



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

G.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

**CERTIFIED MAIL: 7012 1010 0002 0836 1918**

January 30, 2014

Irene Michael, Administrator  
Life Care Center of Sandpoint  
1125 North Division Street  
Sandpoint, ID 83864-2148

Provider #: 135127

Dear Ms. Michael:

On **January 17, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Life Care Center of Sandpoint by the Department of Health & Welfare, 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, and a similar State Form 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" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag 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 both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in

Irene Michael, Administrator  
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the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 12, 2014**. Failure to submit an acceptable PoC by **February 12, 2014**, may result in the imposition of civil monetary penalties by **March 4, 2014**.

The components of a Plan of Correction, as required by CMS include:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
  - a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
  - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
  - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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 both the federal survey report, Form

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CMS-2567 and the state licensure survey report, State Form.

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 **February 21, 2014 (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 **February 21, 2014**. A change in the seriousness of the deficiencies on **February 21, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **February 21, 2014** includes the following:

Denial of payment for new admissions effective **April 17, 2014**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, 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 **July 17, 2014**, 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, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; 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

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Regional Office or the State Medicaid Agency beginning on **January 17, 2014** 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 noncompliance 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:

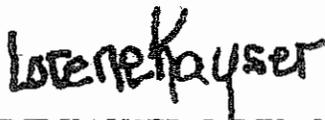
- BFS Letters (06/30/11)

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

This request must be received by **February 12, 2014**. If your request for informal dispute resolution is received after **February 12, 2014**, 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, please contact us at (208) 334-6626.

Sincerely,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor  
Long Term Care

LKK/dmj  
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  135127	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 1/17/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF SANDPOINT	STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 281	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure licensed nursing staff did not document the administration of medications until after the resident actually was administered medications. This affected 1 of 3 (#17) random residents. Findings included:</p> <p>Random Resident #17 was admitted to the facility with multiple diagnoses including hypertension (HTN).</p> <p>The resident's 12/21/03 quarterly MDS coded severely impaired cognitive skills.</p> <p>The resident's Physician Orders January 2014 (recapitulation orders) contained, in part, - Order date 5/14/08, "8:00 pm amlodipine 2.5 milligram tablet by mouth [mg tab po] daily, give 1 tablet at bedtime [hs]" for HTN - Order date 2/17/09, "8:00 pm lisinopril 40 mg tab po hs, give 1 tablet every evening" for HTN - Order date 9/13/08, 4:00 pm calcium carbonate-vitamin D3 600 mg calcium-200 unit capsule 1 tab po 2 times a day with meals</p> <p>The following was observed: On 1/14/14 at 5:32 p.m., LN #1 was observed administering medications to Random Resident #17 in the main dining room. The LN remained with the resident until the resident swallowed the medications. *At 5:35 p.m., the surveyor asked the LN what medications were administered to the resident. The LN replied, "Calcium carbonate, amlodipine, and lisinopril." The surveyor and the LN reviewed the resident's current MAR. The three identified medications had handwritten initials in the January 14th column of the MAR. The LN stated, "I should not sign [initial] the medications were administered before administering the medications. I signed the medications off prior to her swallowing the medications." At this time the surveyor and the LN discussed the Idaho Board of Nursing's expectation for medication administration.</p> <p>The Bureau of Facility Standards Information Letter #97-3, dated 4/16/97 states, "...long term care facility staff were signing medications as given at the time of the medication preparation, not after the resident actually had taken the medication. ...the Board's [of Nursing] expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do."</p> <p>Please refer to F309 as it related to not following the physician's order for the HTN medication administration times of 8:00 pm.</p> <p>On 1/16/14 at 5:50 p.m., the ED was informed of the observation. The ED said the nurse informed her of the observation.</p>
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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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/17/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual Federal recertification and complaint investigation surveys of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Karen Marshall, MS RD LD Team Coordinator Sherri Case LSW BSW Rebecca Thomas RN Amy Barkley RN BSN</p> <p>The survey team entered the facility on Monday January 13, 2014 and exited the facility on Friday January 17, 2014.</p> <p>Survey Definitions: ADLs = Activities of Daily Living CNA = Certified Nurse Aide DNS/DON = Director Nursing Services/Director of Nursing ED = Executive Director F = Fahrenheit FDA = Food and Drug Administration HS = At Bedtime LN = Licensed Nurse MDS = Minimum Data Set assessment MAR = Medication Administration Record PRN = As Needed RN = Registered Nurse TAR = Treatment Administration Record</p>	F 000	<p>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p> <p style="text-align: right;"><b>RECEIVED</b> FEB 12 2014</p>	
F 156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and</p>	F 156	<p>F156 <b>Corrective Actions:</b> We now have Residents Rights form 3126R which section 11 on page 2 explains Notification of changes. 13 Of 13 residents identified or their responsible party will received a copy of this form.</p> <p><b>Identify other res. Who may have been affected:</b> Our current residents all received a copy of the Residents Rights Form 3126R on or before 2/20/14.</p>	

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

TITLE

(X6) DATE

*Shene M. H. E.D.* 2/11/14

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.

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

PRINTED: 01/29/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/17/2014
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F 156	<p>Continued From page 1</p> <p>responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged; and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;  A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section</p>	F 156	<p><b>Systemic change:</b> Admission coordinator will ensure all admission packets have form 3126R included in them. An updated checklist will be done to ensure all documents are signed during the admission process to include form 3126R.</p> <p><b>How corrective action will be monitored:</b> The Business Office Manager or her designee will monitor the Acknowledgment Signatures page for form 3126R is received for every admitted resident on a weekly basis for three months then monthly on new admissions for three months. The audits will be brought to the Performance Improvement Committee monthly for monitoring compliance.</p> <p><i>Audits begin on 2-14-14 per ED Telephone. Km 2.21.14 12:45 hrs</i></p>	

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F 156	<p>Continued From page 2</p> <p>1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility's Admission</p>	F 156			

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F 156	Continued From page 3 Agreement and staff interviews, it was determined the facility failed to ensure the Agreement included the resident right: the facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; or a need to alter treatment significantly. This affected 13 of 13 (#s 1-13) sample residents and had the potential to affect all residents who were admitted to the facility. Findings included:  On 1/16/14 at 9:55 a.m., the surveyor reviewed the facility's Resident Admission Agreement with the facility's Director of Support Services (DSS). The DSS reviewed the Agreement and stated, "I cannot find the verbiage (regarding family and physician notification) in the Agreement."  On 1/16/14 at 11:50 a.m., the surveyor discussed the Agreement with the ED. The ED stated, "We had that resident right in the Agreement until approximately April 2013. Somehow that information was not included in the new packet. That information will be included in the Agreement from now on."  On 1/17/14 at 10:30 a.m., the ED and the DON were informed of the concern. The facility did not provide any additional information.	F 156			
F 240 SS=E	483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE  A facility must care for its residents in a manner	F 240	F240  <b>Corrective Actions:</b> Res. # 2, 9 and the three anonymous,	2-20-14	

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F 240	<p>Continued From page 4 and in an environment that promotes maintenance or enhancement of each resident's quality of life.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, Resident Group interview, and resident and staff interview, it was determined the facility failed to ensure residents were served meals within a reasonable time according to the facility's scheduled "Meal Service Times." This was true for 2 of 10 sample residents (#2 and #9), 3 residents who requested to remain anonymous, 2 random residents, and 6 residents who attended the Resident Group interview. This practice created the potential for harm should the residents experience dissatisfaction with meal service, experience feelings of hunger, diminished nutritional status, or a lack of self-worth. Findings included:</p> <p>On the wall, adjacent to the facility's kitchen and visible to those residents dining in the main dining room, was an 8 by 10 inch piece of paper titled, "Meal Service Times." The facility's scheduled "Meal Service Times" documented the following meal - service schedule: Long Term Hall Trays: 11:30 - 11:50 AM Sub Acute Hall Trays: 11:50 - 12:05 PM Assisted Dining Room: 12:05 - 12:15 PM Main Dining Room: 12:15 - 12:45 PM</p> <p>1. On 1/14/14 at 9:05 AM, Resident #2 was interviewed and stated, "sometimes it takes up to an hour for meals to be served." At 12:15 PM, Resident #2 was observed seated in the dining room and stated, "the food is normally late." The</p>	F 240	<p>plus two random residents and res. #6 have been served as you would in a restaurant. Once they arrive they are given a choice if they have any table mates if they would like to wait for them or go ahead and order their food. Res. who do not have table mates tickets will be given to the kitchen for service once they are seated and drinks are served. Times are posted and resident will be encouraged to note the times as many arrive much before the service time.</p> <p><b>Identify other res. Who may have been affected:</b> Restaurant style service is in place. Resident's meal tickets are given to the dining room managers and they will give the ticket to the kitchen once the resident arrives in the dining room. If they choose to wait for a table mate they can or they can be served whatever is their preference. If they are served prior to their table mate every effort will be made to get the table mate's food as promptly as possible once they arrive. It will work the same with assisted tables but we will wait until the table is full then order their food and the aide will assist with serving and feeding.</p>		

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F 240	Continued From page 5 resident was not served her food until 1:15 PM (1 hour later).  In addition, the the following was observed on 1/14/14:  a) At 11:55 AM, the hall cart for the Long Term residents left the kitchen. This was 25 minutes after the tray delivery service should started have begun on the hall.  b) At 12:35 PM, staff started passing the trays in the Assisted Dining Room. This was 20 minutes after the meal delivery service should have been completed.  c) At 12:30 PM, Resident #1 was observed sitting at his table in the Assisted Dining Room. The resident had not received his meal. This was .15 minutes after the meal should have been served in that dining room.  d) At 12:40 PM, Random Resident (RR) #22 and RR#23 were sitting in the dining room waiting for their lunch. RR #23 was observed to shake her head back and forth. The surveyor approached RR #23 and asked the resident what was wrong. RR #23 stated the side of the dining room she sits on is served last every day and she waits at least an hour every day to be served breakfast, lunch, and dinner. RR #22 was observed sitting at a table behind RR #23 without his meal. The surveyor asked RR #22 about his dining experience and the resident stated the side of the room he sits on is always served last and by the time his meal is served the vegetables are overcooked and water logged.  e) At 12:50 PM, thirty-six residents in the dining	F 240	<b>Systemic change:</b> To serve as you do in a restaurant once you arrive you place your order and the ticket is given to the kitchen to prepare. The hall trays will be delivered after the main dining room trays. The service in the dining room should encourage residents to come out of their rooms and eat in the dining room. Meal times have changed to dining room being served first then long-term and sub-acute in-room trays.  <b>How corrective action will be monitored:</b> The dining room manager will be monitoring the timelines of service and will document when the service is beyond meal times posted daily for three months and as needed if out of compliance. An audit will be conducted by the E.D. or her designee two times per week for three months to ensure systemic changes are working and we are compliant with the posted meal times. Audits will be forwarded to the Performance Improvement Committee for any additional improvements needed.	
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*Audits begin 2.14.14  
per E.D. DeLeon  
2.21.14 12:45 HRS KM*

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F 240	<p>Continued From page 6</p> <p>room were observed to be without their meal.</p> <p>f) At approximately 1:00 PM, a resident, sitting in the main dining room, called the surveyor over to the table where she was sitting. The resident said, "Are we eating today or tomorrow?" The resident had not received her meal yet. The surveyor asked the resident for her name. The resident asked to remain anonymous. This was 15 minutes after the meal delivery service in the dining room should have been completed.</p> <p>g) Two other residents overheard the above 1:00 PM conversation and said they had been waiting for their lunch since noon and were, "tired of waiting." Each of these residents also asked to remain anonymous.</p> <p>On 1/14/14 from 11:50 a.m. to 12:35 p.m., the surveyor observed tray line in the kitchen. Dietary Aide #8 was asked what the process was for serving residents in the facility. The dietary aide stated the hall trays for the Long Term unit and the Sub Acute Unit go out first, then the assisted residents are served, and finally the remaining residents in the dining room are served. The dietary aide was asked how many residents receive hall trays. The dietary aide stated that currently between the Long Term Unit and the Sub-Acute unit there was 35 residents on hall trays.</p> <p>On 1/14/14 at 12:20 p.m., the surveyor asked the Dietary Manager (DM) about the, "Meal Service Times" and the excessive wait times the residents in the dining room must endure before they are served. The DM stated she was trying to develop a plan for the dining room to be served first. She stated she would like to start serving in</p>	F 240		

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F 240	<p>Continued From page 7</p> <p>the dining room at 11:30 a.m. and end at 1:00 p.m. She stated she would like dinner to start at 4:30 p.m. and end at 6:00 p.m. The suveyor asked the DM when the plan would be implemented. The DM stated nursing wants hall trays delivered first because it is easier for the nursing staff to deliver hall trays first and then assist in the dining room.</p> <p>On 1/14/14 at 2:30 p.m., 19 residents attended the Resident Group interview. During the interview, 6 of 19 residents (31.5%) stated the facility, "Waits too long to feed us." One of the residents said it took so long for his meal to be served that his vegetables were cooked too long. When he pushed the vegetables down with his fork, water would come out of the vegetables. The resident said that meant the vegetables were overcooked.</p> <p>Note: A test tray was requested and evaluated on 1/16/14 at 12:50 p.m. The survey team determined the vegetables served were not overcooked and were flavorful, meat was moist and flavorful, and the foods were at a palatable temperature whether hot or cold.</p> <p>On 1/16/14 at 12:50 PM, the DM stated she did not have a problem with the taste of the food but had trouble with the "process."</p> <p>On 1/16/14 at 5:50 p.m., the survey team informed the ED of the residents' concerns about when meals were scheduled to be served and when the meals were actually served. The ED said the cook was actually a chef and did a great job but when the surveyors were in the facility, he became very nervous.</p>	F 240		

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F 242 F 242 SS=E	Continued From page 8 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, group and resident interview, review of the facility's bathing policy and review of grievances it was determined the facility failed to ensure residents preferences were met. This affected 3 of 10 sampled residents (#s 2, 5 and 9), 4 of 19 residents attending the Resident Group interview with the surveyors and 2 random residents who filed grievances related to food preferences (#s 20 and 21). Resident #9 was served poultry which she did not like. Residents #2 and #5 only received 1 shower a week even though they had requested 2 showers a week. The facility's failure to listen to residents requests created the potential for residents to experience anxiety or loss of self-worth when preferences were not accommodated. Findings included:  1. Resident #9 was admitted to the facility on 12/13/13 with diagnoses which included pain, falls and depression.  On 1/14/14 at 12:50 p.m. the resident was observed to be served her lunch which was chicken with rice pilaf and Brussel sprouts. The	F 242 F 242	F242  <b>Corrective Actions:</b> Resident # 9 will not receive poultry on her plate as this is an identified dislike. Staff in-serviced on checking the plate to ensure no items are served that have been identified as a dislike. Res. #20 and 21 discharged from the facility. Res. #2 and #5 are scheduled to have two showers per week.  <b>Identify other res. who may have been affected:</b> Resident's preference on bathing was gathered and those who request a bath two times a week will be given two baths per week and as needed per company policy.  <b>Systemic change:</b> In-serviced staff on the bathing policy and procedure. Another shower aide has been scheduled to accommodate increased showers for those who want them. Dietary employees and dining room managers have been in-serviced on ensuring resident preferences are served to them and not their dislikes. C.N.A.s who deliver meal trays on the halls were also in-serviced on ensuring their dislikes are not on the tray.	2-20-14

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F 242	<p>Continued From page 9</p> <p>resident was asked about her lunch and she stated she did not like chicken. The resident ate only her ice cream and left the dining room. The Diet Sheet that was left on the table documented the resident "disliked poultry." At that time the Dietary Manager (DM) was shown the resident had only eaten the ice cream and the card which identified she did not like poultry. The DM stated the resident should not have received the chicken and she would prepare a room tray for the resident.</p> <p>The next meal on 1/14/14 was served at 5:40 p.m. The resident was served turkey pot pie. The surveyor asked the resident about her meal and she said she was not going to eat because she did not like poultry. The surveyor encouraged the resident to ask for something else to eat. The resident spoke to the DM who offered the resident several choices. The resident chose a Chef's Salad. Later the resident informed the surveyor the salad was very good.</p> <p>2. On 1/14/14 at 2:30 p.m. the surveyors met with a group of residents. The residents were asked if they were ever served food they had identified to the kitchen they did not like. Four of the 19 residents stated they were served food by the kitchen that was on their "dislike" list.</p> <p>3. The following grievances were reviewed:</p> <p>a. A grievance dated 8/28/13 for Resident #21 documented in the comment section "Keep getting milk-not allowed dairy..."</p> <p>b. A grievance dated 9/13/13 for Resident #20 documented the resident who was allergic to peas was served soup that had peas in it.</p>	F 242	<p><b>How corrective action will be monitored:</b></p> <p>Shower schedules will be developed per resident preference. An audit will be conducted weekly by the RCM (resident care managers) to ensure residents are receiving the showers they requested for eight weeks then monthly for three months to ensure compliance with resident preference for showers. Dietary manager or her designee will inspect 25% of the breakfast, lunch and dinner trays leaving the kitchen for dislikes being served five days per week for three weeks then weekly times three months. Audits will be taken to the Performance Improvement Committee to ensure compliance or need for continued corrective action.</p> <p><i>Audits begin 2.14.14 per ED Telecom 2.21.14 12:45 hrs km</i></p>	

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F 242	Continued From page 10  4. Resident #2 was admitted to the facility on 7/2/13 with multiple diagnoses which included chronic pain, degenerative joint disease of the lumbar spine, sacral decubitus Stage III and osteoporosis.  Resident #2's latest MDS Quarterly Assessment, dated 12/12/13, documented the resident's cognition was intact with a BIMS Score of 15.  On 1/13/14 at 11:10 AM, on initial tour of the facility, Resident #2 told the surveyor the facility was cutting showers down to one day a week.  On 1/14/14 at 10:00 AM, the resident was observed in her room and stated to the surveyor, "I want two showers a week, once a week isn't enough." The surveyor asked the resident if she had told the facility of her desire to have showers two times per week and the resident stated she believed the facility was understaffed.  On 1/15/14 at 3:30 PM, the resident again addressed the shower issue with the surveyor. The resident stated she had previously had showers up to two times per week but the facility stopped providing showers on the weekend and told her she would only be getting one shower a week. When asked who had given her this information the resident stated, "the shower girl." Resident #2 then stated, "I want two showers a week."  On 11/25/13, Resident #2 filled out a Grievance Form stating, "I want two showers a week, one	F 242			

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F 242	<p>Continued From page 11</p> <p>shower on Tuesday and one shower on Friday." The facility investigation and response, dated 12/9/13, documented the resident "will be scheduled on Mondays and will attempt a second shower on Thursday/Friday."</p> <p>The Care Plan for Activities of Daily Living (ADL) with an onset date of 7/15/13, documented an approach, "shower and nail care weekly and PRN."</p> <p>The TAR for the month of January 2014, documented, "Weekly showers Weekly" with a start date of 9/26/13, showed Mondays were blocked off for the month of January, indicating showers were to be given on Mondays.</p> <p>The Seven Day Look Back - Bath schedule documented the resident received two showers for the first two weeks of November 2015. However, the schedule documented the resident only received one shower per week for the rest of November with one refusal documented on 11/25/13. The month of December documented only one shower per week and the month of January documented one shower for the first week of January.</p> <p>5. Resident #5 was admitted to the facility on 8/22/13 with multiple diagnoses which included postop ORIF (open reduction internal fixation) left hip, hypertension and Meniere's disease.</p> <p>Resident #5's most recent MDS Quarterly Assessment, dated 11/21/13, documented the resident's cognition was intact with a BIMS Score of 14.</p> <p>On 1/14/14 at 9:05 AM, the resident was</p>	F 242			

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F 242	<p>Continued From page 12</p> <p>interviewed. When asked if there was anything she would like to change about her room, the resident stated, "No, I just wish it had a shower in it. We get a shower just once a week, that's the rule and they stick to it." When asked if she had told the facility she wanted a shower more than once a week, the resident stated, "No, because they only do it once a week. I give myself a sponge bath every night because you don't feel very clean when you get a bath once a week."</p> <p>The Care Plan for Mobility/ADL, with an onset date of 9/5/13 and a target date of 3/5/14, documented "all grooming and hygiene needs will be met daily - with her full participation as able - thru next review date."</p> <p>The Seven Day Look Back - Bath schedule documented the resident received one shower weekly for the months of November and December, 2013.</p> <p>On 1/14/14 at 12:15 PM, Resident #5's daughter told the surveyor, "the shower situation, one time per week, is unacceptable."</p> <p>On 1/15/14 at 4:20 PM, Resident #5 stated when she asks for a shower she is told, "No, it is not your day for a shower." The resident stated that she gives herself a sponge bath, sometimes the staff will assist, it depends on who is on duty." The resident stated she "went almost two weeks without getting her hair washed."</p> <p>6. On 1/14/14 at 2:30 PM, Resident Group Interview took place in which 19 residents were present. Eight residents expressed they get a shower one time per week. The group reported</p>	F 242			

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F 242	<p>Continued From page 13</p> <p>they have not asked for more than one shower per week as they were told they only get one shower per week. Eight of the residents reported they would like a shower two times per week but have been told "they [staff] don't have time."</p> <p>On 1/15/14 at 10:50 AM, the DON and ED were interviewed about the shower situation. The DON stated, "the facility attempts to accommodate residents who ask to have more than one shower." The ED stated that since she had been in the industry, it has been one shower a week. Both the DON and ED stated in agreement, "if a resident or family member asks to have more than one shower a week then we will accommodate their request."</p> <p>On 1/14/14 at 11:45 AM, CNA #4 and LN #3 were asked about showers and the shower schedule for the residents. Both the CNA and the LN stated, "Showers are mostly one a week. Some residents prefer a shower twice a week. We [the 100 hall] have three residents who are early risers so they receive their showers at approximately 5 or 6 am two times a week. Sometimes families request how frequently to shower a resident. For the most part, it [the shower schedule] is once a week."</p> <p>On 1/15/14 at 3:35 PM, CNA #8, stated all residents receive one shower a week and she has never had a family member ask for more.</p> <p>On 1/15/14 at 3:50 PM, CNA #9, stated residents receive one shower a week unless requested.</p> <p>On 1/16/14 at 12:20 PM, RCM #11 was interviewed and shown the Grievance filed on 11/25/13 by Resident #2 stating she wanted</p>	F 242		

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F 242	Continued From page 14 showers two times per week. The RCM stated she would try to make sure the resident received a shower two times a week per the resident's request.  On 1/17/14 the facility provided their Policy and Procedure for Bathing a Resident which documented, "Tub baths or showers will be given at least two (2) times per week to all residents and more frequently as needed."  The facility failed to follow their bathing policy of at least two times per week and failed to listen to their resident's requests for more than one shower per week thereby causing their residents to experience anxiety along with a loss of control and self worth.	F 242		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280  <b>Corrective Actions:</b> Resident #3 care plan has been updated to include a nose cup for adaptive equipment to assist res. with swallowing liquids. Also the Care plan was updated to reassure resident when having involuntary movements and or tremors.  <b>Identify other residents who may have been affected:</b> Residents who use adaptive equipment/tray aides have had their care plans reviewed to ensure needed adaptive equipment is Care Planned.	2-20-14

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F 280	Continued From page 15  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to update and/or revise resident's care plan after there were changes in the resident's status. This was true for 1 of 10 sample residents (# 3). This failure created the potential for harm if the resident was unable to swallow liquids due to the non-use of adaptive equipment. Additionally the care plan did not include specific interventions for staff when Resident #3 experienced tremors which had the potential for increased anxiety. Findings included:  Resident #3 was admitted to the facility on 8/30/13 with diagnoses which included dementia with Lewy Bodies disease, depressive disorder, chronic pain and convulsions.  a) The resident's 1/2014 Physician Orders (recapitulation) included a 12/13/13 order for Nosey cups with meals. A Nosey cup has a cut-out in the rim to allow the cup to be tipped further up when drinking from it.  The Care Plan for Nutrition for the resident, dated 9/12/13 and updated as recent as 1/8/14, did not include the use of a Nosey cup.  On 1/15/14 at 10:15 a.m. LN #5 stated the registered dietitian had recommended the Nosey cup for the resident as the resident did not position her head correctly when drinking. Later	F 280	No other residents have been identified who have involuntary movements and or seizures at this time.  <b>Systemic change:</b> Licensed nurses and certified nursing assistants have been in-serviced on the need for use of adaptive equipment/ tray aides for resident during meals as Care Planned. Licensed staff and Registered dietician in-serviced on the need for ongoing care plan updating to reflect resident change in status and or new interventions.  <b>How corrective action will be monitored:</b> Resident Care Managers (RCM's) will conduct audits of resident care plans which should include adaptive equipment and or interventions to calm someone during involuntary movements and or seizure activities for inclusiveness of interventions weekly x 4 weeks then monthly x 3 months. Audits to be taken to the Performance Improvement Committee to ensure compliance or needed corrective action taken.	

*Audits begin on  
2.14.14 per EO Telecom  
2.21.14 12:45 hrs. Kim*

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F 280	<p>Continued From page 16 that day LN #5 provided the Nutrition Assessment Recommendations, dated 12/6/13, which included use of the Nosey cup.</p> <p>On 1/14/14 at 12:25 pm CNA #6 was observed assisting the resident to eat. CNA #6 used a spoon to give the resident a bite of soup but the resident would close her mouth tight. The CNA would then attempt to give the resident a drink of apple juice but the juice would run down the side of the resident's mouth. A Nosey cup was observed to be laying on the tray, however the CNA did not attempt to use the cup.</p> <p>During the evening meal 1/14/14 LN #7 was observed to offer the resident soup from a spoon and a drink from a large glass. The Nosey cup was not observed to be on the resident's tray.</p> <p>b) On 1/14/14 at 9:50 a.m. the resident was observed near the door way of the television room. The resident was in her wheelchair and was observed to have involuntary muscle contractions causing her body to shake. The resident responded when staff spoke to her. LN #1 was with the resident and monitored the resident.</p> <p>The resident's 9/12/13 Care Plan contained no information on monitoring the resident or providing reassurance to the resident when the involuntary movements occurred.</p> <p>On 1/16/14 at 3:30 p.m. a family member stated the resident was having more "seizures" than in the past. The family member stated the resident experienced anxiety during the seizures and needed reassurance. The family member stated the facility did not think they were seizures and a</p>	F 280			

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F 280	Continued From page 17 staff member thought she could talk the resident out of the seizures. The family member stated the resident responded to reassurance during the seizures.	F 280		
F 309 SS=E	On 1/16/14 at 6:00 p.m. the DON stated the Care Plan should have included interventions for the involuntary movements.  483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure: * A resident's heels were floated as cared planned. This was true for 1 of 10 residents sampled (#8) for care plan implementation and placed the resident at risk for skin break down; * Physician's orders related to medication administration were followed. Failure to administer medication timely placed a random resident (#17) at risk for compromised effectiveness of the medication. *The development of individualized care plans to meet the needs of residents with dementia who received psychopharmacological medication. This was true for 2 of 10 sample residents (#s 3 and 9)	F 309	F309  <b>Corrective Actions:</b> Resident #8 had no adverse effects from not having his heels floated. He has been discharged from facility. Resident #3 care plan and Behavioral/Intervention Monthly Flow Record (BIMF) has been reviewed and updated to reflect current needs and individual interventions. Resident #9 has had her care plan reviewed and individualized. Her BIMF (Behavioral/Intervention Monthly Flow Record) has also been updated to reflect the appropriate behavior indicating depression. Resident #17 is receiving her medications at the assigned times.  <b>Other residents who may be affected:</b> Residents receiving Psychopharmacological medications	2-20-14

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F 309	<p>Continued From page 18 and placed them at risk for receiving a medication that was not clinically indicated. Findings included:</p> <p>1. Resident #8 was admitted to the facility on 1/8/14 with diagnoses that included a urinary tract infection.</p> <p>The resident's 1/8/14 Care Plan (CP) identified the resident had a "Break in Skin integrity." The interventions had a check mark by "Elevated heels off bed surface and float heels-no pressure on heels."</p> <p>On 1/14/14 at 11:25 a.m. the resident was observed lying on his back sound asleep, with his heels flat on the bed. A pillow was observed to be at the footboard of the bed. The pillow was not wrinkled in any way, but sitting on its side neatly against the footboard as if it had not been placed under the resident's heels.</p> <p>On 1/16/14 at 5:50 p.m. the DON and the Administrator were informed of the above concern. The facility provided no further information.</p> <p>2. Resident #3 was admitted to the facility on 8/30/13 with diagnoses which included dementia with Lewy Bodies disease, depressive disorder, and chronic pain.</p> <p>Resident #3's most recent quarterly MDS assessment, dated 11/21/13, documented in part:</p> <ul style="list-style-type: none"> <li>* Moderately impaired with daily decision making;</li> <li>* Inattention;</li> <li>* Behavior not exhibited for physical behavior symptoms directed toward others, verbal behavioral symptoms directed toward others.</li> </ul>	F 309	<p>have had their care plans and BIMF (Behavioral Intervention Monthly Flow Record) individualized for their specific needs. Care plans reviewed on res. with need for elevating heels to ensure includes intervention of floating heels.</p> <p><b>Systemic change:</b> Support services staff and Licensed Nursing staff in-serviced on the following</p> <ul style="list-style-type: none"> <li>• Need for following the care plan and ensuring heels are floated</li> <li>• Care plans must be individualized for each resident</li> <li>• Behavioral/Intervention Flow Records (BIMF) documented target behavior must be individualized for each resident along with interventions.</li> <li>• All residents to receive their medications at the designated time per the Medication Administration Record.</li> </ul> <p><b>How corrective action will be monitored:</b> Resident Care Managers (RCM's) to monitor 10% of residents who are to have their heels floated weekly x 4 weeks then monthly x 3 months. Director of Support Services / Director</p>	
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F 309	<p>Continued From page 19</p> <p>*Rejection of care 1 to 3 days.</p> <p>The resident's 1/2014 Physician Orders included an order for Olanzapine (antipsychotic) 5 mg every day for dementia with Lewy Bodies with a start date for the medication of 10/4/13.</p> <p>The resident's 9/8/13 Behavior CP identified problems of verbal aggression, resists care and the resident was on an antipsychotic medication. The "Approaches" section included to;</p> <ul style="list-style-type: none"> <li>* Monitor effectiveness and side effects of medications.</li> <li>* Anticipate care needs and provide them before resident becomes overly stressed.</li> <li>* Educate resident/responsible party on the casual factors of the behavior and the planned intervention.</li> <li>* Explain care to resident.</li> <li>* If reasonable, discuss behavior with resident and explain why behavior is unacceptable.</li> <li>* Intervene as needed. Approach in calm manner, divert attention, take to another location as needed.</li> <li>* Encourage activities consistent with resident's interests.</li> <li>* Attempt to determine cause of behavior. Consider location, time of day and persons involved.</li> <li>* Provide non-confrontational environment, opportunities for positive interaction, re-approach resident later if agitated and to reinforce positive behavior.</li> </ul> <p>The resident's 12/2013 "Behavior/Intervention Monthly Flow Record" (BIMF) listed two "behaviors," "Verbally abusive towards others" and "Resistant to Cares." The interventions listed for both behaviors were numbered 1 through 11 and</p>	F 309	<p>of Nursing or designee to monitor all residents on Psychopharmacological medications to ensure care plans are individualized and BIMF (Behavior/Intervention Monthly Flow Record) have appropriate behavior present for monitoring. Audits will be completed weekly x 4 weeks then monthly x 3 months. Audits to be taken to the Performance Improvement monthly meeting to ensure compliance or corrective action taken.</p> <p><i>Audits begin 2.14.14 per ED telecon 2.21.14 12:45 hrs KM</i></p>	

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F 309	<p>Continued From page 20</p> <p>typed on the form. The interventions were: Redirect, 1 on 1, refer to nurse's notes, activity, return to room, toilet, give food or fluids, change position or room temperature and back rub. The Resistant to Cares section had a handwritten note to, "change care givers." The Verbally Abusive behavior section had no other interventions. The BIMF documented there were no behaviors of verbal abuse or resisting cares in December 2013.</p> <p>On 1/14/14 at 8:47 a.m. LN#3 was observed to place a clothing protector on the resident and assist her to drink using a nosey cup. During an observations on 1/14/14 at 9:50 a.m. the resident was observed outside the television room. The resident was having muscle contractions (seizure like appearance) and two unidentified staff were rubbing her arm and reassuring her. The resident was not observed to be verbally aggressive or resist assistance from staff during the observations.</p> <p>On 1/16/14 at 1:35 p.m. the Director of Support Services (DSS) was asked for documentation of other interventions tried when the resident displayed the behaviors. The DSS was also asked how the behaviors were harmful to the resident or others. The DSS stated the verbal abuse was directed at staff and a family member. When asked what the resident was trying to communicate with the behaviors, the DSS stated she did not know. When asked for a baseline of the behaviors, the DSS stated a baseline was not done. The DSS was informed the CP was not individualized for the resident. The DSS stated other residents CPs had been revised but the facility had not had the time to revise this resident's CP. The surveyor stated that an</p>	F 309		

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F 309	<p>Continued From page 21</p> <p>antipsychotic was not to be used unless the behavior was harmful to themselves or others and refusal of cares was not an acceptable reason for the use of the antipsychotic. Refer to F329 as it relates to the use of antipsychotic medication without adequate indication of use.</p> <p>3. Resident #9 was admitted to the facility on 12/13/13 with diagnoses which included pain, falls and depression.</p> <p>The resident's 1/14 Physician Orders included an order for Sertraline (antidepressant) 50 mg daily for depression. NOTE: A document from a local physician documented the resident was started on Sertraline 50 mg on 9/5/13 (3 months prior to admission).</p> <p>The resident's BIMF included the same interventions as listed above in the interventions for verbal abuse for Resident #3. The interventions were not specific to Resident #9 or to the symptoms of depression. Additionally the BIMF documented there had been no documented incidents of "Tearfulness" which was the only behavior identified from the date of admit 12/13/13 through 1/16/14.</p> <p>The resident's 12/23/13 Psychosocial Well-Being CP documented depression and the use of an anti-depressant. The Approach section included: *Monitor side effects of medication. *Determine resident's expectations and discuss each in realistic terms. *Discuss coping strategies with resident. *Encourage family/friends to remain involved. *Introduce resident to others with similar interests.</p>	F 309			

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F 309	<p>Continued From page 22</p> <p>On 1/14/14 at 9:30 a.m. the resident stated she did not like to go to activities with others but preferred to read. During observations on 1/14/14 through 1/16/14 the resident was observed in her room and the curtain was pulled to prevent interaction with her roommate.</p> <p>On 1/16/14 at 11:45 a.m. the DON stated the symptoms displayed for depression were not in the Problem section of the CP. When asked about the interventions, such as "discuss coping strategies with resident" the DON stated she did not know what that meant and to talk with the DSS.</p> <p>On 1/16/14 at 1:35 p.m. the DSS was asked where the CP identified how the symptoms of depression were displayed. The DSS pointed out tearfulness was discussed in the "Approaches" section. The DSS stated a baseline of the behaviors had not been done. When asked what, "encourage family/friends to remain involved" meant, the DSS stated "this" family could be called." The surveyor asked how staff would know that and the DSS agreed the CP did not specifically state to call the family. The surveyor also expressed it was not clear what it meant to "discuss coping strategies with the resident." The DSS stated she had reviewed the federal requirements and was aware the CPs needed to have individualized approaches for each resident.</p> <p>The Administrator and DON were informed of the above concerns on 1/16/14 at 5:50 pm. The facility provided no further information to address the concerns regarding CPs not being individualized for each resident.</p> <p>4. Random Resident #17 was admitted to the</p>	F 309			

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F 309	<p>Continued From page 23</p> <p>facility with multiple diagnoses including hypertension (HTN).</p> <p>The resident's 12/21/03 quarterly MDS coded severely impaired cognitive skills.</p> <p>The resident's Physician Orders January 2014 (recapitulation orders) contained, in part, - Order date 5/14/08, "8:00 pm amlodipine 2.5 mg tablet po [milligram tab by mouth] daily, give 1 tablet at bedtime [hs]" for HTN - Order date 2/17/09, "8:00 pm lisinopril 40 mg tab po hs, give 1 tablet every evening" for HTN - Order date 9/13/08, 4:00 pm calcium carbonate-vitamin D3 600 mg calcium-200 unit capsule 1 tab po 2 times a day with meals</p> <p>On 1/14/14 at 5:32 p.m., LN #1 was observed administering medications to Random Resident #17 in the main dining room. The LN remained with the resident until the resident swallowed the medications.</p> <p>-At 5:35 p.m., the surveyor asked the LN what medications were administered to the resident. The LN replied, "Calcium carbonate, amlodipine, and lisinopril." The surveyor and the LN reviewed the resident's current MAR. The three identified medications had handwritten initials in the January 14th column of the MAR. The administration times (Time Code) on the MAR were as follows: amlodipine 8:00 pm, lisinopril 8:00 pm, &amp; calcium carbonate 4:00 pm. The LN stated, "I gave the 8:00 pm medications now because if I wait until 8:00 pm, [Random Resident #17] is usually sleeping. [Random Resident #17] is usually asleep by 7:00 pm."</p> <p>Random Resident #17's physician ordered two HTN medications to be administered at 8:00 p.m.</p>	F 309		

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F 309	Continued From page 24 The licensed nurse administered both medications at 5:32 p.m. which was 2 1/2 hours before the ordered administration time of 8:00 p.m.  Please refer to F281 as it related to initialing the administration of the medications prior to the actual medication administration.  On 1/16/14 at 5:50 p.m., the ED and the DON were informed of the observation. The ED said the nurse informed her of the observation.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F329 <b>Corrective Action:</b> Resident #3 has had her indication for use of the Olanzapine clarified to be for agitation and hallucinations related to her Lewy Body Dementia. Licensed nurses were in-serviced on ensuring less restrictive interventions are tried prior to adding any psychopharmacological medication. Resident #3 has had her Behavior/Intervention monthly Flow Record (BIMF) individualized for her specific needs.  <b>Other residents who may be affected:</b> Residents on antipsychotic medications have been reviewed to ensure medication is necessary to treat a specific condition documented in the clinical record and that the less	2-20-14

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F 329	Continued From page 25  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure unnecessary medications were not administered to a resident without clinical indications for use. This was true for 1 of 10 (#3) sampled residents. This practice created the potential for harm should the medication regimen result in or contribute to an unanticipated decline or newly emerging or worsening symptoms. Findings included:  Resident #3 was admitted to the facility on 8/30/13 with diagnoses which included dementia with Lewy Bodies disease, depressive disorder, and chronic pain.  The resident's 1/2014 Physician Orders included an order for Olanzapine (antipsychotic) 5 mg every day for dementia with Lewy Bodies with a start date for the medication of 10/4/13.  Resident #3's most recent quarterly MDS assessment, dated 11/21/13, documented in part: * Moderately impaired with daily decision making; * Inattention; and, * Behavior not exhibited for physical behavior symptoms directed toward others, verbal behavioral symptoms directed toward others. *Rejection of care 1 to 3 days.  The resident's 9/8/13 Behavior CP identified problems of verbal aggression, resists care and the resident was on an antipsychotic medication. [Note: There was no evidence less restrictive	F 329	restrictive interventions are documented prior to starting any anti-psychotic medication.  <b>Systemic changes:</b> Support Services staff and Admitting licensed nurses in-serviced on the need for appropriate diagnosis for use of antipsychotic medications. New residents admitted who are on an anti-psychotic medication will have their indication for use reviewed in the weekly Behavior Meeting following admission to ensure medication is necessary. Also during this meeting the care plans will be reviewed to ensure they are updated with current interventions for the resident.  <b>How corrective action will be monitored:</b> Director of Support Services / Director of Nursing or designee will audit all charts of current residents and newly admitted residents receiving antipsychotic medications weekly x 4 weeks then monthly x 3 months for appropriate clinical indication for use of medication and current interventions. Audits to be brought to the Performance Improvement Committee monthly to ensure compliance.	

*Audits begin  
2.14.14 per EO Telecom  
2.21.14 12:45 hrs.  
KM*

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F 329	<p>Continued From page 26</p> <p>interventions had been attempted prior to the use of the antipsychotic.] The "Approaches" section included to;</p> <ul style="list-style-type: none"> <li>* Monitor effectiveness and side effects of medications.</li> <li>* Anticipate care needs and provide theme before resident becomes overly stressed.</li> <li>*Educate resident/responsible party on the casual factors of the behavior and the planned intervention.</li> <li>*Explain care to resident.</li> <li>*If reasonable, discuss behavior with resident and explain why behavior is unacceptable.</li> <li>*Intervene as needed. Approach in calm manner, divert attention, take to another location as needed.</li> <li>*Encourage activities consistent with resident's interests.</li> <li>*Attempt to determine cause of behavior. Consider location, time of day and persons involved.</li> <li>*Provide non-confrontational environment, opportunities for positive interaction, re-approach resident later if agitated and to reinforce positive behavior.</li> </ul> <p>The resident's 12/2013 "Behavior/Intervention Monthly Flow Record" (BIMF) listed two "behaviors," "Verbally abusive towards others" and "Resistant to Cares." The interventions listed for both behaviors were numbered 1 through 11 and typed on the form. The interventions were: Redirect, 1 on 1, refer to nurse's notes, activity, return to room, toilet, give food or fluids, change position or room temperature and back rub. The Resistant to Cares section had a handwritten note to, "change care givers." The Verbally Abusive behavior section had no other interventions. The BIMF documented there were</p>	F 329			

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F 329	Continued From page 27 no behaviors of verbal abuse or resisting cares in December 2013.  On 1/16/14 at 1:35 p.m. the Director of Support Services (DSS) was asked how the behaviors were harmful to the resident or others. The DSS stated the verbal abuse was directed at the resident's family member. The surveyor told the DSS refusal of care by a resident or a behavior which was not harmful to the resident or others did not provide clinical indication for the need for an antipsychotic.  NOTE: Guidance for antipsychotic medication at F 329 documents antipsychotic medications not appropriate for elderly residents unless prescribed to treat previously diagnosed mental illness such as schizophrenia.	F 329			
F 369 SS=D	The Administrator and DON were informed of the above concerns on 1/16/14 at 5:50 pm. The facility provided no further information. 483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS  The facility must provide special eating equipment and utensils for residents who need them.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not ensure special eating equipment was provided for residents who needed it. This was true for 1 of 11 residents (#3) sampled for adaptive equipment. The deficient practice had the potential to cause more than minimal harm if the resident	F 369	F369 <b>Corrective Actions:</b> Resident #3 has nose cup available for all meals. <b>Other residents who may be affected:</b> Residents who require use of adaptive equipment for eating will have it available for use.  <b>Systemic Changes:</b> Licensed Nurses and Certified nursing assistants have been in-serviced on the need for using the special eating	2-20-14	

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F 369	<p>Continued From page 28</p> <p>experienced dehydration when not provided a special cup for beverages. Findings included:</p> <p>Resident #2 was admitted to the facility on 11/17/06 with diagnoses which included dementia with Lewy Bodies disease, depressive disorder, chronic pain and convulsions.</p> <p>The resident's current 1/2014 Physician Orders (recapitulation) included a 12/13/13 order for "Nosey" cups with meals. A Nosey cup has a cut-out in the rim to allow the cup to be tipped further up when drinking from it.</p> <p>On 1/14/14 at 12:25 pm CNA #6 was observed assisting the resident to eat. CNA #6 used a spoon to give the resident a bite of soup but the resident closed her mouth tight. The CNA then attempted to give the resident a drink of apple juice. The juice ran down the side of the resident's mouth. A Nosey cup was observed to be lying on the tray; however the CNA did not attempt to use the cup.</p> <p>During the evening meal on 1/14/14 LN #7 was observed to offer the resident soup from a spoon and a drink from a large glass. The Nosey cup was not observed to be on the resident's tray.</p> <p>On 1/15/14 at 10:15 a.m. LN #5 stated the registered dietitian had recommended the Nosey cup for the resident as the resident did not position her head correctly when drinking. Later that day LN #5 provided the Nutrition Assessment Recommendations, dated 12/6/13, which included the Nosey cup.</p> <p>On 1/15/14 at approximately 6:00 pm the Administrator and the DON were informed of the</p>	F 369	<p>equipment/adaptive and utensils during meals as care planned.</p> <p><b>How corrective action will be monitored:</b> Resident Care Managers (RCM's) to conduct audits of 1 meal per week for each resident who uses special eating equipment is being used per care plan. Audits to be completed weekly x 4 weeks then monthly x 3 months. Audits to be taken to the Performance Improvement Committee monthly for monitoring of compliance.</p> <p><i>audits will begin 2.14.14 per ED Sullivan 2.21.14 12:45 hrs LM</i></p>		

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

PRINTED: 01/29/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 01/17/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
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F 369	Continued From page 29 concern. The facility provided no further information.	F 369			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to: 1) ensure the meat slicer frame was free of debris, and 2) obtain all food temperatures prior to serving food. This affected 2 of 3 random residents (#s 18 & 19) and had the potential to affect residents on renal diets and those residents who preferred unbreaded meats. This practice created the potential for contamination of food and exposed the residents to disease causing pathogens. Findings included:  1. On 1/13/14 the Dietary Manager (DM) accompanied the surveyors during the initial tour of the facility's kitchen. At 11:04 a.m., an opaque plastic bag covered the meat slicer. The DM said the slicer was cleaned. The DM removed the plastic bag from over the slicer. There were debris on various parts of the slicer frame. The	F 371	F371 <b>Corrective Actions:</b> Kitchen employees have been in-serviced on how to properly clean the slicer. Cook #2 educated on the importance of all temperatures being taken before serving to residents to ensure proper temperature. Res. #18 & 19 plates were discarded and plates were re-served after temps were taken.  <b>Identify other res. Who may have been affected:</b> No food was served without being temped due to being caught by the surveyor. The kitchen employees were educated on how to properly clean the food slicer and on the importance of making sure all temps are taken prior to food delivery and service.  <b>Systemic change:</b> The food slicer will be inspected prior to use to ensure no accumulation or food residue is left on it prior to use. If found to not be clean the Dietary Manager will be notified and the person responsible for cleaning it will be given disciplinary action. Cooks will take temps of all foods prior to meal delivery.	2-20-14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/17/2014
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F 371	<p>Continued From page 30</p> <p>DM stated, "The slicer was supposed to be cleaned since the slicer was covered with the plastic bag."</p> <p>The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart 601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils indicated, "... (C) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."</p> <p>2. On 1/15/14 at 11:25 a.m., the surveyors observed the lunch meal service. Cook #2 obtained temperatures of foods held for serving on the steam table. Other additional food items were located in individual serving pans within a larger serving pan on the range top. These food items were peas, chopped fish, hamburger patties, and beef minestrone soup. The large serving pan set on the range top and covered an area the size of two gas burners. One burner did not have a visible flame and the other burner was lit with a visible flame. At 11:45 a.m. the surveyors asked Cook #2 what the food items located on the range top were for. Cook #2 stated, "For renal diets and for residents who do not like breaded meats."</p> <p>a. At 11:51 a.m., Cook #2 placed the chopped fish on a plate for Random Resident #18. The plate was placed on a tray and the resident's tray was placed on a cart to be delivered to the resident.</p> <p>b. At 11:52 a.m., Cook #2 placed two hamburger patties and a serving of peas on a plate for Random Resident #19. The plate was placed on a tray and the resident's tray was placed on a cart</p>	F 371	<p><b>How corrective action will be monitored:</b></p> <p>The dietary manager or her designee will check for temperatures of the meals being taken by cook #2 to ensure all items are being temped prior to service on days scheduled for three weeks then weekly for cook #2 for three months.</p> <p>Temperatures will be copied to ensure all foods have been temped and copies will be brought to the Performance Improvement Committee for any further interventions needed.</p> <p><i>audits will begin 2.14.14</i></p> <p><i>per ED Telecom</i></p> <p><i>2.21.14 12:45</i></p> <p><i>Km</i></p>	

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

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F 371	<p>Continued From page 31 to be delivered to the resident.</p> <p>On 1/15/15 at 11:55 a.m., the surveyor asked the DM if the food temperatures were determined for the food items on the range top. The DM asked Cook #2 if the temperatures of the food items located on the range top were determined. Cook #2 indicated the temperatures were not determined prior to service. The DM told the Cook to remake the food items that "temperatures were not determined prior to serving."</p> <p>Federal guidance at F371 specified, in part, "...Service of food during meal times...Observe the staff measuring the temperature of all hot...menu items...Hot foods should be at 135 degrees F or above when served."</p> <p>On 1/17/14 at 10:30 a.m., the ED and the DON were informed of the observations. The facility did not provide any additional information.</p>	F 371			

Bureau of Facility Standards

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C 000

**16.03.02 INITIAL COMMENTS**

The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.

The following deficiencies were cited during the State licensure and complaint investigation surveys of your facility.

The surveyors conducting the survey were:

Karen Marshall MS RD LD Team Coordinator  
Sherni Case BSW LSW  
Rebecca Thomas RN  
Amy Barkley RN BSN

Survey Definitions:

ED = Executive Director

C 000

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**FEB 12 2014**  
**FACILITY STANDARDS**

C 117

**02.100,03,c,i Fully Informed of Rights**

i. Is fully informed, as evidenced by the patient's/resident's written acknowledgement, prior to or at the time of admission and during his stay, of these rights and of all rules, regulations and minimum standards governing patient/resident conduct and responsibilities. Should the patient/resident be medically or legally unable to understand these rights, the patient's/resident's guardian or responsible person (not an employee of the facility) has been informed on the patient's/resident's behalf;

This Rule is not met as evidenced by:

C 117

See Plan of correction for F156

2/20/14 dy

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE  
*Sherrill M. ...* ED.  
(X6) DATE  
2/11/14

Bureau of Facility Standards

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C 117	Continued From page 1  Please refer to F156 as it related to the facility's Resident Admission Agreement not including all resident rights.	C 117		
C 121	02.100,03,c,v Encouraged/Assisted to Exercise Rights  v. Is encouraged and assisted, throughout his period of stay, to exercise his rights as a patient/resident and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; This Rule is not met as evidenced by: Please refer to F242 as it related to resident choices.	C 121	See plan of correction for F242	2/20/14
C 147	02.100,05,g Prohibited Uses of Chemical Restraints  g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Refer to F329 as it relates to monitoring of antipsychotic medications.	C 147	See plan of correction for F329	2/20/14

Bureau of Facility Standards

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C 296	Continued From page 2	C 296		
C 296	02.107,05 MENU PLANNING AND MEAL SERVICE  05. Menu Planning and Meal Service. At least three (3) meals or their equivalent shall be served daily at regular times, with not more than a fourteen (14) hour span between a substantial evening meal and breakfast. This Rule is not met as evidenced by: Please refer to F 240 as it relates to meal service.	C 296	See plan of correction for F240	2/20/14
C 325	02.107,08 FOOD SANITATION  08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F371 as it related to the food slicer cleanliness.	C 325	See plan of correction for F371	2/20/14
C 703	02.152,03,a,i Idaho Licensed Social Worker  i. Is a social worker licensed by the state of Idaho as a social worker or who receives regular consultation from such a qualified social worker. This Rule is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure the Director of Support Services (DSS) received regular consultation from a Licensed Social Worker (LSW). This affected 13 of 13 (#s	C 703	C703  <b>Corrective Actions:</b> A Licensed social worker will be providing regular consulting services to our Support Services Director and team on a quarterly basis starting in February 2014. No evidence noted from resident that they have been affected by not having LSW consulting.	2/20/14

Bureau of Facility Standards

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C 703	Continued From page 3  1-13) sampled residents and had the potential to affect all residents who resided in the facility. Findings included:  On 1/13/14 at 10:30 a.m. the survey team entered the facility. As part of the survey process, the facility provided the survey team with a List of Key Facility Personnel. The facility listed the name of a LSW and the LSW's license number. The List also contained the name of the DSS.  On 1/13/14 at approximately 11:30 a.m., the surveyor discussed with the ED the state requirement for periodic consultation from a LSW. The ED stated, "I know it is a requirement. We have not had any consultation visits from the LSW identified on the Key Facility Personnel list. The LSW does not work for our facility. The LSW works for a different facility in a town approximately 1 hour drive from here. We are in the process of setting up how the consultation visits will be done. Nothing has been finalized yet."  On 1/15/14 at 8:37 a.m., the LSW identified on the List of Key Facility Personnel came to the facility. The LSW stated, "The corporation is in the process of determining how I can provide social services to the facility." The LSW verified she had not provided "periodic consultation services" as of the date of the survey process.	C 703	<b>Identify other res. Who may have been affected:</b> Unable to find evidence that residents have been affected by not having regular consulting visits by a LSW.  <b>Systemic change:</b> A Licensed social worker will provide quarterly consulting to our support services team. Consultant will provide reports on what they reviewed quarterly.  <b>How corrective action will be monitored:</b> Consultant reports will be reviewed quarterly during the Performance Improvement Committee meetings to ensure recommendations are completed and interventions implemented.	
C 782	02.200.03,a,iv Reviewed and Revised  iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by:	C 782	See plan of correction for F280	2/20/14

Bureau of Facility Standards

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C 782	Continued From page 4  Please refer to F 280 as it relates to care plan revision.	C 782		
C 787	02.200,03,b,iii Fluid/Nutritional Intake  iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Please refer to F 369 as it relates to providing an adaptive cup for drinks.	C 787	See plan of correction for F369	2/20/14
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered  iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Please refer to F 309 as it relates to a resident not receiving a medications at the time ordered by the physician.	C 788	See plan of correction for F309	2/20/14
C 804	02.200,04,g Recorded on Medication Record  g. Each patient's/resident's medication is properly recorded on his individual medication record by the person administering the medication. The record shall include: This Rule is not met as evidenced by: Please refer to F281 as it related to signing or initialing a medication was administered prior to the actual medication administration.	C 804	<i>Found Compliant with F281. No plan of correction required. Meets Professional Standard.</i>	2/20/14
C 882	02.203,02,a Resident Identification Requirements	C 882		2/20/14

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**MAR 19 2014**

**FACILITY STANDARDS**

Bureau of Facility Standards

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C 882	<p>Continued From page 5</p> <p>a. Patient's/resident's name and date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service (if applicable); name, address and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and disposition, signed by the attending physician, shall be part of the medical record.</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the cause of death signed by the physician was maintained in the resident's closed record. This affected 1 of 3 (#16) closed records reviewed. Findings included:</p> <p>Resident #16 was admitted to the facility with multiple diagnoses including renal insufficiency. The resident passed away in the facility on 10/19/13.</p> <p>Review of the resident's closed record did not provide evidence the physician signed a cause of death.</p> <p>On 1/16/14 at 12:20 p.m., the surveyor asked the Medical Records Supervisor (MRS) for a cause of death signed by the physician. The MRS stated, "An audit was done on 10/22/13 and we found</p>	C 882	<p><b>C882</b></p> <p><b>Corrective Actions:</b> Res. #16 the physician has now documented the cause of death on the Discharge Assessment Summary form.</p> <p><b>Identify other res. Who may have been affected:</b> Residents who passed away in the last three months will be audited to ensure the cause of death was received. If the cause of death is not on the form the Medical Records personnel will make one more attempt prior to contacting the Medical Director for his assistance in getting the final diagnosis or cause of death for the Discharge Assessment Summary form.</p> <p><b>Systemic change:</b> Medical Records personnel will ensure the final diagnosis or cause of death is filled out on the Discharge Assessment Summary form prior to closing the chart. This has been added to the closed chart review audit form.</p>	

Bureau of Facility Standards

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C 882	<p>Continued From page 6</p> <p>there was no Discharge Summary in the closed record. The Summary was sent to the MD for signature. The Summary was not returned."</p> <p>On 1/17/14 at 10:30 a.m., the ED and the DON were informed of the finding. The facility did not provide any additional information.</p>	C 882	<p><b>How corrective action will be monitored:</b></p> <p>An audit will be done weekly by Medical records for three months to ensure compliance with the discharge summary ensuring the cause of death is documented by the physician. Audits will be brought to the Performance Improvement committee monthly to ensure compliance.</p> <p><i>Audits will begin on 2-14-14.</i></p>	

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MAR 19 2014

FACILITY STANDARDS



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

March 5, 2014

Irene Michael, Administrator  
Life Care Center of Sandpoint  
1125 North Division Street  
Sandpoint, ID 83864

Provider #: 135127

Dear Ms. Michael:

On **January 17, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Sandpoint. Becky Thomas, R.N., Amy Barkley, R.N., Karen Marshall, R.D. and Sherri Case, L.S.W., Q.M.R.P., conducted the complaint investigation. This complaint and two other complaints were investigated in conjunction with the facility's annual recertification and State licensure survey.

During the survey process, ten different residents including the identified resident, were reviewed for the residents' daily life, quality of life, quality of care, drug therapies, and other additional areas as required by Federal guidelines.

Interviews were conducted as follows:

- Four individual residents;
- Family members of two different residents;
- Resident Group interview with nineteen residents in attendance;
- Four Certified Nurse Aides (CNAs) who provided direct cares for the identified resident ;
- Two Licensed Nurses;
- The Director of Support Services;
- The Director of Maintenance;
- The Director of Nursing;
- The identified resident's Resident Care Manager;
- The Executive Director;
- The Accounts Payable staff member;
- An employee who worked for a local eyeglass repair store; and
- The Regulatory Compliance Registered Nurse.

Irene Michael, Administrator  
March 5, 2014  
Page 2 of 14

The following documents were reviewed:

- The identified resident's medical record;
- The facility's Concern and Comment forms (including grievances) from July 1, 2013 through January 12, 2014;
- The facility's Concern and Comment forms from January 1, 2013 through January 31, 2013;
- The facility's three-week nursing schedule from December 22, 2013 through January 10, 2014;
- The facility's nursing schedule from January 1, 2013 through January 31, 2013;
- The facility's Incident Follow-up & Recommendation Forms (Incident and Accident reports) from July 1, 2013 through January 13, 2014; and
- The identified resident's Incident and Accident reports from January 1, 2013 through January 31, 2013.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00005886**

**ALLEGATION #1:**

The complainant stated that in October 2012 an identified resident was over sedated with Paxil to the point of being unable to feed himself or converse.

**FINDINGS:**

The identified resident was admitted to the facility on September 14, 2011 with multiple diagnoses including Alzheimer's disease.

A September 14, 2011, local health center report documented the resident was transferred from assisted living in a different state to the facility. The resident had progressing dementia. The resident's balance was becoming a problem. The resident often fought being transferred from one surface to another, i.e. bed to chair, and was apparently fearful of falling. The resident also wore glasses.

Review of the identified resident's medical record provided evidence, when the resident was admitted to the facility, the resident's status was as follows:

- Severely impaired cognition;
- Did not walk in room or corridor;
- Required extensive two person physical assistance for transfers and bed mobility, dressing, and toilet use; and
- Required extensive one person physical assistance for personal hygiene, eating, and locomotion on and off unit.

Over the course of the resident's stay, the resident's assistance to dine varied from one person limited

assistance to one person extensive assistance.

During the survey process, the resident was observed receiving encouragement to dine independently, which he did, and at other times he required extensive assistance, which he was provided. During these dining observations, a licensed nurse or CNA sat with the resident at his dining table.

On September 20, 2012, the resident's physician ordered Paxil, ten milligrams, daily for depression. Telephone consent was obtained from a family member, and the resident was placed on alert charting for possible medication adverse reactions.

On November 15, 2012, the resident was seen by his medical doctor with a family member present. The doctor's progress note documented the resident was started on Paxil on September 20, 2012, for anxiety especially during transfers, when he seemed distressed and grabbing at things. On October 28, 2012, the Paxil was tapered off primarily due to lethargy and family concern about possible weight loss, although weight measurements had actually been stable.

The 2014 Nursing Drug Handbook identified an initial dosage of Paxil for adults was twenty milligrams per day. The resident received ten milligrams of Paxil, which was half of the initial recommended dosage.

The resident was administered ten milligrams of Paxil for approximately thirty-eight days, from September 20, 2012 to October 28, 2012, due to anxiety, when he seemed distressed during transfers. On October 29, 2012, the resident's physician tapered the dosage to five milligrams per day and on November 8, 2012, the medication was discontinued.

The survey team determined the facility was in substantial compliance with Federal guidelines related to the use and discontinuation of the medication Paxil.

#### CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

The complainant stated the facility was understaffed, which lead to an identified resident being left in soiled Attends (incontinence briefs) for long periods of time and developing skin redness. The resident's care plan called for Attends to be changed every two hours. The resident had a red scrotum.

Resident has also been found with uncombed hair and food on his clothes.

Lack of staff leads to call lights not being answered.

Irene Michael, Administrator  
March 5, 2014  
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#### FINDINGS:

There were no dates or times provided related to the identified resident developing skin redness and a red scrotum, having uncombed hair and food on his clothes or call lights not being answered.

Upon entering the facility, the survey team observed residents on all hallways in the facility. The survey team did not observe any residents with uncombed, unkept hair. The survey team did not observe any residents with unexplained food on their clothing.

Staffing from January 1, 2013 through January 31, 2013, and from December 21, 2013 through January 11, 2014, was reviewed. The facility staffing exceeded the State's requirement. The survey team did not observe a lack of residents' cares due to insufficient staffing.

During the survey process, the survey team continued to observe residents for grooming concerns. The survey team did not observe or identify grooming concerns for the residents.

During the survey process, observations were made by the survey team on all hallways to determine the length of time from when a call light was activated and sounded at the nurses stations until a staff member answered the resident's call lights. The maximum waiting time during those observations was three minutes.

The facility's Concern and Comment forms (grievances) were reviewed. These forms did not include a grievance for the identified resident related to uncombed, unkept hair or food on the resident's clothing. These forms did not include a grievance about the identified resident's call light not being answered in a timely manner.

The nineteen residents who attended the Resident Group interview were asked if the facility provided grooming for those residents who could not speak for themselves or perform their own hygiene. None of the nineteen residents voiced concerns related to grooming for those residents who could not speak for themselves or perform their own hygiene. The residents in the group interview were asked if there were residents who were left with food on their clothing that should not have food on their clothing. The residents did not voice any concerns related to residents left with food on their clothing. The residents did not voice concerns related to the amount of time the residents had to wait for a call light to be answered.

The identified resident's care plan contained a May 10, 2012, intervention, the resident wanted to grow his hair out long enough for a pony tail.

On November 10, 2012, the resident's progress notes documented the resident was always clean shaven. The CNAs groomed the resident's eyebrows and ear hairs. The family insisted on letting the resident's hair grow, but the resident's hair had stopped growing.

During the survey process, the resident appeared well groomed and bathed. The resident's face and hair

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appeared clean and well kept.

On several observations, the surveyor observed staff asking the resident if he needed to use the restroom, and also, ask the resident if he felt like his adult incontinence product was wet. One time, the resident said he did not need to use the restroom. Another time, the resident said he did need to use the restroom. The staff were observed taking the resident to his room, at which time his incontinence product was checked by staff. On other observations, staff transferred the resident from his wheelchair to his bed. During these observations, the staff checked and, when needed, changed the resident's incontinence product. The surveyor observed staff checking and changing the resident in the morning, after lunch and before laying the resident down for an afternoon nap.

A surveyor observed the identified resident's buttocks, scrotum and penis. The resident had a small shiny red spot on the right testicle. The resident was receiving an over the counter McKesson cream to the peri area, every shift for redness, and also receiving nystatin topical cream to the groin, two times a day for yeast rash.

The resident's November 14, 2012, progress note documented the wound team saw the resident for an area on his scrotum. The area appeared as a closed scab that had no drainage from the area, no redness and was on the left scrotum. The resident's doctor was notified and would see the resident on rounds the following day.

The doctor's November 15, 2012, progress note documented the resident was examined with a family member present. The resident had a rash under the scrotum, which was being treated with vitamin A and D barrier cream.

The resident's November 15, 2012, nurses progress notes documented in part, the resident's doctor arrived to assess the resident. The doctor, two licensed nurses and a family member were in the room during the doctor's examination of the resident. There was an extensive conversation about the resident's care and condition. The family member had multiple concerns including a rash that the resident had for three weeks and a decubitus sore on the resident's testicles. There was no sign of a rash to the resident's groin or testicles. The resident's scrotum area was slightly yellow in color, there was no firmness, was not open and there was no drainage. The progress note documented the doctor stated with the resident's incontinence there was a chance for excoriation and recommended barrier cream, that was ordered and applied. The progress note also documented that the family member was okay with the results of the meeting.

On January 29, 2013, the facility sent a fax to the resident's doctor that documented in part, the resident has recurring excoriation on his scrotum/peri-area from incontinence. It comes and goes. Already have McKesson and vitamin A and D ointment every shift and as needed. Is there anything else you would recommend? On January 30, 2013, the doctor replied to the fax with, continue current treatment.

CONCLUSION:

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Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #3:

The complainant stated charting showed an identified resident was verbally and physically abusive to staff. The complainant stated the resident was a quiet, loveable man. The complainant also stated a family member was not made aware of the resident's abusive behavior.

The complainant stated the resident was afraid of falling and would grab your arm when being moved.

#### FINDINGS:

There were no dates or times provided related to the identified resident being verbally and physically abusive to staff.

The facility's Concern and Comment forms (grievances) were reviewed. The Concern and Comment forms did not include a grievance for the identified resident, related to the facility not informing the family of the resident's abusive behavior.

A September 14, 2011, local health center report documented in part that the resident transferred from an assisted living facility in a different state where the resident exceeded the facility's ability to take care of him. His dementia was apparently progressing, balance was becoming a problem and the resident often fought transfers apparently fearful of falling. The resident was admitted to the facility at that time.

Review of the resident's nurses progress notes revealed the resident was verbally and physically abusive to facility staff beginning in October 2011.

On November 15, 2012, the resident was seen by his medical doctor with a family member present. The doctor's progress note documented in part anxiety, especially during transfers, when the resident seemed distressed and grabbing at things. The resident has had a steady down hill course.

On November 15, 2012, the resident's nurses progress notes documented in part that the resident's doctor and two licensed nurses discussed with a family member the medication that was ordered previously for anxiety. The progress note documented that no further medications would be ordered. Other interventions that were discussed were towels or stuff animals for the resident to hold onto during transfers. The progress note also documented that the family member was okay with the results of the meeting.

The licensed nurse who electronically signed the November 14, 2012, entry in the resident's nurses progress notes was interviewed. The nurse said the resident's aggression was discussed with a family member on November 14, 2012, and the changes were made to the resident's care plan as a result of the

discussion. The nurse said the facility had several meetings and conversations with the family about the resident being fearful and aggressive. The nurse said the facility tried different caregivers, towels and stuffed animals for the resident to hold onto during transfers and education to staff, but the resident continues to be fearful of transfers.

Two CNAs were observed transferring the resident from his wheelchair to his bed using a sit-to-stand mechanical device. As the CNAs were preparing the resident for transfer, the resident held onto the arm of one of the CNAs and held onto the transfer device with the other hand. The resident would not release his grip on the CNA's arm until he was sitting firmly on his bed and was reassured several times by the CNA that he was laying on the bed. After the transfer observation, both of the CNAs said the resident was fearful during transfers, sometimes would hold onto a CNA's arm and not release his grip even after the transfer was completed and sometimes would throw his arms around. Both CNAs said they thought the resident threw his arms around because he had a fear of transfers, but the resident was not able to transfer on his own. In addition, both CNAs said the resident was more fearful of the hoyer (another kind of transfer device) than the sit-to-stand transfer device.

A different licensed nurse was interviewed about the resident's verbal and physical aggression. The nurse said several times that the resident's behaviors were discussed with the family when the facility did the Federally required assessments. The nurse said the resident was administered Depakote at one time for behaviors. The Depakote was discontinued. The resident's symptoms increased after the Depakote was discontinued. The resident's doctor discussed the resident's anxiety with the family, and the doctor prescribed Paxil at ten milligrams, once a day. However, the doctor discontinued the Paxil shortly after ordering Paxil, and the family did not want the resident to receive any other medications for anxiety or aggression.

On August 8, 2012, the facility assessed the resident as required by Federal guidelines. The annual assessment documented that the facility obtained input from the family regarding the resident. The documentation included that the resident's family was aware that the resident had times of being verbally and physically inappropriate with cares and was on the medication Depakote to help with that. The family signed the necessary consents for the medication.

On November 24, 2012, the facility assessed the resident as required by Federal guidelines and obtained input from the family regarding the resident. The assessment documented that the family was aware that the resident could become physical with staff when working with the resident on transfers.

On January 29, 2013, the resident's nurses progress notes documented the resident was resistive to hoyer transfer on January 27, 2013, and swinging arms in the air during transfer. A family member was in the facility earlier in the day and was made aware of the situation.

The survey team determined the facility was in compliance with Federal guidelines.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated an identified resident has had numerous unexplained skin tears and currently has one on his arm.

FINDINGS:

The identified resident's medical record and Incident and Accident reports were reviewed.

The resident had sustained numerous skin tears since admission to the facility.

The facility documented and evaluated the possible causes of the skin tears. The predominant cause of the resident's skin tears was the resident would flail his arms during transfers due to his anxiety and fearfulness of transfers.

The resident's nurses progress notes documented nursing staff monitored the resident's skin tears.

The facility requested and the resident's doctor ordered geri-sleeves and elbow protectors for both arms to be worn every shift.

The doctor ordered bed wedges to both sides of the resident's bed while the resident was in bed for fall prevention. The facility determined that the zippers on the underside of the wedges caused skin tears to the resident's arms. The facility removed those bed wedges and ordered different wedges with Velcro closures instead of zippers.

The resident was observed wearing geri-sleeves and elbow protectors during the survey, as ordered by the resident's doctor.

The two Certified Nurse Aides who were observed transferring the resident from his wheelchair to his bed said they noticed the resident had less skin tears and bruising with the use of the sit-to-stand transfer device.

Although the resident sustained skin tears, the facility continually investigated possible causes, put appropriate interventions into place and had reduced the number of skin tears and bruises the resident sustained.

The survey team determined the facility was in compliance with Federal guidelines.

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CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated an identified resident's nurses notes were not complete. The resident's medical record had no charting for a ten-day period in October 2012.

FINDINGS:

There were no specific dates identified, related to the ten-day period in October 2012, when the identified resident's medical record was without charting in the nurses notes.

The identified resident's progress notes from September 24, 2012 through October 31, 2012, were reviewed. There were no progress note entries from September 25, 2012 through October 6, 2012.

During the October 2012 period, the resident's nurses progress notes documented the facility monitored the resident in part for: adverse effects from the decrease in Paxil, adverse reactions related to the influenza vaccination, signs and symptoms of pain, blood glucose levels and a red right eye.

The survey team determined the facility was in compliance with Federal guidelines as there are currently no established guidelines or requirements for the frequency of progress note entries.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated residents were served dinner in a television room. The complainant also stated residents who required assistance from staff to dine were served in a room down the hall from the dining room.

FINDINGS:

During the survey process, the surveyors observed a resident eating in the one-hundred hall television room with the assistance of a staff member. There were no other residents or visitors in the television room at that time.

The Resident Care Manager (RCM) was asked about the resident eating with the assistance of a staff

member. The RCM said that resident required an environment with low stimulation when dining.

During the survey process, the surveyors observed residents who dined independently and who required assistance dining, eating in the main dining room.

The Director of Nursing and the Executive Director both said at one time the residents who required assistance with dining ate in a separate room from the main dining room. However, the number of residents who required assistance with dining had increased and the separate room was too small for all the residents who required assistance with dining. Therefore, the facility decided to move the residents who required assistance with dining to one area of the main dining room.

#### CONCLUSION:

Substantiated. No deficiencies related to the allegation are cited.

#### ALLEGATION #7:

The complainant stated an identified resident had a black eye. There is no documentation or explanation of what happened.

The resident was picking at a skin tear on his hand, but nobody seemed to be doing anything about it.

#### FINDINGS:

On January 29, 2013, the identified resident's nurses progress notes documented a family member approached two licensed nurses and asked about a bruise to the resident's eye. The bruise to the resident's right eyebrow extended down to the eyelid and was approximately two ( 2.0) centimeters by point-zero five (.05) centimeters in size.

The facility's Incident and Accident report dated January 29, 2013, documented the resident's Resident Care Manager (RCM) was made aware of the bruise to the right eye. The RCM investigated and determined the bruise to the right eye was not from the resident's eyeglass frame. The RCM obtained witness statements from the licensed nursing staff who worked the previous three shifts.

The witness statement from a Licensed Nurse (LN) documented on the evening of January 28, 2013, a CNA informed the LN of the resident's right eye. The LN's statement documented a small zero (0) sized spot on the resident's right eye, on the lateral side at the eyebrow line and looked like a small cyst or skin abnormality of some sort.

The witness statements from two other CNAs documented the CNAs noticed a bruise to the resident's right eyebrow but did not notify the nurse on duty.

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The facility educated all staff on the importance of reporting changes in skin conditions when the changes occur.

The survey team substantiated the allegation that the resident had a black eye and there was no documentation or explanation of what happened. The facility was not cited as the facility took appropriate counseling and education actions with staff. No other issues related to lack of reporting or investigation of unknown injury was noted for any other residents reviewed during the recertification survey, so the facility was not cited for this incident.

#### ALLEGATION #8:

The complainant stated facility's staff is not trained on residents' needs.

The complainant stated a staff member was observed and overhead to tell a resident to feed himself. The complainant stated this resident is paralyzed and unable to move his arms.

#### FINDINGS:

Information was not provided as to the resident's identity who was paralyzed, told to feed himself and was unable to move his arms.

Two CNAs were asked how the facility's CNAs were trained to meet residents' needs. Both CNAs said the residents' care directives were completed on admission and the reports were given to staff. In addition, there was a report given at the change of each shift, each day. Both CNAs said there was a care directive book at the nurses' station for the CNAs to use.

The facility's Comments and Grievance forms were reviewed. These forms did not include a grievance about staff telling a resident who was paralyzed and unable to move his arms, to feed himself. These forms did not include a grievance about staff not being trained on residents' needs.

During the initial tour of the facility, the survey team observed the residents who resided in the facility to determine if there was a resident who was paralyzed and unable to move his arms. The survey team did not observe any resident who was paralyzed and unable to move his arms.

During the survey process, residents who required assistance to dine and residents who did not require assistance to dine were observed to determine the amount of assistance provided by staff. Staff were observed providing assistance with set up help for those residents who dined independently. Staff were also observed providing minimal to extensive assistance for residents who required assistance to dine.

Staff were observed taking trays to residents who dined in their rooms. After delivering the room trays

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to the residents, staff were heard to ask residents if they needed any other assistance before the staff left the room to deliver another room tray to a different resident.

The residents who attended the Resident Group interview were asked if there were times when residents required assistance to dine and the facility staff did not provide assistance to dine, specifically a resident who was paralyzed and unable to feed himself. The nineteen residents who attended the Resident Group interview were not aware of and had not seen staff tell a resident to feed himself who could not feed himself.

The facility's Roster Matrix did not include a resident who was paralyzed and unable to move his arms.

The Director of Nursing was asked about a resident who was paralyzed and unable to move his arms. The Director said she was not aware the facility had a resident, currently or in the past, that was paralyzed and unable to move his arms.

The Resident Care Manager for the one hundred hall was asked about a resident who was paralyzed and unable to move his arms. The Manager said she could not recall any resident who was not able to move his arms due to paralysis.

The Regulatory Compliance Registered Nurse was asked about a resident who was paralyzed and unable to move his arms. The nurse said approximately two years prior there was a resident who was in a coma, and he received nourishment by way of a tube feeding. The nurse could not remember a resident who was paralyzed and unable to move his arms.

The Executive Director was asked about a resident who was paralyzed and unable to move his arms. The Director said she was not aware of a resident who could not feed himself and was told by staff to feed himself.

#### CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #9:

The complainant stated an identified resident was taken to meals without his dentures.

The complainant stated the facility recently lost the resident's glasses, and the family had to replace the lost glasses.

#### FINDINGS:

There were no dates or times provided related to the identified resident being taken to meals without his dentures or when the facility lost the resident's glasses, and the family had to replace the lost glasses.

During the survey process, the identified resident was observed with his dentures in his mouth throughout the day. During dining observations, the resident was taken to meals with his dentures in his mouth.

The survey team observed other residents who wore dentures. The survey team did not observe any issues or concerns in regards to residents being taken to meals without their dentures.

The nineteen residents who attended the Resident Group interview were asked if the staff ensured residents who had dentures were taken to meals with their dentures. None of the residents voiced a concern related to residents being taken to meals without their dentures.

The facility's Concern and Comment forms were reviewed. These forms did not include a grievance about the resident being taken to meals without his dentures. These forms did not include a grievance about the resident's lost eyeglasses.

The resident's Resident Care Manager was asked about the resident's lost eyeglasses. The Manager could not remember an occasion when the resident's eyeglasses were lost. The Manager said if the resident's eyeglasses were lost, a room check would be completed and if the eyeglasses were not found, it would be turned over to the Director of Support Services.

A Certified Nurse Aide (CNA) who provided cares to the resident was asked about the resident losing his eyeglasses. The CNA did not remember the resident losing his glasses but remembered the lenses of the resident's eyeglasses would fall out. The Director of Support Services had the glasses repaired.

The Director of Support Services was interviewed and said she could not remember the resident's eyeglasses being lost but remembered the facility repaired the eyeglass frames for the resident. The eyeglasses were given to the Director of Maintenance for repair.

The Director of Maintenance was interviewed and said he remembered more than once when the resident's eyeglass frames needed repaired but did not remember the resident's eyeglasses being lost in the facility. The Director of Maintenance said the facility had an agreement with a local ophthalmologist for repair of eyeglass frames. The Director of Maintenance provided the surveyor with the phone number of the repair person at the local ophthalmologist office. The Director of Maintenance said residents' names were not given to the person who performed the eyeglass repair. The surveyor spoke with the person at the ophthalmologist's office who repaired eyeglasses for the facility. That person verified he worked for the ophthalmologist and repaired eyeglasses at no charge to the facility or the residents.

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The Director of Nursing (DoN) was asked about the resident's eyeglasses being lost and the family having to replace the lost glasses. The Director of Nursing said when residents lose clothing or personal items such as eyeglasses, a Concern and Comment form would be completed, and the facility would do an investigation to determine the cause or to locate the missing item. The DoN said the facility would cover the cost to replace the lost eyeglasses.

The Accounts Payable staff member was interviewed and said the facility had a make it right policy when residents' items were lost. The Accounts Payable person said a Concern and Comment form would be completed, and the facility would cover the cost of the lost eyeglasses. The Accounts Payable person said it was not brought to her attention that the resident's eyeglasses were lost, and the family had to replace the lost eyeglasses. The Accounts Payable person remembered a time when the facility replaced the resident's dentures when the dentures were misplaced or lost in the facility.

The Executive Director was asked if the resident's eyeglasses were lost, and the family had to replace the eyeglasses. The Director said she did not remember the resident losing his eyeglasses. The Director remembered the resident's eyeglasses frames were repaired at one time.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

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

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor  
Long Term Care

LK/lj



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

March 5, 2014

Irene Michael, Administrator  
Life Care Center of Sandpoint  
1125 North Division Street  
Sandpoint, ID 83864

Provider #: 135127

Dear Ms. Michael:

On **January 17, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Sandpoint. Becky Thomas, R.N., Amy Barkley, R.N., Karen Marshall, R.D., and Sherri Case, L.S.W., Q.M.R.P., conducted the complaint investigation. This complaint and two other were investigated in conjunction with the facility's annual Recertification and State Licensure survey.

During the survey process, ten different residents, including the identified resident, were reviewed for the residents' daily life, quality of life, quality of care, drug therapies and other additional areas as required by Federal guidelines.

Interviews were conducted with four individual residents, family members of two different residents, nineteen residents who were in attendance at a Resident Group meeting and numerous facility staff including Certified Nurse Aides (CNAs), Licensed Nurses, the Director of Nursing (DoN) and the administrator.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006068**

ALLEGATION #1:

The complainant stated that initially a nurse refused to adjust the identified resident's arm brace. When the nurse finally took the brace off, the nurse hurt the resident.

**FILE COPY**

Irene Michael, Administrator

March 5, 2014

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#### FINDINGS:

All the residents who attended the Resident Group meeting with the surveyors were in agreement that staff treated them with respect and they were not aware of staff hurting any resident.

Four sample residents who were interviewed stated staff had never hurt them. A resident who had a leg brace was interviewed. She stated that the nurses were very careful when working with her brace and they had never caused her pain.

A Concern and Comment Form (grievance) dated May 14, 2013, documented the identified resident requested muscle relaxer and her "makeshift" splint be loosened. According to the form, the nurse replaced the dressing but not "properly." The resident asked the nurse to re-do the brace but the nurse refused, telling the resident it was "not good for her hand." The resident requested the nurse not to take care of her anymore. The form documented the nurse had been changed to avoid future "personality issues."

Interviews conducted with facility staff confirmed there was a personality conflict between the resident and the nurse who was identified as hurting the resident. The Director of Support Services stated she had talked with the identified resident's Psychosocial Rehabilitation worker who stated the resident was known to "target" people if they did not do as she requested. The administrator stated the resident was unhappy that the nurse had not been fired and felt the administrator should be fired.

#### CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

The complainant stated she did not eat pork, carrots or soup, but all three were served to her.

#### FINDINGS:

Although it could not be determined what was actually served to the identified resident, observations during the survey revealed that a resident was served poultry for two meals. The resident's diet sheet indicated the resident did not like poultry.

Facility grievances documented that residents were served food items they did not like or were allergic to. Residents at the group meeting stated they were often served food that was on their "dislike" list.

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March 5, 2014  
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The facility was cited at F242 for failure to accommodate residents' preferences related to food choices.

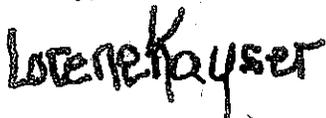
CONCLUSION:

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

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

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and slanted.

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor  
Long Term Care

LK/lj



IDAHO DEPARTMENT OF  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

February 6, 2014

Irene Michael, Administrator  
Life Care Center of Sandpoint  
1125 North Division Street  
Sandpoint, ID 83864

Provider #: 135127

Dear Ms. Michael:

On **January 17, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Sandpoint. Karen Marshall, R.D., Sherri Case, L.S.W., Q.M.R.P., Amy Barkley, R.N. and Becky Thomas, R.N. conducted the complaint investigation. This complaint was investigated in conjunction with two other complaints and the Recertification and State Licensure survey of January 17, 2014.

The following documents were reviewed:

- The identified resident's closed record, and the records of 16 other sampled residents;
- Grievances from August 2013 to January 2014;
- Resident Council Meeting minutes from August 20, 2013, to January 2014; and
- The facility's Infection Control Program.

The following interviews were conducted:

- Quality of Life Resident Group Interview on January 14, 2014, with 19 residents in attendance; and
- Quality of Life Assessment Resident Interviews during the Recertification and State Licensure survey.

This complaint covers two admissions: December 2012 and April 26 through August 13, 2013.

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The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006155**

**ALLEGATION #1:**

The complainant had a concern related to lack of physician visits for the identified resident.

**FINDINGS:**

Review of the identified resident's closed record for the admission dated December 12, 2012, documented that the resident was seen by the physician on December 13, 2012, and January 13, 2013, than discharged to home on January 30, 2013.

Review of the identified resident's closed record for the admission dated April 26, 2013, documented that the resident was seen by a physician on April 26, May 23, 28, 30, June 2, 15, July 18, 24, 2013. The resident was discharged to home on August 13, 2013.

At the Resident Group Interview, residents were asked if they could see their physician upon request. The residents stated this was not a problem since there is a physician at the facility. Additionally, the residents stated they were able to see their physician if they so desired.

On January 14, 2014, the facility's physician was interviewed and stated he currently sees approximately 50 residents at the facility. However, he is available to answer questions from other physician's residents and is willing to consult the physician on his/her behalf if necessary.

One family member was interviewed and asked about their family member seeing a physician; however, they denied any concerns.

Four individual resident's interviews were conducted in which residents verbalized they were able to see a physician when needed.

Grievances were reviewed and did not include any concerns regarding physician's visits.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #2:**

The complainant stated the identified resident developed MRSA (Methicillin-resistant

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Staphylococcus Aureus) while at the facility in both legs and the wounds "were not doing well."

#### FINDINGS:

Review of the identified resident's closed medical record documented the resident was admitted on December 13, 2012, with diagnosis of decubitus on buttocks. The second admission on April 26, 2013, documented the resident was admitted with diagnoses including MRSA, cellulitis of leg and abscess of leg.

The facility's Infection Control nurse was interviewed on January 16, 2014, regarding the facility's Infection Program, specifically identification and treatment of MRSA. If the facility is concerned that a resident has MRSA, they obtain an order from the physician to collect a culture. The resident is placed on appropriate isolation precautions pending culture results. The facility uses the CDC guidelines to determine the appropriate intervention. In addition, the facility has an in-house physician whom they consult with regarding concerns related to MRSA and/or other infections. A repeat culture is obtained after antibiotic treatment.

The resident's closed record review included the treatment administration record, skin sheets and nursing notes, which provided documentation that the wound was improving. There was documentation that nursing staff provided treatment per physician's orders and the resident was being followed by the wound nurse. The closed record included a care plan for MRSA.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #3:

The complainant stated staff are not respectful of residents when they are sleeping, they bang doors and turn on lights.

#### FINDINGS:

During the Resident Group Interview, residents were asked if staff "banged doors shut" and turned on the lights when they were trying to sleep. The residents present, as a whole did not verbalize complaints about the noise level at night.

Five individual residents were interviewed about the noise level at night and stated it was generally quiet.

Grievances were reviewed and did not include any concerns related to increased noise at night.

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The facility was observed on the evening of January 15, 2014, from 9:00 p.m. to 10:15 p.m. for noise levels and staff interaction with residents. The facility was found to be relatively quiet with normal TV sounds. Staff were rounding from room-to-room in a quiet manner. A pill crusher being used at the Nurses Station was heard in the hallway. The facility was notified and stated they would buy a quiet pill crusher.

The Resident Case Manager was interviewed and stated this was a typical night. She reported that sometimes there is a little more noise at change of shift. The surveyors observed change of shift and there was no noticeable difference.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #4:

The complainant had the following complaints:

1. Crust on the resident's scalp, which got worse.
2. Staff did not put the resident in clean clothes after a shower and did not groom him. His beard was dirty and crusty.
3. Staff did not help the resident with washing his face and refused to give him a bath, documenting the resident had refused a bath.

#### FINDINGS:

Review of the identified resident's closed record for the first admission documented on the Monthly Flow Report the resident received only one bath/shower in the eighteen days he was in the facility for the month of December 2012. The January 2013 Monthly Flow Report documented the resident received three showers with one refusal for the entire month. Similar findings were documented for the second admission.

During the Resident Group Interview, residents were asked if they had any concerns with bathing and grooming. Eight of the residents stated they would like a shower more often than one time per week and were told by the facility that they only get one shower per week.

The facility's Policy for "Bathing a Resident" documented, "tub baths or showers will be given at least two (2) times per week to all residents and more frequently as needed."

At the Resident Group Interview, when asked if the residents received help with activities of daily living, such as washing their face, the residents stated the staff did a good job.

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Two residents during the initial tour of the Recertification and State Licensure survey expressed concerns related to only receiving one bath per week. A random resident stated, "The shower situation desperately needs improvement. I have to wait sometimes four or five days for a shower. There is no set schedule."

Grievances were reviewed and documented concerns related to one shower per week or missed showers.

During the survey, residents were observed at different times throughout the day to be well groomed, faces washed, hair combed and in clean apparel.

This allegation was substantiated, and the facility was cited at F242 for failure to ensure that residents were able to make choices about his/her life in the facility that were significant to the resident.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #5:

The complainant stated the family had brought in the resident's lift chair, when it became soiled, the facility did not try to clean it but instead placed a pad on top of the soiled cushion.

#### FINDINGS:

The facility was observed throughout the survey process for soiled equipment, such as lounge chairs, lift chairs, Hoyer slings, wheelchairs and shower chairs. However, all equipment was found to be clean and in good working condition.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #6:

The complainant stated the facility did not assist the resident with feeding and did not provide silverware he could use.

#### FINDINGS:

During the survey process, residents who needed assistance with feeding were observed being

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helped. However, it was observed that the facility failed to ensure special eating equipment was provided for residents who needed it.

The facility was cited at F369 for failure to provide adaptive equipment during meals.

**CONCLUSIONS:**

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

**ALLEGATION #7:**

The complainant stated when the resident didn't like the food he was served, the facility refused to get the resident something different to eat. In addition, the resident was served small portions.

**FINDINGS:**

The identified resident's medical record contained a care plan for nutrition, which documented an approach for substitutions should the resident eat less than 50% of his meal. The care plan was updated on July 3, 2013, for the resident to have regular size portions. The care plan for nutrition documented the resident received morning, afternoon and evening snacks. Additionally, the CNA Monthly Flow Report documented, the resident accepted his meals and snacks consuming anywhere from 50-100%.

During the Resident Group Interview, residents were asked if they did not like what was being served, if they were offered an alternate. The residents stated, "Yes," and if they didn't like the alternate tray, there was another selection of food they could choose from.

During three resident interviews, residents stated the facility did a good job with providing an alternate tray.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #8:**

The complainant stated the facility did not manage his pain well.

**FINDINGS:**

A closed record review of the identified resident's Medication Administration Record revealed the resident received Gabapentin, Naproxen and Methadone on a twice per day schedule.

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Additionally, he had a PRN order for Tylenol. Nursing notes did not document concerns related to the resident verbalizing inadequate pain control.

Grievances were reviewed and did not include any pain control concerns.

Interviews with residents and their families during the Recertification and State Licensure survey, indicated residents were happy with their pain control/medications and did not have problems with pain.

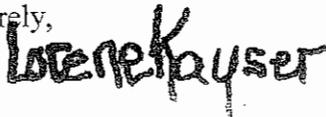
**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

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

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and slanted.

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor  
Long Term Care

LKK/dmj