



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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April 5, 2016

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 March 30, 2016.

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
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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 **April 18, 2016**, 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

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 April 18, 2016. If a request for informal dispute resolution is received after April 18, 2016, 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

TF/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 03/30/2016
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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey conducted from 3/28/16 - 3/30/16.</p> <p>The surveyor conducting your survey was:</p> <p>Jim Troutfetter, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>IPP - Individual Program Plan QIDP - Qualified Intellectual Disability Professional</p>	W 000		
W 436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview it was determined the facility failed to ensure an individual was provided with adaptive equipment for 1 of 4 individuals (Individual #4) who required adaptive eating equipment. This resulted in an individual not being provided with adaptive equipment to take his medications. The findings include:</p> <p>1. Individual #4's IPP, dated 3/17/16, documented a 20 year old male whose diagnoses included severe intellectual disability.</p>	W 436	<p style="text-align: center;">RECEIVED APR 27 2016 FACILITY STANDARDS</p> <p><i>The individual in question developed a preference and ability to use normal spoons. His comprehensive functional assessment only reflected his abilities at the time the assessment was done and it had not been modified since trying normal spoons. Since the survey date, he has begun using normal utensils across the board as he does not need nor does he prefer the modified adaptive utensils. Our efforts are to make his life and choices as normal for him and his environment as possible. His assessment has been revised to reflect his current use of normal utensils. We will continue to allow residents choices as opportunities to change present themselves. DOC: 04/04/2016 Responsible: Facility Manager and QIDP</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Jene Stephens

Administrator 4/25/16

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

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W 436	Continued From page 1 During medication pass observations on 3/28/16 from 3:50 - 3:58 p.m. and 3/29/16 from 7:27 - 7:35 a.m., Individual #4 was noted to use a plastic spoon to take medication mixed with pudding. However, during meal observations on 3/28/16 from 6:11 - 6:26 p.m. and 3/29/16 from 7:40 - 8:05 a.m., Individual #4 was noted to use a spoon and a fork with built up handles. During an interview on 3/30/16 at 9:25 a.m., the QIDP stated Individual #4's adaptive eating equipment should have been used during the medication pass. The facility failed to ensure Individual #4's adaptive eating equipment was used during his medication administration.	W 436			
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift of personnel for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses or identify problem areas in the event of an emergency. The findings include: 1. The facility's evacuation drills were reviewed	W 440	This drill was missed even though we have a reminder system in place to keep this from happening. The facility manager for this home was on maternity leave and her leadworker was filling in during her absence. A reminder was sent for this final drill at the time the manager was transitioning back to work. Even though the leadworker received the reminder, she thought the manager would perform the drill, which did not happen since she was adjusting to a newborn, catching up with work and had the Christmas holiday schedules upon her. In the future the leadworker will perform the drills in the absence of the manager. DOC: 4/4/2016 Responsible: Facility Manager, Leadworker, and Administrator		

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W 440	Continued From page 2 and did not include documentation that an evacuation drill had been completed for the night shift (11:00 p.m. - 7:00 a.m.) during the fourth quarter (November - December) of 2015. During an interview on 3/29/16 at approximately 8:05 a.m., the Home Manager stated the evacuation drill for the night shift had not been completed due to an oversight. The facility failed to ensure an evacuation drill was completed for the night shift during the fourth quarter of 2015.	W 440		

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the licensure survey conducted from 3/28/16 to 3/30/16. The surveyor conducting your survey was: Jim Troutfetter, QIDP	M 000		
MM169	16.03.11700 Physical Environment The requirements of Sections 700 through 799 of these rules are modifications and additions to the requirements in 42 CFR 483.470 - 483.470(1)(4), Condition of Participation: Physical Environment, incorporated in Section 004 of these rules. Other documents incorporated in Section 004 of these rules related to an ICF/ID physical environment are the NFPA's Life Safety Code and IDAPA 07.03.01, "Rules of Building Safety." This Rule is not met as evidenced by: Refer to W436 and W440.	MM169	See reply to W436 and W440	

RECEIVED
APR 27 2016
FACILITY STANDARDS

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Gene Stephens</i>	TITLE Administrator	(X6) DATE 4/25/16
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STATE FORM 8899 KH6Y11 If continuation sheet 1 of 1