



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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October 24, 2019

Josh Smith, Administrator
Avamere Transitional Care & Rehab - Boise
1001 South Hilton Street
Boise, ID 83705-1925

Provider #: 135077

Dear Mr. Smith:

On **October 10, 2019**, a survey was conducted at Avamere Transitional Care & Rehab - 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 an isolated 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.

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 **November 4, 2019**. Failure to submit an acceptable PoC by **November 4, 2019**, may result in the imposition of penalties by **November 26, 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 **November 14, 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 **January 10, 2020**. A change in the seriousness of the deficiencies on **November 24, 2019**, may

Josh Smith, Administrator
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result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 10, 2020** includes the following:

Denial of payment for new admissions effective **January 10, 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 **April 10, 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 **January 10, 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:

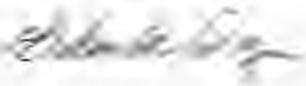
- BFS Letters (06/30/11)

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

This request must be received by **November 4, 2019**. If your request for informal dispute resolution is received after **November 4, 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/dr

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

PRINTED: 11/19/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/10/2019
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during a complaint survey conducted at the facility from 10/8/19 through 10/10/19. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Brad Perry, LSW Abbreviations: A-DON = Acting Director of Nursing DON = Director of Nursing MAR = Medication Administration Record mcg = microgram MDS = Minimum Data Set RCM = Resident Care Manager TAR = Treatment Administration Record	F 000			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure medications were given as ordered, laboratory tests were completed as ordered, and orders were obtained to discontinue an indwelling	F 684	1) Resident #1 no longer resides in facility. For resident #2, residents medical record will be reviewed and revised as needed to ensure thyroid medication and lab orders are care planed and followed	11/14/19	

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

TITLE

(X6) DATE

Electronically Signed

10/30/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 684	<p>Continued From page 1</p> <p>urinary catheter. This was true for 2 of 5 residents (#1 and #2) whose records were reviewed. These failures created the potential for residents to experience adverse outcomes if they did not receive ordered medications, medications were not adjusted if necessary, and urinary catheters were removed without physician authorization. Findings include:</p> <p>The facility's Medication Orders policy, dated April 2010, documented the physician's orders were to be reviewed for accuracy, completeness, and were to be followed.</p> <p>This policy was not followed.</p> <p>1. Resident #1 was admitted to the facility on 6/12/19, with multiple diagnoses including hypothyroidism (underactive thyroid gland).</p> <p>a. Resident #1's record included an order from the hospice physician, dated 6/13/19, which documented to discontinue all non-comfort medications.</p> <p>A hospice physician order, dated 6/27/19 at 10:20 AM, documented Resident #1 wanted her thyroid medication back. The order documented Levothyroxine (thyroid medication) 1 tablet of 0.3 milligrams (300 mcg) once a day. The note further documented "(Not Hospice Covered) Bubble pack please."</p> <p>A Nurse's Progress Note, dated 6/27/19 at 7:42 PM, documented the facility's pharmacist requested clarification of Resident #1's 300 mcg order of Levothyroxine due to the high dose.</p>	F 684	<p>per policy.</p> <p>2) All residents with catheters and thyroid related diagnoses have the potential to be affected by the deficient practice. All residents with catheters and thyroid related diagnoses will have medical records reviewed and care plans/orders revised as needed to ensure that catheters and thyroid diagnoses related medication/monitoring are managed per policy.</p> <p>3) 3) All LN staff to be in-serviced related to catheter care, charting requirements as related to catheter care, appropriate catheter diagnoses, MD order entry, order clarification and MD notification of change of condition/refusal of services requiring MD follow up policies.</p> <p>4) Catheter audit developed and implemented daily x5, weekly x4, monthlyx3 and quarterly x2 and brought to QAPI committee to review results and ensure sustained compliance. Thyroid medication audits developed and implemented daily x5, weekly x4, monthlyx3 and quarterly x2 and brought to QAPI committee to review results and ensure sustained compliance. Laboratory diagnostic testing audits developed and implemented daily x5, weekly x4, monthlyx3 and quarterly x2 and brought to QAPI committee to review results and ensure sustained compliance. DNS or designee to conduct audits.</p>		

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F 684	<p>Continued From page 2</p> <p>A hospice physician order, dated 6/28/19 at 2:53 PM, documented a medication clarification to discontinue the 300 mcg of Levothyroxine and to start 150 mcg of Levothyroxine 1 tablet once a day. The order further documented "(Not Hospice Covered) Bubble pack please." The order documented to fax the order to the hospice's pharmacy. The order was acknowledged and signed by two facility nurses with a handwritten note to not fax to the facility's pharmacy.</p> <p>A pharmacy receipt from the hospice's pharmacy, dated 6/27/19 at 7:34 PM, documented 60 doses of 150 mcg of Levothyroxine were delivered to the facility for Resident #1.</p> <p>A verbal phone order from the facility's pharmacy, dated 6/28/19 at 1:29 PM, documented per Resident #1's hospice provider, "Please discontinue order for Levothyroxine." The order was acknowledged and signed by two facility nurses on 6/30/19 and 7/1/19. The order did not document which dosage was to be discontinued.</p> <p>A Nurse's Progress Note, dated 6/30/19 at 2:04 PM, documented the facility received a communication from the pharmacy to discontinue Resident #1's Levothyroxine per the hospice provider.</p> <p>Resident #1's June 2019 MAR, documented Levothyroxine 150 mcg was started on 6/28/19 and discontinued on 6/30/19. The MAR documented Resident #1 received 150 mcg of Levothyroxine on 6/29/19 and 6/30/19. Resident #1's July 2019 and August 2019 MARs did not include the Levothyroxine, and she did not receive the medication.</p>	F 684			

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F 684	Continued From page 3 Resident #1's hospice recertification, dated 7/16/19, included a list of her current medications. The medication list included Levothyroxine 125 mcg daily, dated 6/28/19. The recertification did not document the medication was discontinued and the dose was inconsistent with her MAR which documented 150 mcg of Levothyroxine daily. A Nurse's Progress Note, dated 8/1/19, documented Resident #1 was discharged from hospice and was now followed by the facility physician. A physician progress note, dated 8/1/19, documented Resident #1 had hypothyroidism and the physician ordered laboratory tests to check her thyroid levels. On 10/9/19 at 11:45 AM, RCM #1 said Resident #1 did not receive her Levothyroxine in July and August 2019. RCM #1 said the Levothyroxine order was filled by the hospice pharmacy and not the facility pharmacy as it normally would be. She said according to the hospice recertification medication list, Resident #1 should have received 125 mcg of Levothyroxine daily beginning on 6/28/19. On 10/9/19 at 3:00 PM and 3:50 PM, the MDS Coordinator said Resident #1 did not receive her Levothyroxine in July or August. He said the Levothyroxine order was filled by the hospice pharmacy and the facility had the 150 mcg Levothyroxine in the facility during her stay. He said between the original order and the hospice recertification medication list, Resident #1 should	F 684			

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F 684	<p>Continued From page 4</p> <p>have been receiving 150 mcg of Levothyroxine and not 125 mcg. The MDS Coordinator said there was a lack of communication between the hospice, the facility, and the facility's pharmacy regarding the Levothyroxine medication order.</p> <p>On 10/10/19 at 8:15 AM, the DON said he expected Resident #1's Levothyroxine order to be clarified.</p> <p>The facility failed to recognize what dose of Levothyroxine was to be administered to Resident #1, clarify the order, communicate with the two pharmacies involved, and administer the Levothyroxine when the facility had the medication in the facility.</p> <p>b. Resident #1's hospice physician ordered an indwelling urinary catheter and catheter care every shift for terminal care, dated 6/13/19.</p> <p>Resident #1's record, documented she had the indwelling catheter in place from 6/13/19 to 7/30/19.</p> <p>A Nurse's Progress Note, dated 7/30/19 at 9:42 PM, documented Resident #1 had pain, cramping, and burning from her vaginal area. The note stated her indwelling catheter was removed and discontinued. There was no documentation the physician was notified of the change in condition and an order received to discontinue the indwelling catheter.</p> <p>On 10/10/19 at 9:05 AM, the DON said there was no order to discontinue Resident #1's catheter when it was removed on 7/30/19.</p>	F 684			

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F 684	<p>Continued From page 5</p> <p>2. The facility's Lab and Diagnostic Test Results policy, dated April 2013, documented the physician will order lab testing based on monitoring needs, the staff will process and arrange for the lab tests, the laboratory will report the test results to the facility, the staff will follow or coordinate the procedure, and then report the results to the physician.</p> <p>Resident #2 was readmitted to the facility on 5/2/19, with multiple diagnoses including hypothyroidism.</p> <p>The October 2019 Physician's Order Summary Report documented Resident #2 received Levothyroxine 225 mcg by mouth daily at bedtime, dated 5/2/19.</p> <p>A physician's order, dated 7/19/19, documented a T4 and TSH (a blood level for thyroid function) laboratory test for Resident #2.</p> <p>The July 2019 TAR, dated 7/19/19, documented the T4 and TSH laboratory tests were obtained for Resident #2.</p> <p>A laboratory receipt, dated 7/19/19, documented the blood was obtained from Resident #2 by the laboratory technician. Resident #2's record did not include the blood test results or documentation the physician was notified.</p> <p>On 10/9/19 at 12:05 PM, the A-DON stated Resident #2's record did not include the results of the T4 and TSH on 7/19/19. The A-DON stated he called the laboratory and they did not have the T4 and TSH results for Resident #2.</p>	F 684			

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F 684	Continued From page 6 On 10/9/19 at 2:00 PM, RCM #2 stated Resident #2 refused to have his blood drawn on 7/19/19. RCM #2 stated when a resident was to have blood drawn, she documented on a checklist to follow up on the results of the blood test to notify the physician. RCM #2 provided the checklist where she documented Resident #2 refused to have his blood drawn. RCM #2 stated she did not document in Resident #2's record or notify the physician he refused to have his blood drawn.	F 684			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 690		11/14/19	

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F 690	<p>Continued From page 7 continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>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 indwelling urinary catheters were medically justified and had provider orders for their use. This was true for 2 of 4 residents (#1 and #2) reviewed for urinary catheters. These failures created the potential for harm if residents developed urinary tract infections, or other complications, due to unnecessary catheter use. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 6/12/19, with multiple diagnoses including end stage cardiac disease and respiratory failure.</p> <p>Resident #1's hospice physician orders, dated 6/11/19, documented she was admitted to the facility with a poor prognosis and was minimally responsive.</p> <p>Resident #1's hospice physician ordered an indwelling urinary catheter and catheter care every shift for terminal care, dated 6/13/19.</p> <p>Resident #1's care plan, dated 6/13/19, documented she had a urinary catheter for terminal pain and comfort per physician order.</p>	F 690	<p>1) Resident #1 no longer resides in facility. Resident #2, chart will be reviewed as needed to ensure catheter care orders are entered and followed per policy.</p> <p>2) All residents with catheters have the potential to be affected by the deficient practice. All residents with catheters will have medical records reviewed and care plans/orders revised as needed.</p> <p>3) All LN staff to be in-serviced related to catheter care, charting requirements as related to catheter care, appropriate catheter diagnoses, MD order entry, order clarification and notification of change of condition policies.</p> <p>4) Catheter audit developed and implemented daily x5, weekly x4, monthlyx3 and quarterly x2 and brought to QAPI committee to review results and ensure sustained compliance. DNS or designee to conduct audits.</p>		

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F 690	Continued From page 8 Resident #1's record documented she had the catheter in place from 6/13/19 to 7/30/19. A Nurse's Progress Note, dated 6/14/19 at 3:21 PM, documented Resident #1 was alert and oriented, and was able to make her needs known. Resident #1's admission MDS assessment, dated 6/19/19, documented she had a catheter for terminal pain and comfort, and was at risk for urinary tract infections related to the catheter. A Nurse's Progress Note, dated 7/17/19 at 9:23 AM, documented Resident #1 wanted her catheter removed. The hospice nurse was notified and orders were obtained for a voiding trial (clamp catheter for bladder to fill) for 24 hours and then to discontinue the catheter. A hospice physician order, dated 7/17/19 at 10:38 AM, documented Resident #1 was not tolerating the catheter. The order was to clamp the catheter every four hours for 20-30 minutes, discontinue the catheter the next day, and then to perform a bladder scan (portable ultrasound of the bladder) every 4-6 hours after the catheter removal to ensure she was not retaining urine. Resident #1's July 2019 TAR, documented the catheter was clamped one time on 7/17/19, two times on 7/18/19, and refused two times on 7/18/19. The TAR documented the voiding trial was not completed and the catheter was not discontinued on 7/18/19. There were no progress notes regarding the reason for the refusals, the incomplete voiding trial, or why the catheter was	F 690			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/10/2019
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 690	<p>Continued From page 9 not discontinued.</p> <p>A hospice physician order, dated 7/18/19, documented to "Continue Foley catheter, Do Not DC (discontinue)." There was no documentation regarding the justification for the continued use of the catheter for Resident #1.</p> <p>A Care Conference note, dated 7/30/19 at 3:10 PM, documented Resident #1 wanted to keep her catheter in place and she was educated by RCM #1 regarding the risks of indwelling catheters.</p> <p>A Nurse's Progress Note, dated 7/30/19 at 9:42 PM, documented Resident #1 had pain, cramping, and burning from her vaginal area. The note stated her catheter was removed and discontinued. There were no physician orders to discontinue the catheter.</p> <p>On 10/9/19 at 2:10 PM, RCM #1 said Resident #1's catheter was not clinically indicated and did not have a documented diagnosis to support the need for the catheter.</p> <p>On 10/9/19 at 3:50 PM, the MDS Coordinator said Resident #1 came to the facility on hospice and was not expected to live more than 2 days and had the catheter due to pain. The MDS Coordinator said she subsequently improved. The MDS Coordinator said he was not sure why the catheter was not removed.</p> <p>On 10/10/19 at 8:15 AM and 9:05 AM, the DON said there was no documentation why Resident #1 had the indwelling catheter, what the refusals meant on the 7/18/19 TAR, why the voiding trial</p>	F 690			

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F 690	<p>Continued From page 10 was not complete, or why the catheter was not discontinued on 7/18/19.</p> <p>2. Resident #2 was readmitted to the facility on 5/2/19, with multiple diagnoses including urinary retention and benign prostatic hyperplasia (enlargement of the prostate gland).</p> <p>Resident #2's quarterly MDS assessment, dated 8/9/19, documented he had an indwelling urinary catheter.</p> <p>Resident #2's October 2019 Physician Order Summary Report directed licensed staff to change the catheter bag as needed for leakage or if torn and to monitor placement of the catheter strap every shift. The summary report did not include an order for a urinary catheter, the type of catheter, the diagnosis for the catheter, the size of the catheter, the size of the balloon, or how often the catheter was required to be changed.</p> <p>Resident #2's care plan, dated 5/2/19, documented Resident #2 had a catheter per physician orders and the catheter was to be changed by a urologist only. The care plan did not include documentation of the type of catheter, the diagnosis for the catheter, the size of the catheter, the size of the balloon, or how often the catheter was required to be changed.</p> <p>A Urology Consultation Report, dated 9/20/19, documented Resident #2's catheter wire (a glidewire inserted into the bladder, followed by the placement of a Foley catheter over the glidewire) was difficult to change.</p> <p>On 10/9/19 at 10:20 AM, RCM #2 stated</p>	F 690			

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F 690	Continued From page 11 Resident #2 had a wire type catheter that only a urologist could change. On 10/9/19 at 10:21 AM, the MDS Coordinator stated Resident #2's record should have a physician's order for the catheter, what type of catheter, and a diagnosis for the catheter. The MDS Coordinator stated the physician's order should have stated only a urologist was to change the catheter and directions for the licensed staff if the catheter became dislodged.	F 690			
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of	F 849		11/14/19	

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F 849	Continued From page 12 the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to,	F 849			

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F 849	<p>Continued From page 13</p> <p>providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.</p> <p>(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.</p> <p>(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.</p> <p>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.</p> <p>§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a</p>	F 849			

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F 849	Continued From page 14 clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient.	F 849			

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F 849	<p>Continued From page 15</p> <p>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.</p> <p>§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.</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 there were orders for hospice care, that care was coordinated with a hospice provider, and duties of the hospice provider and the facility were delineated. This was true for 1 of 1 resident (Resident #1) reviewed for hospice care and services. This failure contributed to Resident #1 not receiving ordered medication and placed her at risk of receiving inadequate and inappropriate care and services. Findings include:</p> <p>The facility's Hospice policy, dated December 2011, documented the facility was to coordinate the plan of care with the hospice agency and was to coordinate the provision of medications as needed to manage terminal illness and related conditions.</p> <p>This policy was not followed.</p> <p>Resident #1 was admitted to the facility on</p>	F 849	<ol style="list-style-type: none"> 1) Resident #1 no longer resides in facility. 2) All hospice residents have the potential to be affected by the deficient practice. All hospice residents will have their medical records reviewed to ensure that they have hospice orders, as well as coordination of care and delineation of services in place per policy. Orders and care plans revised as needed. 3) IDT team to be educated on hospice requirements related to orders, coordination of care and delineation of services necessary to meet hospice requirements. 4) Hospice audit to be implemented and conducted next business day following admission to ensure all requirements meet for residents on hospice services. Audits will be conducted next business day and audits brought to QAPI committee monthly x3, quarterly x2 to 		

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F 849	<p>Continued From page 16</p> <p>6/12/19, with multiple diagnoses including end stage cardiac disease, hypothyroidism (underactive thyroid gland), and respiratory failure. She also received hospice services.</p> <p>Resident #1's care plan, dated 6/12/19, directed staff to collaborate and coordinate with a local hospice agency and the physician in all aspects of care.</p> <p>Resident #1's record did not include hospice admission orders or a hospice contract which delineated care and services provided. Resident #1's hospice Coordinated Plan of Care, dated 6/18/19, also did not delineate which care and services were provided by the hospice agency, the facility, or both.</p> <p>Resident #1's hospice physician order, dated 6/13/19, documented to discontinue all non-comfort medications.</p> <p>A hospice physician order, dated 6/27/19 at 10:20 AM, documented Resident #1 wanted her thyroid medication back. The order documented Levothyroxine (a thyroid medication) 1 tablet of 0.3 milligrams (300 mcg) once a day. The order further documented "(Not Hospice Covered) Bubble pack please."</p> <p>A Nurse's Progress Note, dated 6/27/19 at 7:42 PM, documented a pharmacist at the facility's pharmacy requested clarification for the order of Levothyroxine 300 mcg due to the high dose.</p> <p>Resident #1's hospice physician, on 6/28/19 at 2:53 PM, documented a medication clarification to discontinue the 300 mcg Levothyroxine and to</p>	F 849	ensure continued compliance. DNS or designee to conduct audits.		

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F 849	<p>Continued From page 17</p> <p>start 150 mcg of Levothyroxine 1 tablet once a day. The note further documented "(Not Hospice Covered) Bubble pack please." The order documented to fax the order to the hospice's pharmacy. The order was acknowledged and signed by two facility nurses with a handwritten note not to fax to the facility's pharmacy.</p> <p>A pharmacy receipt from the hospice's pharmacy, dated 6/27/19 at 7:34 PM, documented 60 doses of 150 mcg of Levothyroxine were delivered to the facility for Resident #1.</p> <p>A verbal phone order from the facility's pharmacy, dated 6/28/19 at 1:29 PM, documented per Resident #1's hospice provider, "Please discontinue order for Levothyroxine." The order was acknowledged and signed by two facility nurses on 6/30/19 and 7/1/19. The order did not document which dose of Levothyroxine was to be discontinued.</p> <p>A Nurse's Progress Note, dated 6/30/19 at 2:04 PM, documented the facility received a communication from the facility's pharmacy to discontinue Resident #1's Levothyroxine per the hospice provider.</p> <p>Resident #1's June 2019 MAR, documented Levothyroxine 150 mcg was started on 6/28/19 and discontinued on 6/30/19. The MAR documented she received 150 mcg of Levothyroxine on 6/29/19 and 6/30/19. Resident #1's July 2019 and August 2019 MARs did not include an order for Levothyroxine and she did not receive the medication.</p> <p>Resident #1's hospice recertification, dated</p>	F 849			

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F 849	<p>Continued From page 18</p> <p>7/16/19, included a list of her current medications. The medication list included Levothyroxine 125 mcg daily, dated 6/28/19. The recertification did not document the medication was discontinued and the dose was inconsistent with her MAR which documented 150 mcg of Levothyroxine daily.</p> <p>A Nurse's Progress Note, dated 8/1/19, documented Resident #1 was discharged from the hospice agency and was followed by the facility physician.</p> <p>Resident #1's physician progress note, dated 8/1/19, documented she had hypothyroidism and the physician ordered laboratory tests to check her thyroid levels.</p> <p>On 10/9/19 at 11:45 AM, RCM #1 said when hospice providers came to the facility she expected them to check with the RCM regarding care and services for residents. She said Resident #1 did not receive her Levothyroxine in July and August 2019. RCM #1 said the Levothyroxine order was filled by the hospice pharmacy and not the facility pharmacy as it normally would be. She said according to the hospice recertification medication list, Resident #1 should have received 125 mcg of Levothyroxine beginning on 6/28/19.</p> <p>On 10/9/19 at 3:00 PM and 3:50 PM, the MDS Coordinator said Resident #1's record did not contain delineation of care and services between the facility and the hospice agency. He said Resident #1 did not receive her Levothyroxine in July and August 2019. He said the Levothyroxine order was filled by the hospice pharmacy and the</p>	F 849			

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F 849	<p>Continued From page 19</p> <p>facility had the 150 mcg Levothyroxine order in the facility during her stay. He said between the original order and the hospice recertification medication list, Resident #1 should have been receiving 150 mcg of Levothyroxine and not 125 mcg. The MDS Coordinator said there was a lack of communication between the hospice, the facility, and the facility's pharmacy regarding the Levothyroxine order.</p> <p>On 10/10/19 at 8:15 AM and 9:05 AM, the DON said when Resident #1 received hospice services there was not a physician order for her to receive the services and he expected staff to obtain an order which included the name of the hospice agency. The DON said he expected Resident #1's Levothyroxine order to be clarified.</p> <p>On 10/10/19 at 9:25 AM, the Administrator said he could not find a hospice agreement for Resident #1's hospice provider.</p> <p>The facility failed to obtain a physician's order for hospice services for Resident #1 and establish a written agreement with the hospice agency. The facility failed to delineate coordination of care and services with the hospice agency which contributed Resident #1 not receiving her medication as ordered or needed.</p>	F 849			



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February 18, 2020

Josh Smith, Administrator
Avamere Transitional Care & Rehab - Boise
1001 South Hilton Street
Boise, ID 83705-1925

Provider #: 135077

Dear Mr. Smith:

On **October 8, 2019** through **October 10, 2019**, an unannounced on-site complaint survey was conducted at Avamere Transitional Care & Rehab - Boise. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008217

ALLEGATION #1:

Residents were verbally threatened by staff.

FINDINGS #1:

During the investigation, five resident records were reviewed, abuse allegations were reviewed, the facility's policies, grievances, and Resident Council minutes were also reviewed, observations were conducted, and interviews were conducted with residents and staff.

Four residents were observed for verbal abuse by staff and no concerns were identified. The residents said there were no concerns with abuse or they felt or were threatened by staff.

Josh Smith, Administrator
February 18, 2020
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Record review of five residents, including a resident admitted to the facility June 2019, were reviewed for abuse. An allegation of verbal abuse, dated 8/7/19, documented an allegation of verbal threats for a resident admitted to the facility June 2019. The allegation was investigated and the allegation was found to be unsubstantiated.

Three nurses, one CNA, and one housekeeper said if they saw abuse or staff threatening residents, they immediately stopped it, made sure the resident was safe, and immediately reported it to their supervisor, the Director of Nursing (DON), or the Administrator.

The Administrator, who was also the abuse coordinator, said staff received abuse training and staff knew how and when to report incidents of potential abuse.

It could not be established the facility failed to act on potential abuse concerns.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Residents were not given ordered medication.

FINDINGS #2:

During the investigation resident records were reviewed, facility policies were reviewed, and staff were interviewed.

The facility's Medication Orders policy, dated April 2010, documented the physician's orders were to be reviewed for accuracy, completeness, and were to be followed.

Five resident records were reviewed for medication orders. One resident's record, admitted June 2019, included an order from the hospice physician, dated 6/13/19, which documented to discontinue all non-comfort medications. A hospice physician order, dated 6/27/19 at 10:20 AM, documented an order for Levothyroxine (thyroid medication) 300 micrograms (mcg) 1 tablet once a day. The note further documented "(Not Hospice Covered) Bubble pack please."

A Nurse's Progress Note, dated 6/27/19 at 7:42 PM, documented the facility's pharmacist requested clarification of the resident's 300 mcg order of Levothyroxine due to the high dose. A hospice physician order, dated 6/28/19 at 2:53 PM, documented a medication clarification to discontinue the 300 mcg of Levothyroxine and to start 150 mcg of Levothyroxine 1 tablet once a day. The order further documented "(Not Hospice Covered) Bubble pack please." The order documented to fax the order to the hospice's pharmacy. The order was acknowledged and signed by two facility nurses with a handwritten note to not fax to the facility's pharmacy. A pharmacy receipt from the hospice's pharmacy, dated 6/27/19 at 7:34 PM, documented 60 doses of 150 mcg of Levothyroxine were delivered to the facility for the resident. A verbal phone order from the facility's pharmacy, dated 6/28/19 at 1:29 PM, documented per the resident's hospice provider, "Please discontinue order for Levothyroxine." The order was acknowledged and signed by two facility nurses on 6/30/19 and 7/1/19. The order did not document which dosage was to be discontinued. A Nurse's Progress Note, dated 6/30/19 at 2:04 PM, documented the facility received a communication from the pharmacy to discontinue the resident's Levothyroxine per the hospice provider. The resident's June 2019 Medication Administration Record (MAR), documented Levothyroxine 150 mcg was started on 6/28/19 and discontinued on 6/30/19. The MAR documented the resident received 150 mcg of Levothyroxine on 6/29/19 and 6/30/19. The resident's July 2019 and August 2019 MARs did not include the Levothyroxine, and they did not receive the medication. The resident's hospice recertification, dated 7/16/19, included a list of their current medications. The medication list included Levothyroxine 125 mcg daily, dated 6/28/19. The recertification did not document the medication was discontinued and the dose was inconsistent with their MAR which documented 150 mcg of Levothyroxine daily.

On 10/9/19 at 11:45 AM, a Resident Care Manager (RCM) said the resident did not receive their Levothyroxine in July and August 2019. The RCM said the Levothyroxine order was filled by the hospice pharmacy and not the facility pharmacy as it normally would be. She said according to the hospice recertification medication list, the resident should have received 125 mcg of Levothyroxine daily beginning on 6/28/19.

On 10/9/19 at 3:00 PM and 3:50 PM, the Minimum Data Set (MDS) Coordinator said the resident did not receive their Levothyroxine in July or August. He said the Levothyroxine order was filled by the hospice pharmacy and the facility had the 150 mcg Levothyroxine in the facility during their stay. He said between the original order and the hospice recertification medication list, the resident should have been receiving 150 mcg of Levothyroxine and not 125 mcg. The MDS Coordinator said there was a lack of communication between the hospice, the facility, and the facility's pharmacy regarding the Levothyroxine medication order. On 10/10/19 at 8:15 AM, the DON said he expected the resident's Levothyroxine order to be clarified.

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The allegation was substantiated, and a deficiency was cited at F684 related to the failure of the facility to ensure medication was administered to residents.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #3:

Call lights were not answered in a timely manner.

FINDINGS #3:

During the survey, observations were conducted, facility grievances were reviewed, Resident Council minutes were reviewed, residents were interviewed, and staff were interviewed.

Call light response times were observed throughout the survey. Call lights were answered within an acceptable time, often within two minutes or less.

The facility's Grievance file and Resident Council minutes from July 2019 to October 2019 were reviewed and there were no concerns related to call lights not being answered in a timely manner.

Four residents said they received the care and assistance they needed, and they had no concern with their call lights not being answered in timely manner.

Three nurses and a CNA said call lights were answered in a timely manner and residents' needs were met. The MDS Coordinator said call lights were audited and were answered in a timely manner.

It could not be established the facility failed to ensure call lights were answered in a timely manner.

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

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #4:

Residents who were incontinent were left wet.

FINDINGS #4:

During the survey, observations were conducted, resident records were reviewed, facility grievances were reviewed, residents were interviewed, and staff were interviewed.

Four residents were observed for incontinence care throughout the survey and residents incontinent needs were addressed and they were not left wet for extended periods.

Five resident records, including a resident admitted to the facility June 2019, were reviewed for incontinence care. The records did not indicate a concern regarding residents left wet.

The facility's Grievance file from July 2019 to October 2019 did not document concerns regarding residents' incontinence care.

Four residents said they received appropriate incontinence care and were not left wet. Three nurses and a CNA said residents' received appropriate incontinence care and were not left wet. The MDS Coordinator said residents were not left wet.

It could not be established the facility failed to ensure residents who were incontinent were not left wet.

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

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #5:

Staff dropped residents during transfers.

FINDINGS #5:

During the survey, observations were conducted, resident records were reviewed, residents were interviewed, and staff were interviewed.

Two residents were observed for transfers and staff transferred them correctly and did not drop them.

Record review of five residents, including a resident admitted to the facility June 2019, were reviewed for transfers. The records did not document a concern with their transfers.

Four residents said staff transferred them correctly and had not been dropped.

Three nurses and one CNA said residents were transferred correctly, according to their care plan and were not dropped. The MDS coordinator said staff were trained to properly transfer residents.

It could not be established the facility failed to ensure residents were dropped during transfers.

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

ALLEGATION #6:

The facility used urinary catheters on residents without clinical justification.

FINDINGS #6:

Three resident's records were reviewed for urinary catheter use. One resident's record, admitted June 2019, included an order from the hospice physician, dated 6/13/19, for an indwelling urinary catheter and catheter care every shift for terminal care. The resident's care plan documented they had a urinary catheter for terminal pain and comfort per physician order. The resident's record documented they had the catheter in place from 6/13/19 to 7/30/19.

The resident's record documented the resident was alert and oriented, and was able to make their needs known and the resident wanted the catheter removed. The hospice nurse was notified and orders were obtained for a voiding trial (clamp catheter for bladder to fill) for 24 hours and then to discontinue the catheter.

The resident's record stated the voiding trial was not completed and the catheter was not discontinued. There were no progress notes regarding the reason for the refusals, the incomplete voiding trial, or why the catheter was not discontinued. A hospice physician order documented to "Continue Foley catheter, Do Not DC (discontinue)." There was no documentation regarding the justification for the continued use of the catheter for the resident.

The resident's record included a Care Conference note which documented the resident wanted to keep their catheter in place and they were educated by the Resident Care Manager (RCM) regarding the risks of indwelling catheters. A Nurse's Progress Note documented the resident had pain, cramping, and burning from their genital area. The note documented their catheter was removed and discontinued. There were no physician orders to discontinue the catheter.

On 10/9/19 at 2:10 PM, the RCM said the resident's catheter was not clinically indicated and did not have a documented diagnosis to support the need for the catheter.

On 10/9/19 at 3:50 PM, the MDS Coordinator said the resident came to the facility on hospice and was not expected to live more than 2 days and had the catheter due to pain. The MDS Coordinator said the resident subsequently improved. The MDS Coordinator said he was not sure why the catheter was not removed.

On 10/10/19 at 8:15 AM and 9:05 AM, the Director of Nursing said there was no documentation why the resident had the indwelling catheter or why the catheter was not discontinued.

The allegation was substantiated, and a deficiency was cited at F690 related to the failure of the facility to ensure urinary catheters were clinically indicated.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #7:

Residents developed severe UTI's (Urinary Tract Infections) due to improper care.

FINDINGS #7:

During the survey, resident records were reviewed, residents were interviewed, and staff were interviewed.

Five resident's records, including a resident admitted to the facility June 2019, were reviewed for UTI's. The record for a resident admitted June 2019 documented lab results, dated 8/3/19, were within normal limits related to dehydration and infections. Nurse Progress notes documented the resident had refused cares, would not allow staff to take their temperature, agreed to go to the hospital for evaluation, and was sent to the hospital.

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Four residents said they received appropriate incontinence care and did not have UTI's.

Three nurses and a CNA said residents received appropriate incontinence care and watched for signs of UTI's. The nurses said if they noticed signs and symptoms of a UTI, they notified the physician.

It could not be established the facility failed to ensure residents developed UTI's due to improper care.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj