



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, 2014

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 8, 2014.

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, 2014  
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, 2014**, 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, 2014. If a request for informal dispute resolution is received after May 27, 2014, 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.

Sincerely,

  
JIM PROUTFETTER  
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

PRINTED: 05/14/2014  
FORM APPROVED  
OMB NO. 0938-0391

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  05/08/2014
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 recertification survey conducted from 5/5/14 to 5/8/14.  The survey was conducted by: Jim Troutfetter, QIDP  Common abbreviations used in this report are: HRC - Human Rights Committee QIDP - Qualified Intellectual Disability Professional	W 000		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS  The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.  This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals' rights were promoted for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in implementation of blanket restrictions to knives, not based on individual need, and without assuring due process protections. The findings include:  1. During an environmental review on 5/6/14 from 11:42 a.m. - 12:15 p.m., a sign prompting staff to ensure all knives and items with sharp blades were to be locked up was noted on a cabinet in the kitchen.	W 125	RECEIVED  JUN - 9 2014  FACILITY STANDARDS  W125 All individuals will be assessed in the home to determine if a need to secure said sharps (to protect self and others) is needed. Given there is an assessed need WICs and programmatic approaches will be implemented so that the persons not directly affected will not have their rights violated. At the time of admission the individual in question will be provided the appropriate information pertaining to the securing of sharps or will be assessed and programming in place to teach appropriate use of sharps. WICs/Assessments for all individuals that live in the home will be reviewed quarterly by the Facility Manager, Nurse, QIDP or Administrator to ensure that they are current and accurately reviewed by the HRC. Date of Correction: 06-30-2014	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Rene Stephens* TITLE: *Administrator* (X6) DATE: *6/9/14*

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.

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W 125	Continued From page 1	W 125			
W 264	<p>During an interview on 5/8/14 from 8:34 - 9:15 a.m., the QIDP stated the knives were to be locked up for safety reasons and verified the facility restricted access to knives without determining individual need for the restriction.</p> <p>The facility failed to ensure individuals' rights to free access of knives was ensured.</p> <p><b>483.440(f)(3)(iii) PROGRAM MONITORING &amp; CHANGE</b></p> <p>The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure the HRC reviewed and approved facility practices that restricted individuals' free access to knives for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in access to knives being restricted without cause. The findings include:</p> <p>1. During an environmental review on 5/6/14 from 11:42 a.m. - 12:15 p.m., a sign prompting staff to ensure all knives and items with sharp blades were to be locked up was noted on a cabinet in the kitchen.</p>	W 264	<p><b>W264</b></p> <p>All individuals will be assessed in the home to determine if a need to secure said sharps (to protect self and others) is needed. Given there is an assessed need, WICs and programmatic approaches will be implemented so that the persons not directly affected will not have their rights violated. At the time of admission the individual in question will be provided the appropriate information pertaining to the securing of sharps or will be assessed and programming in place to teach appropriate use of sharps. WICs/Assessments for all individuals that live in the home will be reviewed quarterly by the Facility Manager, Nurse, QIDP or Administrator to ensure that they are current and accurately reviewed by the HRC. Date of Correction: 06-30-2014</p>		

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W 264	Continued From page 2  During an interview on 5/8/14 from 8:34 - 9:15 a.m., the QIDP stated the knives were to be locked up for safety reasons and verified the facility restricted access to knives without determining individual need for the restriction.  During a follow-up interview on 5/13/14 from 1:26 - 1:29 p.m., the Administrator stated consent for the restriction and review and approval from the HRC had not been obtained.  The facility failed to ensure all practices resulting in potential rights violations were reviewed and approved by the HRC.	W 264		
W 481	483.480(c)(2) MENUS  Menus for food actually served must be kept on file for 30 days.  This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a record of food served was kept for 30 days, which directly impacted 3 of 6 individuals (Individuals #3, #4 and #6) residing at the facility and had the potential to impact all individuals (Individuals #1 - #6) residing at the facility. This resulted in the potential for individuals to not receive an adequate variety of food. The findings include:  1. A meal observation was conducted at the facility on 5/5/14 from 5:00 - 6:15 p.m. The facility's menu was reviewed and documented the meal was to consist of the following: - 1 cup minestrone barley soup - 2 ounce wheat roll	W 481		

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W 481	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>- 1 cup berries</li> <li>- 1.5 cup skim milk</li> </ul> <p>However, the following was observed:</p> <ul style="list-style-type: none"> <li>- At 5:50 p.m., Individual #4 was noted to be eating a sandwich. When asked about the sandwich, a direct care staff stated it was a grilled cheese sandwich.</li> <li>- At 6:08 p.m. Individual #6 was noted to be eating a bowl of chicken noodle soup which he had made. He then refused the berries and requested pears, which were served to him.</li> <li>- At 6:08 p.m., Individual #3 was also noted to request pears which he was served.</li> </ul> <p>On 5/6/14, the meal substitutions form was reviewed and documented two servings of pears had been substituted for berries on 5/5/14. However, the form did not identify which individuals received the pears.</p> <p>When asked on 5/6/14 at 7:16 a.m., a direct care staff stated she was not sure how to tell who received substitutions based on the information on the form.</p> <p>Additionally, the meal substitutions form did not include information related to Individual #4 consuming a grilled cheese sandwich during the 5/5/14 dinner observation.</p> <p>During an interview on 5/8/14 from 8:34 - 9:15 a.m., the QIDP stated the meal substitutions form should have documented the individuals receiving the substitutions.</p>	W 481	<p><b>W481</b></p> <p>Meal/Item substitution forms have been updated for the facility and include all needed components to track the amount, item and individual served. QIDP, Facility Manager and Leadworker will do quarterly checks to ensure that the documents are being accurately recorded.</p> <p>Date of Correction: 05-30-2014</p>		

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W 481	Continued From page 4 Without having information related to which individuals received substitutions, the facility would be unable to identify individual dietary concerns.  The facility failed to ensure accurate documentation of meals actually served was kept.	W 481			

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments  The following deficiencies were cited during the annual licensure survey conducted from 5/5/14 to 5/8/14.  The survey was conducted by: Jim Troutfetter, QIDP	M 000	MM168 – see response to W125	
MM168	16.11.03.075.07(a) Rights as a Citizen  Rights as a citizen refer to all the rights of citizens of this country and any particular state or locality. These include, but are not limited to, voting, marriage, divorce, executing instruments (e.g., wills), acquiring and disposing of property, and choosing to practice or not practice a religion. This Rule is not met as evidenced by: Refer to W125.	MM168	MM194 – see response to W264	
MM194	16.03.11.075.10(a) Approval of Human Rights Committee  Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W264.	MM194	MM672 – see response to W481	
MM672	16.03.11.07(a) Menu Preparation  Menus must be prepared at least a week in advance. Menus must be corrected to conform with food actually served. (Items not served must be deleted, and food actually served must be written in.) The corrected copy of the menu and diet plan must be dated and kept on file for thirty (30) days. This Rule is not met as evidenced by: Refer to W481.	MM672		

RECEIVED  
JUN - 9 2014  
FACILITY STANDARDS

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Rene Stephens* TITLE: *Administrator* (X6) DATE: *6/9/14*