STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	**1001 SOUTH HILTON STREET BOISE, ID 83705**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents' records included an Advance Directive or documentation an Advance Directive was discussed or offered. This was true for 5 of 24 residents (#33, #47, #49, #51 and #107) whose records were reviewed for an Advance Directive. This failed practice created the potential for harm if residents' wishes regarding end of life or emergent care were not honored if they became incapacitated. Findings include: The State Operations Manual, Appendix PP, defines an Advance Directive as .a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. The State Operations Manual also states a Physician order [REDACTED]. medical condition into consideration. A POLST [MEDICATION NAME] form is not an Advance Directive. The facility's Advance Directive policy, dated (NAME)2008, documented the following: * Upon admission social services will provide written information to the resident concerning the right to formulate an Advance Directive. * Social Services will inquire about the existence of an Advance Directive. * Information about whether a resident has executed an Advance Directive shall be prominently displayed in the medical record. This policy was not followed. 1. Resident #49 was admitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Resident #49's physician orders, dated 8/10/16, documented her code status was do not resuscitate. A care plan initiated on 6/6/17, documented Resident #49's Advance Directive would be reviewed quarterly, and as needed, with any changes to her condition. Resident #49's record did not include an Advance Directive, or documentation one was offered or discussed with her. On 3/3/20 at 1:53 PM, the Social Worker stated there was no documentation in Resident #49's record that an Advance Directive was discussed with her. 2. Resident #51 was admitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Resident #51's physician order, dated 10/30/19, documented his resuscitation status was Full Code (a person will allow all interventions needed to get their heart started). A care plan, dated 2/5/20, documented Resident #51's Advance Directive would be reviewed quarterly, and as needed, with any changes to his condition. A Social Services progress note, dated 10/31/19, documented Resident # 51 did not have an Advance Directive. Resident #51's record did not include an Advance Directive, or documentation one was offered or discussed with him. On 3/3/20 at 1:53 PM, the Social Worker stated there was no documentation in Resident #51's record that an Advance Directive was discussed with him. 3. Resident #107 was admitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Resident #107's physician orders, dated [DATE], documented her code status was do not resuscitate. Resident #107's record did not include an Advance Directive, or documentation one was offered or discussed with her. On 3/3/20 at 1:53 PM, the Social Worker stated there was no documentation in Resident #107's record an Advance Directive was discussed with her. 4. Resident #33 was admitted to the facility on [DATE] and readmitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Resident #33's physician orders [REDACTED]. Resident #33's quarterly MDS assessment, dated 1/10/20, documented he was cognitively intact. Resident #33's care plan documented his code status was Full Code. Resident #33's Physician order [REDACTED]. The POST differed from the care plan, which documented Full Code with aggressive interventions. A Huddle Note, dated 11/4/19 at 9:11 AM, documented Resident #33 had an Advance Directive and a copy was to be obtained for his record. There was no documentation in Resident #33's record of an Advance Directive, or that one was discussed with him. On 3/3/20 at 2:33 PM, the Recreation Therapist, who also assisted with social service functions, said Resident #33 was on the list to have Advance Directives discussed with him, and only a POST was documented in his record. 5. Resident #47 was admitted to the facility on [DATE] and readmitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Resident #47's annual MDS assessment, dated 2/2/20, documented she was cognitively intact. Resident #47's physician orders [REDACTED]. Resident #47's care plan documented her status was Full Code, she had a POST, and directed staff to review her code status quarterly, and as needed, with her and her family. Resident #47's POST documented she wished for her status to be Full Code with aggressive interventions, and it was signed by her on 11/2/12. Resident #47's record did not contain an Advance Directive or documentation one was discussed with her. On 3/3/20 at 2:25 PM, the Recreation Therapist said Resident #47 was on the list to have Advance Directives discussed with her, and only a POST was documented in her record.
F 0580 **Level of harm -** Actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and staff interview, it was determined the facility failed to notify the physician of a resident's change of condition in a timely manner. This was true for 1 of 1 resident (Resident #19) reviewed for change of condition. Resident #19 was harmed when the facility did not call the physician immediately when he presented with low blood pressure, slurred speech, and difficulty responding to requests. Resident #19 was subsequently admitted to the intensive care unit of the hospital for septic shock (a life-threatening condition caused by a severe localized or system-wide infection that requires immediate medical attention). Findings include: The facility's policy for Change in a Resident's Condition or Status, revised (NAME)2011, stated .The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: . A significant change in the resident's physical/emotional/mental condition; . A need to transfer the resident to a hospital/treatment center. This policy was not followed. The website www.mayoclinic.org, accessed on 3/19/20, documented the following [MEDICAL CONDITION] and septic shock: To be diagnosed with [REDACTED].* Change in mental status * A first (upper) number in a blood pressure reading - also called the systolic pressure - that's less than or equal to 100 millimeters of mercury (mm Hg) * Respiratory rate higher than or equal to 22 breaths a minute [MEDICAL CONDITION] can progress to septic shock when certain changes in the circulatory system, the body's cells and how the body uses energy become more abnormal. Septic shock is more likely to cause death [MEDICAL CONDITION] is. To be diagnosed with [REDACTED].* The need for medication to maintain blood pressure greater than or equal to 65 millimeters of mercury (mm Hg). * High levels of lactic acid in your blood (serum [MEDICATION NAME]) after you have received adequate fluid replacement. Having too much lactic acid in your blood means that your cells aren't using oxygen properly. Resident #19 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. An

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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F 0580 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) admission MDS assessment, dated 11/13/19, documented Resident #19 was cognitively intact, had no difficulty with swallowing, his speech was clear, and he was able to understand others. A Progress Note for Resident #19, dated 11/30/19 at 2:00 PM, documented .(Resident #19) had a difficult day. Mid morning he began hyperventilating (rapid breathing) and had systolic (top number in blood pressure) BP (blood pressures) in the low 70's and diastolic (bottom number in blood pressure) BP (blood pressures) in the low 40's, now WNL (within normal limits) .He is alert but with slurred, difficult to understand speech .Responds to verbal requests but sometimes with difficulty . There was no documentation that Resident #19's physician was notified of his low blood pressures, slurred speech, and difficulty responding to verbal requests. A Progress Note for Resident #19, dated 11/30/2019 at 6:45 PM, documented Resident #19 was typically alert and oriented to person, time, and place, and was able to follow commands. The note also stated Resident #19's urine was typically amber with sediment in it. The note documented Resident #19's status at that time was Resident urine is red, Decrease in LOC (level of consciousness), and murmured speech, Resident has an increase in respiratory rate (shallow). Resident does not recall the time or facility that they are located in. The urine in the (F)oley (catheter bag) is red. Resident unable to swallow food. Resident states pain in chest and stomach. Request: hospitalization for evaluation of condition A Progress Note, dated 11/30/2019 at 7:39 PM, documented .(Resident #19's Physician) recommended transfer to (the) hospital. Patient picked up at 19:00 (7:00 PM) by emergent transport, taken to (Hospital). Resident #19's Hospital History and Physical, dated 11/30/19 at 11:00 PM, documented the physician's impression was Septic shock present on admission presumed in relation to urinary tract infection versus possible healthcare acquired right lower lobe pneumonia (lung inflammation caused by bacterial or [MEDICAL CONDITION] infection) . The physician's plan stated, .The patient is critically ill . A Progress Note for Resident #19, dated 12/1/19 at 1:07 AM, documented .Received call from (Hospital) stating patient has been admitted for severe urosepsis (harmful organisms in the blood or other tissues that is caused by an infection in the urinary tract) . Resident #19's Hospital Discharge Summary, dated 12/6/19 at 8:00 PM, when Resident #19 was discharged back to the long term care facility, documented while at the hospital he was admitted to the Intensive Care Unit due to his [MEDICAL CONDITION] (low blood pressure). During an interview with the DON on 3/5/20 at 11:01 AM, he was asked if he would consider a resident with a systolic blood pressure in the low 70s and diastolic blood pressure in the low 40s, along with slurred speech and difficulty responding to verbal requests, to have a change of condition. The DON stated, I would assume a change of condition. When asked if he would expect Resident #19's physician to be notified regarding the change in his condition, the DON stated, Yes. When asked how soon the physician should be notified about a resident with the above listed symptoms, the DON stated, As soon as possible. The DON was asked to review the Progress Notes documented above and to determine the time Resident #19's physician was notified. He read the notes and stated, He (Resident #19) was picked up at 7:00 PM. It doesn't say what time she (Resident #19's physician) was notified. When asked what time the Progress Notes documented Resident #19's symptoms of low blood pressure, slurred speech, and difficulty responding to verbal requests were first documented, he stated, Mid-morning. The DON was asked, according to the documentation in the Progress Notes, if licensed staff recognized Resident #19 was in an emergent state mid-morning. He stated, It doesn't seem like it. When asked if the resident's physician should have been notified of the change of condition in the morning, he stated, I would have, yes. During an interview on 3/5/20 at 2:22 PM, Resident #19's the Medical Director was asked if she would expect to be notified if a resident's blood pressure was in the 70s/40s and he had slurred speech and difficulty responding to verbal requests. She stated, Yes. When asked how soon after the symptoms were noted she would expect staff to notify her, she stated, Immediately.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a written notice of transfer was provided to a resident and/or their representative, and the local ombudsman was notified of residents being transferred out of the facility. This was true for 2 of 2 residents (#19 and #56) reviewed for transfers, and had the potential for harm if residents were not aware of or able to exercise their rights as members of a long-term care facility. Findings include: The facility's policy for Transfer or Discharge, Emergency, revised December 2012, documented if a resident was transferred emergently, a transfer form was sent with the resident, and the resident's representative or other family member was notified. The facility's policy for Transfer or Discharge Documentation, revised December 2012, documented an appropriate notice was provided to the resident and/or their representative. These policies were not followed. 1. Resident #19 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. a. A Progress Note, dated 11/30/19 at 7:39 PM, stated Resident #19 was transferred to the hospital after experiencing blood in his urine, a change in level of consciousness, and murmured speech. There was no documentation in Resident #19's record which stated the facility provided written notification of the reason for the transfer to the hospital to Resident #19 and his respresentative. There was also no documentation in the record the Ombudsman was notified of Resident #19's transfer on 11/30/19. b. A Progress Note, dated 2/10/20 at 6:00 AM, documented Resident #19 was transferred to the hospital after experiencing increasing confusion, blood in his urine, and severe pain. There was no documentation in Resident #19's record which stated the facility provided written notification of the reason for transfer to the hospital to Resident #19 and his respresentative. There was also no documentation in the record the Ombudsman was notified of Resident #19's transfer on 2/10/20. c. A Progress Note, dated 2/14/20 at 4:09 PM, documented Resident #19 was transferred to the hospital after experiencing abdominal distention and abdominal pain. There was no documentation found in Resident #19's record which stated the facility provided written notification of the reason for the transfer to the hospitalto Resident #19 and his respresentative. There was also no documentation in the record the Ombudsman was notified of Resident #19's transfer on 2/14/20. On 3/5/20 at 10:11 AM, the Social Worker was interviewed. When asked if the facility had notified the Ombudsman regarding Resident #19's transfers to the hospital on [DATE], 2/10/20, and/or 2/14/20, she stated she did not know the Ombudsman was to be notified when a resident was transferred to the hospital. On 3/5/20 at 12:46 PM, the DON was asked if Resident #19 and/or his representative had been provided written notification of the reason for his transfer to the hospital on [DATE], 2/10/20, and/or 2/14/20. He stated the facility had not provided written notification of the reason for transfer for any of the transfers. 2. Resident #56 was admitted to the facility on [DATE] and readmitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Resident #56's discharge MDS assessment, dated 12/18/19, documented she had an unplanned discharge to the hospital. A Progress Note, dated 12/18/19 at 5:22 AM, documented Resident #56 became unresponsive when the CNAs were preparing to transfer her using the Hoyer (a mechanic lift). Her pulse was 168, blood pressure was 52/48, and temperature was 100.1 Fahrenheit. Resident #56's husband requested to transfer her to the hospital and 911 was called. Resident #56's record did not document the Ombudsman was notified of her transfer to the hospital. On 3/5/20 at 9:56 AM, the DON said the facility notified the Ombudsman monthly of transfer/discharges, and Social Services did that. On 3/5/20 at 10:02 AM, the Recreation Therapist, who also assisted with social service functions, said if there were concerns about a resident's discharge then she would call the Ombudsman, and otherwise she did not report it to the Ombudsman. The Recreation Therapist said she thought nursing staff reported transfer/discharges, and when she asked the DON about it he said he did not know anything about that.
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a bed hold notice was provided to residents upon transfer to the hospital. This was true for 2 of 2 residents (#19 and #56) reviewed for transfers. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time. Findings include: The facility's Admission Agreement, dated 5/27/17, contained a Bed Hold Policy, which stated A bed hold will be offered at the time of transfer to an acute hospital. If the bed hold is not completed upon discharge, Facility staff will contact the Resident regarding

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F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) their decision to hold the bed. The Bed Hold Policy also documented the resident signed the Admission Agreement, including the Bed Hold Policy, upon admission, and the Bed Hold Policy applied to all transfers and discharges. These policies were not followed. 1. Resident #19 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. a. Resident #19's Progress Notes, dated 11/30/19 and 12/6/19, documented he was transferred to the hospital on [DATE] and re-admitted to the facility on [DATE]. There was no documentation in Resident #19's record which stated the facility provided written notification of the bed hold policy to him or his representative upon transfer to the hospital on [DATE]. b. Resident #19's Progress Notes, dated 2/10/20 and 2/13/20, documented Resident #19 was transferred to the hospital on [DATE] and re-admitted to the facility on [DATE]. There was no documentation in Resident #19's record which stated the facility provided written notification of the bed hold policy to Resident #19 or his representative upon transfer to the hospital on [DATE]. c. Resident #19's Progress Notes, dated 2/14/19 and 2/19/20, documented Resident #19 was transferred to the hospital on [DATE] and re-admitted to the facility on [DATE]. There was no documentation in Resident #19's record which stated the facility provided written notification of the bed hold policy to him or his representative upon transfer to the hospital on [DATE]. On 3/5/20 at 10:23 AM, the Administrator was interviewed. When asked if the facility provided written notification of the bed hold policy to Resident #19 or his representative when he was transferred to the hospital on [DATE], 2/10/20, and 2/14/20, the Administrator stated there was probably no documentation the facility's bed hold policy was provided to Resident #19 or his representative upon any of the transfers to the hospital. 2. Resident #56 was admitted to the facility on [DATE] and readmitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Resident #56's discharge MDS assessment, dated 12/18/19, documented she had an unplanned discharge to the hospital. Resident #56's Progress Note, dated 12/18/19 at 5:22 AM, documented she became unresponsive when the CNAs were preparing to transfer her using the Hoyer (a mechanic lift). Her pulse was 168, blood pressure was 52/48, and temperature was 100.1 Fahrenheit. Resident #56's husband requested to transfer her to the hospital and 911 was called. Resident #56's record did not document a bed hold notice was provided upon her transfer to the hospital. On 3/5/20 at 9:56 AM, the DON said residents were brought back to their same room in the facility if they were transferred to the hospital. The DON said he did not know where it would be documented the bed hold policy was provided to the resident. On 3/5/20 at 10:21 AM, the Administrator saidhe thought the bed hold notice was documented on the pink sheet that was sent to the hospital with the resident, and he was aware the bed hold notice was supposed to be provided to the resident upon transfer.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents' care plans were revised to accurately reflect toileting status and included related interventions, and quarterly care conferences were held. This was true for 3 of 16 residents (#3, #33, and #49) whose care plans were reviewed. This failure created the potential for harm if care was based on inaccurate care plan information. Findings include: The facility's policy for Care Plans-Comprehensive, revised October 2010, documented Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change(s). The facility's policy for Care Plans, Goals and Objectives, dated (NAME)2011, documented goals and objectives were reviewed or revised when the resident was readmitted to the facility and at least quarterly. These policies were not followed. 1. Resident #49 was admitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. A significant change MDS assessment, dated 2/4/20, documented Resident #49 received hospice services and required extensive assistance of two staff members for bed mobility and toileting, Resident #49 was frequently incontinent, and was not on a urinary toileting program. Resident #49's care plan, initiated on 10/17/19, documented she was a candidate for scheduled toileting and was placed on an incontinent program to include toileting upon rising, before and after meals and at bedtime, and was to be continent at all times through the next care plan review date. Resident #49's record included documentation of her toileting, dated 2/1/20 to 2/29/20. A section for day shift, evening shifts, and a night shift included documentation of bladder function and type of toileting. Resident #49's toileting did not follow the interventions on her care plan for an incontinent program with specific times. On 2/3/20, [DATE] to 2/10/20, 2/13/20 to 2/16/20, 2/19/20, and 2/21/20 to 2/23/20, the documentation stated Resident #49 was incontinent and used briefs. Resident #49's care plan was not updated to reflect her current toileting status. On 3/5/20 at 2:24 PM, RCM #1 stated Resident #49's care plan should have been changed and was not. 2. Resident #3 was admitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Resident #3's care plan initiated on 12/4/19, documented she was on an incontinent program to include toileting upon rising, before and after meals, and at bedtime and to be continent at all times through the next care plan review date. A bowel and bladder evaluation, dated 2/7/20, documented Resident #3 was incontinent and pads and briefs were used daily. On 3/5/20 at 2:24 PM, RCM #1 stated Resident #3's care plan should have been changed to reflect her current toileting status and was not. 3. Resident #33 was admitted to the facility on [DATE] and readmitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Resident #33's MDS assessments documented the following: * An Admission MDS assessment, dated [DATE], documented he was admitted to the facility on [DATE] from the community. * A Discharge MDS assessment, dated [DATE], documented he was discharged to the hospital on [DATE]. * An Entry Tracking Record MDS assessment, dated 1/6/20, documented he re-entered the facility from the hospital on [DATE]. A 72 Hour Huddle note, dated 11/4/19 at 9:11 AM, documented a care plan meeting was held with Resident #33, the Social Worker, and the MDS nurse. There was no documentation of other care plan meetings held with Resident #33 after 11/4/19. On 3/2/20 at 3:31 PM, Resident #33 said he never had care plan meetings with the facility. On 3/3/20 at 2:33 PM, the Recreation Therapist said Resident #33 was due for a care conference. On 3/4/20 at 10:03 AM, the DON said care plan meetings should be held at the 72 hour huddle (after admission) then quarterly, and the Interdisciplinary Team attended the care plan meetings. The facility did not provide documentation of other care conference meetings for Resident #33 other than the 72 hour huddle on 11/4/19.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure bathing was provided to meet residents' needs. This was true for 2 of 16 residents (#3 and #49) reviewed for ADL care. This created the potential for residents to experience skin breakdown and a negative effect to their psychosocial well-being when care was not provided as needed. Findings include: 1. Resident #3 was admitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. A quarterly MDS assessment, dated 2/7/20, documented Resident #3 required extensive assistance with one staff member for bathing. Resident #3's ADL report for February 2020, documented there were no showers provided from [DATE] through 2/13/20 (6 days), and 2/15/20 through 2/23/20 (9 days). On 3/4/20 at 2:13 PM, RCM #1 stated Resident #3 did not receive a shower for 6 days from [DATE] through 2/13/20 and 9 days from 2/15/20 through 2/23/20. 2. Resident #49 was admitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. A significant change MDS assessment, dated 2/4/20, documented Resident #49 received hospice services and required extensive assist with one staff member for bathing. Resident #49's care plan, revised on 1/31/20, documented she was to receive 2 showers per week from hospice health aides. Resident #49's ADL report for February 2020 documented there were no showers provided from 2/1/20 through [DATE] (6 days). There were no showers provided from [DATE] through 2/13/20 (6 days). The documentation showed no showers were provided from 2/18/20 through 2/28/20 (11 days). On 3/5/20 at 2:12 PM, RCM #1 stated Resident #49 did not receive a shower twice during the week of 2/3/20 and the week of 2/10/20. She stated Resident #49 did not receive 2 showers per week from 2/18/20 through 2/28/20 (11 days). She stated when hospice aides provided services they gave written documentation of resident cares to a licensed nurse and the documentation was either scanned into the resident's record or a progress note was completed in the resident's record. She was unable to find documentation hospice aides provided 2 showers per week as directed by the deliniation of cares. RCM #1 stated if hopsice aides do not complete resident cares, the facility was responsible to ensure

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F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) the resident received ADL cares to meet their needs.
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, the facility failed to obtain emergent care in a timely manner. This was true for 1 of 1 resident (Resident #19) reviewed for Quality of Care related to a change of condition. Resident #19 was harmed when the facility when nursing staff failed to recognize and act on significant changes in condition such as low blood pressure, slurred speech, and difficulty responding to requests. Resident #19 was subsequently admitted to the intensive care unit of the hospital for septic shock (a life-threatening condition caused by a severe localized or system-wide infection that requires immediate medical attention). Findings include: The facility's policy for Transfer or Discharge, Emergency, revised December 2012, stated: Our facility shall make an emergency transfer or discharge when it is in the best interest of the resident. The facility's policy for Change in a Resident's Condition or Status, revised (NAME)2011, stated .The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been . A significant change in the resident's physical/emotional/mental condition; . A need to transfer the resident to a hospital/treatment center. These policies were not followed. The website www.mayoclinic.org, accessed on 3/19/20, documented the following [MEDICAL CONDITION] and septic shock: To be diagnosed with [REDACTED].* Change in mental status * A first (upper) number in a blood pressure reading - also called the systolic pressure - that's less than or equal to 100 millimeters of mercury (mm Hg) * Respiratory rate higher than or equal to 22 breaths a minute [MEDICAL CONDITION] can progress to septic shock when certain changes in the circulatory system, the body's cells and how the body uses energy become more abnormal. Septic shock is more likely to cause death [MEDICAL CONDITION] is. To be diagnosed with [REDACTED].* The need for medication to maintain blood pressure greater than or equal to 65 millimeters of mercury (mm Hg). * High levels of lactic acid in your blood (serum [MEDICATION NAME]) after you have received adequate fluid replacement. Having too much lactic acid in your blood means that your cells aren't using oxygen properly. Resident #19 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. An admission MDS assessment, dated 11/13/19, documented Resident #19 was cognitively intact, had no difficulty with swallowing, his speech was clear, and he was able to understand others. A Progress Note for Resident #19, dated 11/30/19 at 2:00 PM, documented .(Resident #19) had a difficult day. Mid morning he began hyperventilating (rapid breathing) and had systolic (top number in blood pressure) BP (blood pressures) in the low 70's and diastolic (bottom number in blood pressure) BP (blood pressures) in the low 40's, now WNL (within normal limits) .He is alert but with slurred, difficult to understand speech .Responds to verbal requests but sometimes with difficulty . There was no documentation that Resident #19's physician was notified of his low blood pressures, slurred speech, and difficulty responding to verbal requests. A Progress Note for Resident #19, dated 11/30/2019 at 6:45 PM, documented Resident #19 was typically alert and oriented to person, time, and place, and was able to follow commands. The note also stated Resident #19's urine was typically amber with sediment in it. The note documented Resident #19's status at that time was Resident urine is red, Decrease in LOC (level of consciousness), and murmured speech, Resident has an increase in respiratory rate (shallow). Resident does not recall the time or facility that they are located in. The urine in the (F)oley (catheter bag) is red. Resident unable to swallow food. Resident states pain in chest and stomach. Request: hospitalization for evaluation of condition A Progress Note, dated 11/30/2019 at 7:39 PM, documented .(Resident #19's Physician) recommended transfer to (the) hospital. Patient picked up at 19:00 (7:00 PM) by emergent transport, taken to (Hospital). Resident #19's Hospital History and Physical, dated 11/30/19 at 11:00 PM, documented the physician's impression was Septic shock present on admission presumed in relation to urinary tract infection versus possible healthcare acquired right lower lobe pneumonia (lung inflammation caused by bacterial or [MEDICAL CONDITION] infection) . The physician's plan stated, .The patient is critically ill . A Progress Note for Resident #19, dated 12/1/19 at 1:07 AM, documented .Received call from (Hospital) stating patient has been admitted for severe urosepsis (harmful organisms in the blood or other tissues that is caused by an infection in the urinary tract) . Resident #19's Hospital Discharge Summary, dated 12/6/19 at 8:00 PM, when Resident #19 was discharged back to the long term care facility, documented while at the hospital he was admitted to the Intensive Care Unit due to his [MEDICAL CONDITION] (low blood pressure). During an interview with the DON on 3/5/20 at 11:01 AM, he was asked if he would consider a resident with a systolic blood pressure in the low 70s and diastolic blood pressure in the low 40s, along with slurred speech and difficulty responding to verbal requests, to have a change of condition. The DON stated, I would assume a change of condition. When asked if he would expect Resident #19's physician to be notified regarding the change in his condition, the DON stated, Yes. When asked how soon the physician should be notified about a resident with the above listed symptoms, the DON stated, As soon as possible. The DON was asked to review the Progress Notes documented above and to determine the time Resident #19's physician was notified. He read the notes and stated, He (Resident #19) was picked up at 7:00 PM. It doesn't say what time she (Resident #19's physician) was notified. When asked what time the Progress Notes documented Resident #19's symptoms of low blood pressure, slurred speech, and difficulty responding to verbal requests were first documented, he stated, Mid-morning. The DON was asked, according to the documentation in the Progress Notes, if licensed staff recognized Resident #19 was in an emergent state mid-morning. He stated, It doesn't seem like it. During an interview on 3/5/20 at 2:22 PM, the Medical Director was asked if she would expect to be notified if a resident's blood pressure was in the 70s/40s and he had slurred speech and difficulty responding to verbal requests. She stated, Yes. When asked how soon after the symptoms were noted she would expect staff to notify her, she stated, Immediately.

F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents received respiratory care as ordered by a physician. This was true for 2 of 2 residents (#51 and #107) reviewed for respiratory care. This failure created the potential for adverse outcomes related to low oxygen levels and infection from contaminants. Findings include: 1. Resident #51 was admitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. A quarterly MDS assessment, dated [DATE], documented Resident #51 was using oxygen therapy. A physician's orders [REDACTED].* Check oxygen saturation every shift and as needed for acute [MEDICAL CONDITION]. * Administer oxygen at 4 liters per minute via nasal cannula to maintain oxygen saturations equal to or greater than 90 percent for shortness of breath. On 3/2/20 at 10:50 AM, Resident #51's oxygen concentrator was set at 3 liters per minute, he was wearing a nasal cannula. On 3/3/20 at 3:16 PM, CNA #1 and CNA #2 stated during the evening shift, they set the oxygen liter flow to what the nurse told them to set it to. On 3/3/20 at 3:35 PM, the DON stated that CNAs were not to adjust oxygen settings. On 3/3/20 at 3:43 PM, Resident # 51's oxygen was set to 1 liter per minute. The DON came to the room and verified the setting was 1 liter per minute and stated that was not correct per his physician orders. 2. Resident #107 was admitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. The facility's policy for Continuous Positive Airway Pressure (machine that uses mild air pressure to keep breathing airways open), undated, documented staff were to wash the mask in warm water and air dry, then store the mask and tubing in a plastic bag labeled with the resident's name and the date the tubing was pulled into use. This policy was not followed. A physician's orders [REDACTED].#107's continuous positive airway pressure ([MEDICAL CONDITION]) use: * [MEDICAL CONDITION] with 2 liters of continuous oxygen at bedtime for obstructive sleep apnea. * [MEDICAL CONDITION]-monitor every 2 hours during the night to assure equipment is in place. * [MEDICAL CONDITION]-document oxygen liters per minute and saturations every night. *Oxygen [MEDICAL CONDITION] tubing to be replaced every 3 months. * Empty water reservoir daily and wash mask one time a day A care plan, dated 2/28/20, directed staff to replace Resident #107's [MEDICAL CONDITION] tubing every 3 months and to empty the water reservoir and wash the [MEDICAL CONDITION] mask once a day. Resident #107's Treatment Administration Record (TAR), dated 3/1/20 through 3/4/20, directed staff to empty the water reservoir from her [MEDICAL CONDITION] and wash the mask once daily. Resident #107's TAR did not include replacement of the [MEDICAL CONDITION] tubing. On 3/2/20 at 9:50 AM, Resident #107's [MEDICAL CONDITION] mask was observed attached to the [MEDICAL CONDITION] tubing and the [MEDICAL CONDITION] machine was laying on Resident #107's unmade bed. On 3/3/20 at 3:14 PM, Resident #107's [MEDICAL CONDITION] mask was attached to the [MEDICAL CONDITION] tubing and the [MEDICAL CONDITION] machine was laying on the windowsill next to her bed. On 3/3/20 at 3:16 PM, CNA #1 and CNA #2 both stated they did not know who cleaned the [MEDICAL CONDITION] masks. When asked if Resident #107's mask, which was sitting on the windowsill, was cleaned and they stated it was not. On

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	**1001 SOUTH HILTON STREET BOISE, ID 83705**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) 3/3/20 at 3:35 PM, the DON stated nurses or CNAs cleaned the masks. On 3/4/20 at 11:02 AM, RCM #1 stated [MEDICAL CONDITION] masks should be cleaned when they were taken off residents in the morning.
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents received appropriate monitoring while receiving [MEDICAL CONDITION] medications. This was true for 1 of 5 residents (Resident #22) reviewed for unnecessary medications when a resident received antidepressant medication without appropriate monitoring. This failure created the potential for harm if residents experienced adverse effects from unnecessary [MEDICAL CONDITION] medications. Findings include: The facility's policy for [MEDICAL CONDITION] Management Guideline, dated October 2015, documented the following: * The facility routinely evaluated residents for behaviors and actively attempted to decrease or eliminate the use of psychoactive medications. * Residents were monitored daily for side effects and effectiveness of the medication. The facility's policy for Sleep Disorders, revised October 2010, documented the following: * Nursing staff described any sleep disturbance in detail. * Sedatives/hypnotics were prescribed judiciously, at the lowest possible dose for the shortest amount of time. * The physician and staff monitored the resident's progress with sleep, and adjusted interventions appropriately. These policies were not followed. Resident #22 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple [DIAGNOSES REDACTED]. Resident #22's quarterly MDS assessment, dated 12/21/19, documented he was cognitively intact, and he received antidepressant medication on 7 of the previous 7 days. Resident #22's physician orders [REDACTED]. The order started on 1/6/20. Resident #22's Medication Administration Records for January, February, and (NAME)2020 documented the [MEDICATION NAME] was administered as ordered. Resident #22's care plan documented he received a sedative/hypnotic medication and directed staff to monitor for side effects and effectiveness. The care plan directed staff to consult the appropriate medical provider if signs/symptoms of sleep deprivation persisted or became worse, and to determine Resident #22's usual sleep habits. Resident #22's record did not document his sleep was monitored prior to 3/4/20. On 3/4/20 at 2:41 PM, the DON said if a resident was taking [MEDICATION NAME] for [MEDICAL CONDITION] the resident's sleep should be monitored unless they had been taking it for a long time, then the monitoring might be discontinued if they were stable. The DON said there was no documentation Resident #22's sleep was being monitored. The facility was unable to provide documentation sleep monitoring was discontinued or not necessary.