

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/17/2025
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Boise		STREET ADDRESS, CITY, STATE, ZIP CODE  808 North Curtis Road Boise, ID 83706	

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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, interview, and facility policy review, the facility failed to ensure one of one resident (Resident (R)34) reviewed for self-administration of medications out of a total sample of 20 had a self-administration assessment completed before medications were left at the resident's bedside. This had the potential for the resident to not take the correct medications per order with a potential for significant medication error. Findings include: Review of the policy titled, Administration of Medications, dated 2025, revealed, . 2. The Facility, in conjunction with the interdisciplinary care team, should assess and determine, with respect to each resident, whether self-administration of medications is safe and clinically appropriate, based on the resident's functionality and health condition. 3. To ensure safe and appropriate self-administration, facility should educate residents to ensure that a resident is able to: 3.1 State the name, dose, strength, frequency, and purpose for use of their medications. 3.2. Understand the possible medication side effects and that they should notify facility staff if they experience any such side effects. 3.3 Correctly administer, inject, or apply all prescribed medications. 3.4. Correctly store their medications in a locked compartment . 5. Facility should ensure that orders for self-administration list the specific medication(s) the resident may self-administer . 9.1 The medication storage compartments should be located in the resident's room so that another resident is not able to access the medications. 9.2. The storage compartment should be locked when not in use . Review of R34's Medical Diagnosis record, located in the electronic medical record (EMR) under the Medical Diagnosis tab, revealed the resident was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (Bipolar type), gastro-esophageal reflux disease (GERD), and chronic pain. Review of R34's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 04/07/25 and located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating the resident was cognitively intact. Review of R34's current physician's Orders, located in the EMR under the Orders tab, revealed an order for Excedrin migraine oral tablet 250 milligrams (mg)-65mg, give two tablets, two times a day for chronic pain, with a start date of 08/01/24. During an observation and interview on 07/14/25 at 10:30 AM, R34's bedside table's top drawer was open. Inside the drawer was a plastic cup with several white pills. R34 said they were Excedrin and Gas-X (for gas and/or bloating) pills. He stated staff give them to him and allow him to keep them in the drawer of his bedside table. During an observation and interview on 07/16/25 at 10:30 AM, the cup of pills was still in the R34's drawer. Licensed Practical Nurse (LPN)1 confirmed there were six Excedrin and six Gas-X pills in the plastic cup in the resident's top drawer of his bedside table. R34 again said that staff gave them to him to keep in his drawer. LPN1 confirmed R34 did not have an assessment completed to ensure his safety for keeping medications at the bedside. During an interview on 07/16/25 at 2:00 PM, the Director of Nursing (DON) confirmed R34 did not have a self-administer assessment and he was not to be administering his own medications. She said it was not safe for him to do so.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review, interview, and facility policy review, the facility failed to obtain and document urinary outputs as ordered for one of three residents (Resident (R) 42) reviewed for the management of indwelling urinary catheters out of a total sample of 20. Failure to obtain and document urinary output may result in delayed identification of complications such as urinary retention, dehydration, infection, or impaired kidney function. Findings include: Review of the facility's policy titled, Indwelling Urinary (Foley) Management, last revised 06/07/23, indicated, . The facility will ensure that residents admitted with a urinary catheter, or determined to need a urinary catheter for medical indication will have the following areas addressed; . 4. Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and infection prevent and control procedures . Additional care practices related to catheterization 1. Recognizing and assessing for complications and their causes and maintaining a record of catheter-related problems; 2. Recognizing and assessing whether residents are at risk for other possible complications resulting from the continuing use of the catheter, such as obstruction resulting from catheter encrustations, urethral erosion, bladder spasms, hematuria, and leakage around the catheter. The policy did not include specific guidance on obtaining and documenting urinary output. Review of R42's admission Record (Face Sheet), located under the Profile tab of the electronic medical record (EMR), indicated that the facility initially admitted R42 on 10/21/21. R42's pertinent diagnoses included bladder-neck obstruction and obstructive and reflux uropathy. Review of R42's Care Plan, last revised on 04/03/25 and located under the Care Plan tab of the EMR, indicated that R42 had an indwelling catheter related to urinary retention and incomplete bladder emptying due to bladder-neck obstructive uropathy, as well as functional urinary incontinence. The pertinent interventions directed staff to monitor output as per facility policy (every shift), observe for and report to medical doctor signs and symptoms of urinary tract infections: pain, burning, blood-tinged urine, cloudiness, no output. Review of R42's quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 04/09/25 and located under the MDS tab of the EMR, revealed R42 did not have cognitive impairments as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. R42 required substantial/maximal assistance with toileting and had an indwelling catheter. Review of the Physician Order, dated 10/31/21 and located under the Orders tab of the EMR, directed staff to record catheter output every shift related to obstructive and reflux uropathy. Review of the Treatment Administration Records (TARs), located under the Orders tab of the EMR and dated 12/01/24 through 06/30/25, revealed staff did not obtain and or document urinary output as follows: 12/2024: Day shift: 12/19 and 12/28; Evening Shift: 12/13/, 12/14, and 12/20/24; and Night shift: 12/14 and 12/21/24. 01/2025: Day shift: 01/03, 01/18, 01/28, and 01/30; and Night shift: 01/01/25. 02/2025: Day shift: 02/07 and 02/09; and Night shift: 02/10, 02/11, 02/12/, 02/13/25 03/2025: Day shift: 03/11; Evening shift: 03/05; and Night shift: 03/02, 03/03, 03/05, 03/13, and 03/19/25. 04/2025: Day shift: 04/04, 04/18/, and 04/26/25. 05/2025: Day shift: 05/03, 05/18, 05/18, 05/24, and 05/30; Evening shift: 05/25; and Night shift: 05/10, 05/15, 05/23, 05/24, and 05/30/25. Review of the nursing Progress Notes, dated 12/01/24 through 06/30/25 and located under the Progress Notes tab of the EMR, revealed no documentation of the above missing urinary output amounts. During an interview on 07/16/25 at 10:14 AM, Licensed Practical Nurse (LPN) 4 stated that the certified nurse aides (CNAs) obtain the urine output and report it to the nurse at the end of their shift. LPN4 stated the nurse documents the resident's output on the TAR. LPN4 stated if a urinary output was not documented, either the CNA did not get it and report it to the nurse or the nurse did not document it on the TAR. During an interview on 07/16/25 at 11:36 AM, CNA1 stated that the CNAs are responsible for emptying the resident's catheter bag, measuring the urinary output, and reporting it to the nurse. She stated that the CNAs report the total amount of output to the nurse verbally or on a sticky note, they do not complete a specific form to document the resident's output, and they do not enter that information into their CNA charting. During an interview on 07/16/25 at 12:34 PM, in the presence of the Director of Nursing (DON), LPN6, the Unit Coordinator, stated that the facility tracks the output on all residents with an indwelling urinary catheter per their policy. LPN6 stated the CNAs are responsible for obtaining the resident's urinary output at the end of each shift and reporting it to the nurse, who documents the output on the TAR. The DON added that their goal is to have 90% of charting completed, ideally 100%. She confirmed that the CNAs were responsible for reporting urinary outputs to the nurse, who then documents the output in the computer. She stated that the standard of nursing is that if it was not documented, it was not done.</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p>(continued on next page)</p>

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, hospital record review, interview, review of recommendations from the Mayo Clinic website for Huntington's disease (<a href="https://www.mayoclinic.org/diseases-conditions/huntingtons-disease/diagnosis-treatment">https://www.mayoclinic.org/diseases-conditions/huntingtons-disease/diagnosis-treatment</a>), review of the recommendations from the Huntington's Disease Society of America website (<a href="https://www.hdsa.org">https://www.hdsa.org</a>), and facility policy review, the facility failed to ensure therapy orders and recommendations were completed for two of two residents (Residents (R)17 and R7) reviewed for rehabilitation out of a total sample of 20. This had the potential for both residents to decline in their mobility and range of motion (ROM). Findings include: Review of the Mayo Clinic recommendations revealed Huntington's Disease (HD) causes nerve cells in the brain to decay over time. The disease affects a person's movements, thinking ability, and mental health. The movement disorders may cause movements that cannot be controlled causing muscle rigidity, muscle contracture, and trouble with speech or swallowing. Physical Therapy can provide safe exercises that enhance strength, flexibility, balance, and coordination. These exercises can help maintain mobility as long as possible and may reduce the risk of falls. Occupational Therapy can provide eating and drinking utensils for people with limited fine motor skills. Review of the Huntington's Disease Society of America recommendations revealed there is currently no cure or treatment that can slow or reverse the progression of the disease. However, there are many treatments and interventions that can help to manage HD symptoms. Physical and Occupational therapists can work with patients to develop strength and to move safely. A person with HD may develop muscle and joint contractures (abnormal shortening of muscles that restrict joint movement). To prevent contractures, active range of motion (AROM) exercises should be performed daily. Review of the facility policy titled, Evaluation and Plan of Care, revised 03/2024, revealed, Procedure 1. Evaluations are completed in the Rehab EMR [electronic medical record] software . 3. Evaluations may be very comprehensive or may be problem-specific, depending on the resident's condition and/or the physician's orders. 4. Evaluations include but not limited to: a. The patient's prior level of function, b. The patient's current level of function c. An accurate description of the patient's functional limitations d. Standardized tests and objective about the resident, such as strength, range of motion, pain level, functional performance, communication status, swallowing ability, etc. e. Medical and treatment diagnosis f. Long term treatment goals . 1. Review of R17's Profile record, located in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE] with a diagnosis of Huntington's Disease and a history of falling. Review of R17's Hospital Discharge Summary, located in the EMR under the Documents tab and dated 02/07/25, revealed skilled nursing and rehab were required on a continuing basis as the resident was receiving skilled nursing care and Physical Therapy (PT) and Occupational Therapy (OT) services while at the hospital. Orders were noted for PT/OT to evaluate and treat. Review of R17's NRSG [Nursing] Admission/readmission Collection Tool, located in the EMR under the Assessment tab and dated 02/07/25, revealed PT and OT were marked under the admission details. Under the Admission/readmission Progress Note in the collection tool also revealed the resident was to be seen by PT/OT for an evaluation. Review of R17's admission Minimum Data Set (MDS), with an assessment reference date (ARD) of 02/13/25 and located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, indicating severe cognitive impairment. There were no behaviors or rejection of care noted. R17 was noted with limited ROM bilaterally to both upper and lower extremities. Review of R17's Progress Note, located in the EMR under the Progress Note tab, dated 02/11/25, and written by the physician, revealed under the assessment plan an order for PT/OT to evaluate and treat. Review of R17's Care Plan, located in the EMR under the Care Plan tab and with a date initiated of 02/19/25, revealed the resident had an Activities of Daily Living (ADLs) self-care deficit related to her diagnosis of Huntington's Disease. The goal indicated that the resident would minimize decline in self-care and mobility through the next review date. Interventions included PT/OT. Review of R17's quarterly MDS, with an ARD of 05/16/25 and located in the EMR under the MDS tab, revealed a BIMS score of six out of 15, indicating severe cognitive impairment. She had no noted behaviors or rejection of care. She was noted to have limited ROM bilaterally to both upper and lower extremities. Review of R17's Care Plan, located in the EMR under the Care Plan tab and revised on 05/23/25, revealed the resident had an alteration in neurological status related to Huntington's Disease. The goal indicated the resident would show improvement with mobility by the review date. Interventions included Physical Therapy</p>		