets, Bisacodyl suppository, and if necessary, Fleets enema were administered. <p>On 5/23/19 at 1:54 PM, LPN #3 stated residents should have a bowel movement at least every 3 days. She stated bowel movements were recorded on the computer and were checked every morning. If a resident did not have a bowel movement for 3 days, they received 2 Senna. If they did not have a bowel movement for 4 days, they received a suppository. If that was not</p>	F 684	<p>related to constipation.</p> <p>Systemic Changes: 1) Facility audit completed for residents with an active diagnosis of constipation to establish standards of practice are followed specific to medication administration for MD ordered bowel protocol. 2) LN staff provided training/education on professional standards of practice are followed for medication administration per MD orders specific to bowel management to minimize potential for residents to experience complications related to constipation. 3) LN staff instructed to review facility's bowel tracking documentation with the on-coming LN to confirm compliance achieved with the administration of MD bowel protocol orders. 4) Accurate documentation will be present in the resident's clinical record for reflection that MD orders for bowl management administered in accordance with professional standards of practice.</p> <p>Monitoring: Resident Care Manager and/or designee to audit documentation of facility residents with an active diagnosis of constipation to insure standards of practice are followed for medication administration related to bowel management protocol 3x weekly for 4 weeks followed by 2x weekly for 4 weeks followed by weekly for 4 weeks.</p> <p>Results of monitoring will be reviewed at QAPI for trending, ongoing education and compliance.</p>		

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F 684	<p>Continued From page 15 effective, they received an enema. LPN #3 stated the physician orders were not followed for Resident #36.</p> <p>2. Resident #37 was admitted to the facility on 4/2/18 with multiple diagnoses which included vascular dementia and constipation.</p> <p>A significant change in status assessment MDS, dated 4/15/19, documented Resident #37 was cognitively intact and required extensive assistance of two people for toileting.</p> <p>Resident #37's physician orders, dated 1/12/19, included the following:</p> <ul style="list-style-type: none"> * Bisacodyl suppository, insert 10 mg rectally as needed for no bowel movement on day 4. If no results, see Fleet enema order. * Fleet enema, 7-19 gm/118 mls, insert one application rectally as needed for constipation if there are no results within 2 hours of the suppository administration. <p>Resident #37's physician's order, dated 3/19/19, directed staff to provide Senna tablet 8.6-50 mg, two tablets by mouth one time a day for constipation.</p> <p>Resident #37's MAR from 5/1/19 to 5/22/19, did not include documentation bowel care medications were provided as ordered by the MD, as follows:</p> <ul style="list-style-type: none"> * From 5/8/19 through 5/12/19, Resident #37 did not have a bowel movement (5 days). Resident #37's MAR did not include documentation the 	F 684			

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F 684	<p>Continued From page 16</p> <p>Bisacodyl suppository, and if necessary, the Fleets enema, were administered.</p> <p>On 5/23/19 at 1:54 PM, LPN #3 stated the physician orders were not followed for Resident #37.</p> <p>On 5/24/19 at 10:45 AM, the Administrator stated staff were to document bowel movements in the resident's electronic medical record daily. Physician orders were to be initiated when needed.</p> <p>3. Resident #29 was admitted to the facility on 4/2/19 with multiple diagnoses, including diabetes mellitus, muscle weakness and difficulty walking.</p> <p>An admission MDS assessment, dated 4/9/19, documented Resident #29 was cognitively intact and he required extensive assistance from one person for most activities of daily living.</p> <p>Resident #29's care plan documented he had bowel incontinence due to his medical condition and staff were directed to assist him with his toileting as needed and administer his medications as ordered by his physician.</p> <p>Resident #29's May 2019 physician's orders included:</p> <p>* Senna tablet 8.6 mg - give two tablets by mouth as needed for constipation if no bowel movement for 3 days.</p> <p>* Bisacodyl Suppository 10 mg - insert 10 mg rectally as needed for no bowel movement on</p>	F 684			

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F 684	Continued From page 17 day 4. If no results in 2 hours, see Fleet enema order. * Fleet Enema (Sodium Phosphate) 7-19 gm/18 ml - insert one application rectally as needed for constipation if no results within 2 hours of suppository administration. Resident #29's Bowel Movement Record, dated 4/23/19 through 5/22/19, documented he did not have a bowel movement for 5 days, from 5/8/19 through 5/12/19. Resident #29's May 2019 MAR, did not document that he received the Senna tablets, Bisacodyl suppository, and if needed, the Fleets enema during the days he was constipated. On 5/22/19 at 10:08 AM, LPN #1 said Resident #29 should have been given two tablets of Senna when he did not have a bowel movement on the third day. LPN #2 said looking at the MAR the bowel protocol was not followed.	F 684			
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by:	F 806		6/27/19	

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F 806	<p>Continued From page 18</p> <p>Based on observation, record and policy review, and resident and staff interview, it was determined the facility failed to provide appropriate meal alternatives to 1 of 10 (Resident #50) residents reviewed for food preferences. This failure created the potential for harm if residents experienced hunger and/or weight loss for not having complete meals served. Findings include:</p> <p>Resident #50 was admitted to the facility on 4/19/19 for skilled therapy services following a cerebrovascular accident (stroke) with left side hemiplegia (paralysis on one side of the body).</p> <p>A 30-day Medicare assessment, dated 5/17/19, documented Resident #50 was cognitively intact, was able to make daily decisions, and was independent with eating.</p> <p>Resident #50's Food and Beverage Preference List, dated 4/19/19, stated that she disliked all juices, except V8 juice, and did not show other dislikes.</p> <p>On 5/20/19 at 2:10 PM, Resident #50 was asked about the food at the facility. She stated, "They serve a lot of things I wouldn't ever eat. I don't like juice of any kind except V8 juice. Breakfast is the hardest meal. They do tell you what is on the menu and they offer an alternative, which I have ordered a couple of times, and did not get it. They say they ran out. Thankfully, my daughters bring me lunch everyday and brought me some Boost to drink."</p> <p>On 5/23/19 at 8:45 AM, Resident #50 was observed in a recliner in her room with her</p>	F 806	<p>Specific Resident: Resident #50 has been discharged from the facility.</p> <p>Other Residents: Facility residents who choose not to eat food that is initially served, or who requests a different meal choice and/or have specific food preferences will receive appealing option(s) of similar nutritive value.</p> <p>Systemic Changes: 1) Facility residents' food preferences reviewed to establish specific preferences/request(s). Food Services Director reviewed alternatives, anytime menu availability and appealing options of similar nutritive value with identified resident(s) with documentation reflected in their clinical record for accurate reflection of accommodation(s) requests. 2) Resident specific accommodations will be listed on residents' dietary card and followed to the highest practicable possibility. If the facility is unable to accommodate, staff will offer an appealing option of similar nutritive value to encourage residents' intake. 3) Review of anytime menu completed to determine availability of listed options for resident choices for accuracy. 4) Education provided to dietary staff/direct care staff on accommodation of food specific preferences, offering appealing option(s) of similar nutritive value, anytime menu availability, and providing preferences listed on dietary card to minimize risk of experienced hunger and/or weight loss for not having complete meals served. 5)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/24/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF IDAHO FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 2725 EAST 17TH STREET IDAHO FALLS, ID 83406		
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F 806	<p>Continued From page 19</p> <p>breakfast tray in front of her. Resident #50 said she asked for a hard-boiled egg and she was given a hard-fried egg. Resident #50 demonstrated that it was rubbery and difficult to cut with a fork. The meal card on her tray had hand written on it "hard-boiled egg or over hard fried egg, and V8 juice." Resident #50 stated, she was not a big breakfast eater, but she could eat a hard boiled egg. Resident #50 was asked about the glass of V8 juice on her tray, and she said it was not V8, it was just tomato juice. The resident also stated, "I only wanted chicken noodle soup for dinner last night and they told me they were out of it."</p> <p>On 5/23/19 at 9:15 AM, the Administrator and the Regional Director of Clinical Services (RDCS) were asked if they had a policy regarding resident food preferences and choices. The RDCS provided a policy titled, "Dignity" with an effective date of 5/6/19, which stated, "Each resident has the right to be treated with dignity and respect. Interactions and activities with residents by staff, temporary agency staff, or volunteers must focus on maintaining and enhancing the resident's self-esteem, self-worth, and incorporating the resident's goals, preferences, and choices. Staff must respect the resident's individuality as well as, honor and value their input... 9. Considering the resident's life style and personal choices identified through their assessment processes to respect and accommodate his or her individual needs and preferences." The Administrator said she would find out why the the kitchen staff did not give Resident #50 the hard boiled egg she requested. The Administrator also said would find out if they were really out of chicken noodle soup.</p>	F 806	<p>Food services director will discuss facility available accommodations to specific requests/preferences, related to meal services, at the time of obtaining food preferences.</p> <p>Monitor: Facility Food Services Director and/or designee to audit 20% of facility residents that have specific preference(s)/request(s) to insure facility honors or that the resident receives appealing option(s) of similar nutritive value 3x weekly for 4 weeks followed by 2x weekly for 4 weeks followed by weekly for 4 weeks.</p> <p>Results of monitoring will be reviewed at QAPI for trending, ongoing education and compliance.</p>		

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

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F 806	Continued From page 20 On 5/23/19 at 10:30 AM, the Administrator stated, they were cooking some eggs for Resident #50, and they were not out of chicken noodle soup. The Administrator said she would investigate who told Resident #50 that they were out of chicken noodle soup.	F 806			