



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, 2015

Philip Herink, Interim Administrator
Life Care Center of Treasure Valley
502 North Kimball Place
Boise, ID 83704-0608

Provider #: 135123

Dear Mr. Herink:

On **February 19, 2015**, a Complaint Investigation survey was conducted at Life Care Center of Treasure Valley by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies 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 2). **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 the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and

Philip Herink, Interim Administrator
March 5, 2015
Page 2 of 4

return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 18, 2015**. Failure to submit an acceptable PoC by **March 18, 2015**, may result in the imposition of civil monetary penalties by **April 7, 2015**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form 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 **March 26, 2015 (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 **March 26, 2015**. A change in the seriousness of the deficiencies on **March 26, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 26, 2015** includes the following:

Philip Herink, Interim Administrator
March 5, 2015
Page 3 of 4

Denial of payment for new admissions effective **May 19, 2015**. [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 **August 19, 2015**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nima Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, Option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **February 19, 2015** 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)

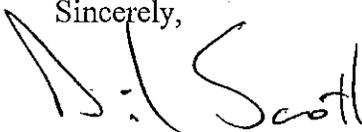
Philip Herink, Interim Administrator
March 5, 2015
Page 4 of 4

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

This request must be received by **March 18, 2015**. If your request for informal dispute resolution is received after **March 18, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2.

Sincerely,

A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large initial "D" and "S".

DAVID SCOTT, R.N., Supervisor
Long Term Care

DJS/dmj
Enclosures

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

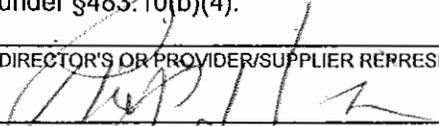
PRINTED: 03/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/19/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704
---	---

(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 complaint investigation survey of your facility. The survey team entered the facility February 18, 2015 and exited the facility February 19, 2015.</p> <p>Team Coordinator Linda Kelly, RN, and Sherri Case, LSW, QIDP, conducted the survey.</p> <p>Survey Definitions: BIMS = Brief Interview for Mental Status; BiPAP = bilevel positive airway pressure; CPAP = continuous positive airway pressure; DON/DNS = Director of Nursing Services TAR = treatment administration record;</p>	F 000	<p><i>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or constitute a deficiency, or that the scope and severity of the deficiencies cited are correct applied.</i></p> <p>RECEIVED MAR 18 2015 FACILITY STANDARDS</p>	
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p>	F 279		<p>F279 SPECIFIC RESIDENT Resident #1 discharged from facility on 2/22/2015 Resident #4 discharged from facility on 2/3/2015 OTHER RESIDENTS: All residents who utilize oxygen and/or CPAP or BiPAP were reviewed to ensure care plans provided direction to staff.</p> <p><i>See Addendum dated 3/31/15 S. Case</i></p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Exec. Dir.	(X6) DATE 3/18/15
--	---------------------	----------------------

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: 03/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/19/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704		
(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 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review, it was determined the facility failed to ensure residents' interim care plans included problem areas present upon admission. This was true for 2 of 6 residents (#s 1 and 4) whose care plans were reviewed. The failure created the potential the residents' assessed needs for oxygen (O2) not to be met due to lack of direction in their care plans. Findings included: 1. Resident #4 was admitted to the facility on 1/28/15 with multiple diagnoses including recent pneumonia and obstructive sleep apnea. Resident #4's 1/28/15 Admission and Discharge Medication Reconciliation Orders from the referring hospital included, "Oxygen 3 liters Nasal...Special instructions: continuous [oxygen]/CPAP with 2.5 Liters/min [minute] while sleeping." The resident's 1/28/15 facility "Physician Orders January 2015" included the O2 (oxygen) and CPAP orders. Resident #4's 1/28/15 Interim Care Plan identified, "At Risk for Break in Skin Integrity" in part related to "OSA [obstructive sleep apnea]." Interventions included the CPAP; however, O2 was not mentioned anywhere in the Interim Care Plan. Review of the clinical record revealed that O2 at 3 liter/minute was noted only twice in the resident's "All Progress Notes" for 1/29/15 through 2/3/15	F 279	<p>SYSTEMIC CHANGES</p> <p>New admission charts will be reviewed to ensure residents who require respiratory treatment have a care plan that provides direction to staff.</p> <p>Care plans will be reviewed quarterly to ensure respiratory diagnosis and treatments are care planned to provide staff with clear direction.</p> <p>Licensed staff have been in serviced on documentation of respiratory treatments on care plan.</p> <p>MONITOR</p> <p>DNS and/or designee will perform care plan and documentation audits to ensure care plans provide direction to staff and documentation is accurate, weekly x 4 monthly x 3 and quarterly x 3. Results will be reported to the Performance Improvement committee.</p> <p>Audits will begin 03/16/2015.</p> <p>DATE OF COMPLIANCE 03/26/2015</p> <p><i>See Addendum dated 3/31/15 S Care</i></p>		

2015 POC For Complaint Survey

Revised: 3/31/15

This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or constitute a deficiency, or that the scope and severity of the deficiencies cited are correct applied.

F279

SPECIFIC RESIDENT

Resident #1 discharged from facility on 2/22/2015

Resident #4 discharged from facility on 2/3/2015

OTHER RESIDENTS

All residents who utilize oxygen and/or CPAP or BiPAP were reviewed to ensure care plans provided direction to staff.

Root Cause:

New admission charts were not reviewed to ensure orders were in place for respiratory needs. Respiratory needs were not reviewed quarterly and with changes of condition to ensure care plan was accurate and provided direction to staff.

Systematic Change:

New admission charts will be reviewed to ensure residents who require respiratory treatment have a care plan that provides direction to staff.

Care plans will be reviewed quarterly to ensure respiratory diagnosis and treatments are care planned to provide staff with clear direction.

Licensed staff have been in serviced on documentation of respiratory treatments on care plan.

MONITOR

DNS and/or designee will perform care plan and documentation audits to ensure care plans provide direction to staff and documentation is accurate, weekly x 4 monthly x 3 and quarterly x 3. Results will be reported to the Performance Improvement committee.

Audits will begin 03/16/2015.

DATE OF COMPLIANCE 03/26/2015

POC Addendum

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

PRINTED: 03/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/19/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704		
(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 279	<p>Continued From page 2</p> <p>and the space to document O2 administration was blank on the day shift on 2/1 in the resident's February 2015 TAR. (Refer to F 328 for details regarding the lack of proper respiratory treatment and care.)</p> <p>On 2/19/15 at 11:10 a.m., the DON was asked for the resident's care plan for O2. The DON reviewed the resident's Interim Care Plan then confirmed that O2 had not been included. She stated, "It's not there."</p> <p>2. Resident #1 was admitted to the facility on 2/16/15 with multiple diagnoses including COPD and small cell lung cancer.</p> <p>Resident #1's medical record included a 2/16/15 physician telephone order for 0-5 liters oxygen to keep saturation levels greater than 90%.</p> <p>Resident #4's 2/18/15 Interim Care Plan an intervention for oxygen 0-5L/min via nasal cannula for dyspnea and shortness of breath.</p> <p>The resident's February 2015 Treatment Administration Record (TAR) documented the resident was to receive oxygen via mask continuous at 0-5 liters to keep saturation levels above 90%.</p> <p>On 2/18/15, the resident was observed in his room with the oxygen concentrator running, however the resident was not wearing an oxygen mask/nasal cannula. A family member was present and stated the resident was not required to use the oxygen at all times.</p> <p>On 2/19/15 at 8:10 a.m., Resident #1 was</p>	F 279			

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

PRINTED: 03/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/19/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704	
(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 279	Continued From page 3 observed in his room with the oxygen concentrator running but the resident was not wearing a mask/nasal cannula. The resident stated the concentrator was left running so he could "grab" it if he needed. On 2/19/15 at 11:10 a.m., the DON was asked if the resident was to receive oxygen as needed or continuous as on the TAR. The DON was also informed the Care Plan did not specify continuous or as needed. The DON stated the resident was to use oxygen as needed and she did not know why the TAR stated "continuous."	F 279		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of active records and closed records, it was determined the facility failed to ensure proper treatment and care was provided for 3 of 6 sample residents (#s 3, 4, & 6) reviewed for respiratory care. These failures created the potential for residents to experience	F 328	F328 SPECIFIC RESIDENT Resident's #4 was discharged from facility on 2/3/2015. Resident # 6 was discharged from facility on 12/12/2014. Physician order for Bi-Pap use was obtained for resident # 3 <i>See Addendum of Care</i>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/19/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704	
(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 328	<p>Continued From page 4</p> <p>respiratory problems when: Resident #3's BiPAP was administered without a physician order; physician orders for CPAP were incomplete for Resident # 4; Resident #4's O2 was not administered as ordered; and, CPAP/BiPAP was not consistently documented as administered for Resident #s 3, 4, and 6. Findings included:</p> <p>1. Resident #3 was admitted to the facility in 2012, and was readmitted 6/14/14, with multiple diagnoses including obstructive sleep apnea.</p> <p>Resident #3's 1/2/15 quarterly MDS assessment coded a BIMS score of 14 (intact cognition) and functional limitation in range of motion in both upper and lower extremities.</p> <p>On 2/18/15 at 3:40 p.m., the resident was observed awake in bed and a BiPAP machine was noted on the resident's bedside table. When asked about the BiPAP, the resident said she used it "every night" and that "whoever is on duty" would help her with it.</p> <p>The resident's care plan identified the potential for difficulty breathing related to chronic obstructive sleep apnea and currently on BiPAP at night. Interventions included, "Oxygen continuous via N/C [nasal cannula]" and "BiPAP @ NOC [at night] per current MD [physician] order 10/22/14."</p> <p>The resident's recapitulation (recap) of Physician's Orders for February 2015 included an order for the O2; however, it did not include any orders for BiPAP and there were no interim orders for the BiPAP. Also, there were no orders for BiPAP found in the resident's recaps of Physician's Orders for December 2014 and</p>	F 328	<p>OTHER RESIDENTS</p> <p>All residents with CPAP/Bi-Pap and/or Oxygen were audited to ensure that Physician orders were in place.</p> <p>SYSTEMIC CHANGES</p> <p>Standardized BIPAP/CPAP orders were established that provided clear direction to staff.</p> <p>All residents who admit to facility with BiPAP/CPAP orders will be evaluated for proper fitting mask and settings on machine.</p> <p>Oxygen concentrators will be labeled with settings to allow for staff to visualize for accurate settings.</p> <p>All Licensed staff were in-serviced on obtaining Physician orders for CPAP/Bi-pap and Oxygen and accurate documentation of use.</p> <p>MONITOR</p> <p>Physician orders will be compared to room to room audits for B/C-Pap & Oxygen use weekly x 4, monthly x 3 and quarterly x 3.</p> <p>Audits will begin 03/16/2015.</p> <p>DATE OF COMPLIANCE 03/26/2015</p>	

2015 POC For Complaint Survey

F328

SPECIFIC RESIDENT

Resident's #4 was discharged from facility on 2/3/2015.

Resident # 6 was discharged from facility on 12/12/2014.

Physician order for Bi-Pap use was obtained for resident # 3.

OTHER RESIDENTS

All residents with CPAP/BIPAP were reviewed by respiratory therapist to ensure settings were accurate and machines are functioning properly.

All residents with oxygen were reviewed to ensure orders are implemented and accurate.

Root Cause: Oxygen/ BIPAP/CPAP orders did not provide clear direction to staff.

Systematic Changes:

Standardized BIPAP/CPAP orders were established that provided clear direction to staff.

All residents who admit or receive orders for CPAP/BIPAP will be assessed by respiratory therapy to ensure settings are accurate and orders are in place.

Oxygen concentrators will be labeled with settings to allow for staff to visualize for accurate settings.

All Licensed staff were in-serviced on obtaining Physician orders for CPAP/BI-pap and Oxygen and accurate documentation of use.

MONITOR

Physician orders will be compared to room to room audits for BPAP/CPap & Oxygen use weekly x 4, monthly x 3 and quarterly x 3.

Audits will begin 03/16/2015.

DATE OF COMPLIANCE 03/26/2015

See POC F279 for C778

See POC F328 for C788

POC Addendum

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

PRINTED: 03/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/19/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704		
(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 328	<p>Continued From page 5 January 2015.</p> <p>The resident's November & December 2014 and January & February 2015 TARs documented the O2 was administered. However, BiPAP use was not mentioned in any of these TARs.</p> <p>On 2/18/15 at 3:50 p.m., the DON was asked whether Resident #3's BiPAP administration would be documented. The DON stated, "Nurses' notes or treatment record. She's been here so long it's probably on the treatment record." The DON was also asked to provide the order for the resident's BiPAP. The DON reviewed the resident's clinical record then confirmed there was no order for BiPAP. She also reviewed the resident's electronic nurses' notes and stated; "No documentation of BiPAP." She then reviewed the aforementioned TARS and stated, "I don't see it."</p> <p>On 2/18/14 at 4:35 p.m., the DON said the resident's BiPAP "got dropped in June" when the resident was readmitted to the facility. The DON said the resident "does wear it" and that there should be an order for the BiPAP. The DON added, "I honestly don't know where that 10/22/14 came from on the care plan."</p> <p>2. Resident #4 was admitted to the facility on 1/28/15 with multiple diagnoses including recent pneumonia and obstructive sleep apnea. The resident was transferred to a hospital emergency room on 2/3/15.</p> <p>Resident #4's 1/28/15 Admission and Discharge Medication Reconciliation Orders from the referring hospital included, "Oxygen 3 liters Nasal...Special instructions: continuous [oxygen]/</p>	F 328		

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

PRINTED: 03/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/19/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704
---	---

(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 328	<p>Continued From page 6 CPAP with 2.5 Liters/min [minute] while sleeping."</p> <p>The resident's 1/28/15 facility "Physician Orders January 2015" included O2 (oxygen) at 3 liters per minute continuously and "...CPAP at current settings with O2 2.5 L/min [liters per minute] bled [sic] in."</p> <p>No other orders for O2 or CPAP were found in the resident's clinical record.</p> <p>The resident's Polysomnogram Report, dated 1/12/15, included the recommendation, "...continue...usual CPAP of 11 with at least 2 L minute of oxygen supplementation."</p> <p>Resident #4's Interim Care Plan, dated 1/28/15, included, "At Risk for Break in Skin Integrity" in part related to "OSA [obstructive sleep apnea]." Interventions included, "CPAP per MD orders 1/29/15." This care plan did not mention O2 use (refer to F 279 regarding incomplete care planning).</p> <p>"All Progress Notes," dated 1/29/15 at 12:24 a.m. through 2/3/15 at 9:33 a.m., noted O2 use only twice, CPAP use only once, and on "RA [room air O2]" twice, as follows: * 1/29/15 at 6:55 a.m. - "...wore CPAP through the shift...oxygen 90 RA with CPAP [O2 saturation 90 percent on room air with CPAP]" * 2/1/15 at 2:55 p.m. - "...O2 @ 3L/NC with Sats 96% [O2 at 3 liters per minute per nasal cannula with O2 saturation 96%]..." * 2/2/15 at 10:24 a.m. - "...93% on 3L..." * 2/2/15 at 10:40 p.m. - "...O2 sat[uration] 93% room air.</p> <p>Resident #4's January 2015 TAR documented</p>	F 328		
-------	--	-------	--	--

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

PRINTED: 03/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/19/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704		
(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 328	<p>Continued From page 7</p> <p>CPAP was administered nightly 1/29 - 1/31.</p> <p>The resident's February 2015 TAR was blank in all of the spaces to document the administration of CPAP on 2/1 - 2/3. Regarding O2 administration, the TAR was blank on the day shift on 2/1.</p> <p>On 2/19/15 at 11:10 a.m., the DON was asked about the resident's CPAP and O2. The DON confirmed that CPAP administration was not documented in February and that room air oxygen was in the progress notes. When asked what the CPAP settings were, the DON said that other than 2.5 L/min O2 bleed in, she did not know what the CPAP settings were. She indicated the facility had not requested clarification of the order.</p> <p>3. Resident #6 was admitted to the facility in 2012, and readmitted 9/11/14, with multiple diagnoses including obstructive sleep apnea. On 12/12/14, the resident was transferred to an acute care setting.</p> <p>Review of Resident #6's closed record revealed a 9/12/14 order for CPAP at 15/8 with 5 liters of O2 bleed in at night and ineffective breathing patterns were care planned with an intervention for CPAP per current physician orders.</p> <p>The resident's TARs for September through December 12, 2014 included the CPAP orders. The September and October TARs documented that CPAP was administered nightly. However, all of the spaces to document CPAP administration in November and December were blank.</p> <p>Review of the resident's "All Progress Notes,"</p>	F 328		

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

PRINTED: 03/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/19/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704
---	---

(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 328	<p>Continued From page 8 dated 9/12/14 through 12/12/14, revealed that CPAP was not mentioned in November or December.</p> <p>On 2/19/15 at 12:30 p.m., the DON was asked about CPAP administration for Resident #6. The DON reviewed the resident's TARs then confirmed that CPAP was not documented in November and December. The DON added, "It's on the care plan and that's what we follow." However, when asked for documented evidence that CPAP was administered in November and December, the DON said there was no documentation.</p>	F 328		
-------	---	-------	--	--

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001430	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/19/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704
---	---

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint investigation survey of your facility. The survey team entered the facility February 18, 2015 and exited the facility February 19, 2015.</p> <p>The surveyors who conducted the survey were Linda Kelly, RN, Team Coordinator, and Sherri Case, LSW, QIDP.</p> <p>Survey Definitions: BiPAP = bilevel positive airway pressure; CPAP = continuous positive airway pressure;</p>	C 000	<p style="text-align: center;">RECEIVED MAR 18 2015 FACILITY STANDARDS</p> <p style="text-align: center;">See POC F279 for C778</p> <p style="text-align: center;">See POC F328 for C788</p>	
C 778	<p>02.200,03,a Resident Care - Care Plan in Writing</p> <p>03. Patient/Resident Care.</p> <p>a. A patient/resident plan of care shall be developed in writing upon admission of the patient/resident, which shall be:</p> <p>This Rule is not met as evidenced by: Refer to F 279 as it related to Interim Care Plans for oxygen use.</p>	C 778		
C 788	<p>02.200,03,b,iv Medications, Diet, Treatments as Ordered</p> <p>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: Refer to F 328 as it related to oxygen and CPAP/BiPAP.</p>	C 788		

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE	(X6) DATE 3/18/15
--	-------	----------------------



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

APR 28 2015
April 28, 2015

Philip Herink, Interim Administrator
Life Care Center of Treasure Valley
502 North Kimball Place
Boise, ID 83704-0608

Provider #: 135123

Dear Mr. Herink:

On **February 19, 2015**, an unannounced on-site complaint survey was conducted at Life Care Center of Treasure Valley.

Immediately after entering the facility on February 18, 2015, a brief tour of residents' rooms and common areas was conducted.

In addition, the following documentation was reviewed:

- The facility's list of residents who used oxygen and/or Bi-level or Continuous Positive Airway Pressure (Bi-PAP or CPAP);
- The identified resident's facility medical records, including pre-admission records and physicians' office visit notes;
- The identified resident's Emergency Department records, hospitalization documents and laboratory reports for February 2015;
- The identified resident's February 2015 Respiratory Services Provider records;
- The medical records of five other residents on oxygen and/or Bi-PAP or CPAP;
- Facility's Incident and Accident reports for December 2014 through February 18, 2015;
- Facility's Abuse Investigations for December 2014 through February 18, 2015;
- The facility's Hot Line report for January 2014 through February 18, 2015; and,
- Facility's policies and procedures regarding oxygen and Bi-PAP/CPAP.

Interviews were conducted with the facility's Director of Nursing Services; another licensed nurse

and three Certified Nurse Aides. Two residents and two family members were also interviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #6863

ALLEGATION # 1:

On Saturday, January 31, 2015, between 1:00 and 2:00 p.m., an identified resident was dressed and laying on top of the bed but was not wearing oxygen, which was ordered to be continuous. The resident's hands were blue. Staff were immediately notified and when they checked the resident, the resident's oxygen saturation level was 67 percent. Oxygen was applied and the resident recovered "somewhat" but was still very sleepy.

FINDINGS # 1:

The identified resident's medical record contained two nursing progress notes that documented the resident was on room air, rather than continuous oxygen per the physician's order. In addition, two of six residents were not care planned for the use of oxygen.

The facility was cited at F328 for the failure to provide proper respiratory treatment and care and at F279 for failure to care plan respiratory treatment and care.

CONCLUSIONS:

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

ALLEGATION # 2:

During an appointment with a physician, an identified resident was difficult to manage because the resident was "so sleepy" and "confused." The identified resident "almost fell off the exam table" during the appointment. The physician was concerned about the resident's status and had lab tests drawn at the appointment. The lab tests were "terrible."

FINDINGS #2:

A physician's office visit note for February 2, 2015, documented the identified resident's oxygen saturation level was 87%; however, whether or not oxygen was in use at the time was not documented. A complete blood count lab test was ordered during the appointment for "2/2/2015 (Approximate)." The office visit note did not include the resident's level of consciousness or document a near fall. Facility's nursing progress notes before and after the physician's office visit that day documented the resident was awake, alert, oriented, denied pain and needed extensive assistance with transfers. Facility deficient practice was not identified.

Philip Herink, Interim Administrator
April 28, 2015
Page 3 of 3

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

On February 3, 2015, an identified resident was taken to an emergency room and was admitted to the Intensive Care Unit (ICU) with carbon dioxide (CO2) retention. The resident's CPAP (continuous positive airway pressure) was only used three out of six nights.

FINDINGS #3:

The identified resident was seen in an Emergency Department in early February 2015 and admitted for observation in stable condition. There was no documented evidence that the resident was diagnosed with carbon dioxide retention that day.

However, three of six residents' records reviewed revealed that Bi-PAP and CPAP were not consistently documented as administered.

The deficient practice was cited at F328.

CONCLUSIONS:

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

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

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj