

NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Morningstar of Boise	RC-1069	5850 North Five Mile Road	208-429-6544
Administrator	City	Zip Code	Survey Date
Janine Eggers	Boise	83713	02/16/2017
Survey Team Leader	Survey Type		Response Due
Watt-Geier, Polly	Health Care Licensure and Follow-Up		03/18/2017

Item #	Rule (16.03.22)	Description
1	.225.01. Evaluation for Behavior Management.	The facility did not evaluate the behavioral symptoms of three Residents they identified as having behaviors: #4, #9 and #10. For example, one resident's behavior was described as "anxiety" without identifying what behaviors the resident exhibited when anxious. Another resident's behavior was called "resistance to assistance with ADLS," but did not describe what the resident did to resist. An identified behavior of screaming was not evaluated to determine the frequency, duration or intensity of the behavior or what events triggered it, so appropriate interventions could be identified and staff trained on them.
2	.225.02. Intervention.	Rather than develop an intervention for each behavioral symptom based on the evaluation of the resident and specific behavior, the facility used the same generic list of interventions for every resident for every behavior. The list did not identify which interventions were to be used for which behavior, or which were to be tried first. See behavior programs for Residents #4, #9 and #10.
3	.305.03. Resident Health Status.	The facility nurse did not assess or document the condition of Resident #3, #4 and #5's wounds. For example:

		*Resident #4's pressure ulcers on the heels were not staged, the condition of the ulcers were not measured and there was no description of how the ulcers were improving. *Resident #5's pressure ulcer on the left buttocks was not properly staged, as the description of the wound identified it as being greater than a Stage II pressure ulcer. Additionally, the pressure ulcer on the left buttocks was not described in size, shape or condition nor were improvements to the ulcer described. The facility nurse also failed to document the condition of a pressure ulcer on Resident #5's right buttock, until it was healed. *Resident #3's pressure ulcer was not staged, the condition of the ulcer was not described or measured and there was no description of how the ulcer improved. Additionally, it was reported that Resident #3 had a wound on the coccyx, which had not been assessed or documented by the facility nurse.
4	.305.06 Self-Administered Medication	The facility nurse did not assess Resident #1, #2 and #5's ability to self-administer medications. For example, Resident #2 and Resident #5 self-administered over the counter medications and were not assessed by the nurse. Resident #1 was not assessed every 90 days on her continued ability to self-administer her medications.
5	.711.01.a. Behavior Management Records.	The facility did not document the time specific behaviors were observed for Resident #4, #9 and #10. For example, Resident #4's Behavior Management Tracking documented she engaged in eight behaviors on 2/10/17, on the day shift, but it was unclear when each behavior occurred.
6	.711.01.b. Behavior Management Records.	The facility did not document which interventions were used when Resident #4, #9 and #10 exhibited behaviors. For example, Resident #4 exhibited behavior number 1, eight times on the day shift, but it was unclear what intervention was used for each time the behavior occurred.

