



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

May 14, 2015

Rene Stephens, Administrator  
Campus View Home  
1411 Falls Avenue East, Suite 703  
Twin Falls, ID 83301

RE: Campus View Home, Provider #13G070

Dear Ms. Stephens:

This is to advise you of the findings of the Medicaid/Licensure survey of Campus View Home, which was conducted on May 13, 2015.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Rene Stephens, Administrator  
May 14, 2015  
Page 2 of 2

6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **May 27, 2015**, and keep a copy for your records.

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 the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

[www.icfmr.dhw.idaho.gov](http://www.icfmr.dhw.idaho.gov)

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by May 27, 2015. If a request for informal dispute resolution is received after May 27, 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 our visit. If you have questions, please call this office at (208) 334-6626, option 4.

Sincerely,

  
JIM TROUTFETTER  
Health Facility Surveyor  
Non-Long Term Care

  
NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

JT/pmt  
Enclosures

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/13/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  CAMPUS VIEW HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 875 MONROE TWIN FALLS, ID 83301
--	---

(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
--------------------	--	---------------	---	----------------------

W 000	INITIAL COMMENTS  The following deficiencies were cited during the annual recertification survey conducted from 5/11/15 to 5/13/15.  The survey was conducted by:  Jim Troutfetter, QIDP  Common abbreviations used in this report are:  IPP - Individual Program Plan QIDP - Qualified Intellectual Disabilities Professional	W 000		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN  The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a behavioral assessment contained comprehensive information for 1 of 3 individuals (Individual #1) whose behavioral assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include:  1. Individual #1's IPP, dated 12/1/14, documented he was a 52 year old male whose diagnoses included severe intellectual disability.  Individual #1's Incident and Accident reports were reviewed from 2/1/2015 to 5/11/15 and documented Individual #1 engaged in hitting	W 214		

RECEIVED  
MAY 21 2015  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rene Stephens</i>	TITLE <i>Administrator</i>	(X6) DATE <i>5/20/15</i>
---	-------------------------------	-----------------------------

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/13/2015
NAME OF PROVIDER OR SUPPLIER  CAMPUS VIEW HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 875 MONROE TWIN FALLS, ID 83301	
(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
W 214	Continued From page 1 himself on the face. Incidents occurred on multiple dates that included, but were not limited to, 2/9/15, 2/11/15, 2/16/15, 2/28/15, 3/2/15, 3/11/15, and 4/17/15.  However, his Behavioral Assessment, dated 3/19/15, did not list head hitting as a behavior he engaged in.  When asked on 5/13/15 at 1:20 p.m., the QIDP stated Individual #1's behavior assessment needed to be updated to include head hitting.  The facility failed to ensure Individual #1's Behavioral Assessment contained comprehensive information.	W 214	The CFA has been updated to address the occurrence of the new behavior reported in the IAR's. A review of all IAR's in this home and other homes will be done to assess the recurrence of newly developed behaviors. CFA's will be updated to account for the new behavioral events. During the monthly face to face QIDP meetings with the Facility Manager a review of the last 30 days of IAR's will take place to assess the recurrence and the persistence of new behaviors. CFA's will be updated and programming adjusted to accommodate for the needs of the individual. A procedural change during the face to face meeting monthly will ensure the new behavioral events are incorporated for all.	
W 472	483.480(b)(2)(i) MEAL SERVICES  Food must be served in appropriate quantity.  This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure each individual received an appropriate quantity of food for 3 of 6 individuals (Individuals #1, #3 and #4) observed during breakfast. This resulted in individuals not receiving a full meal. The findings include:  1. An observation was conducted in the facility on 5/12/15 from 6:35 - 8:17 a.m. During that time, Individuals #1, #3 and #4 were observed to be eating scrambled eggs with green peppers and milk.  The facility's menu was reviewed, (March - June) 2015, and documented individuals were to	W 472	DOC: 6-15-2015 Responsible: QIDP, Facility Manager	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/13/2015
NAME OF PROVIDER OR SUPPLIER  CAMPUS VIEW HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 875 MONROE TWIN FALLS, ID 83301		
(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	
W 472	<p>Continued From page 2</p> <p>receive 2 ounces of whole wheat toast in addition to the eggs and milk.</p> <p>Individuals #1, #3 and #4 were observed to be eating from 8:00 - 8:10 a.m. At 8:07 a.m., Individual #1 had pushed himself away from the table. At 8:09 a.m., Individual #3 was observed taking his dish to the sink and at 8:10 a.m., a direct care staff was observed helping Individual #4 to the kitchen with his dish. At no time were individuals observed to be offered toast during the meal.</p> <p>When asked at 8:10 a.m. about the toast, a direct care staff stated "We missed the toast."</p> <p>When asked on 5/13/15 at 1:25 p.m., the QIDP stated the staff should have followed the menu.</p> <p>The facility failed to ensure Individuals #1, #3 and #4 received their full meal during their breakfast.</p>	W 472	<p>Staff will be retrained to assess the menu and provide all items noted on the menu. Housekeep/ Cook, Leadworker, or Shift Leader will ensure menus have been successfully served. Note: During this surveyor's observation period an error took place during a meal service due to anxiety related to the survey process. This was an outlier event and not a systemic failure on the part of the facility or the staff. A daily checklist will ensure that all items are served according to the established menu. Facility Manager or shift leader will assess the checklist daily to ensure the established menu is successfully delivered.</p> <p>DOC: 6-15-2015 Responsible: Facility Manager, Shift Leader, Housekeeper/Cook</p>		

