



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – GOVERNOR  
RICHARD M. ARMSTRONG – DIRECTOR

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
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RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM  
P.O. Box 83720  
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July 19, 2013

Stephanie Arceneaux, Administrator  
Valley View Investors, LLC - The Bridge at Valley  
1130 North Allumbaugh Street  
Boise, ID 83704

Dear Ms. Arceneaux:

An unannounced, on-site complaint investigation survey was conducted at Valley View Investors, LLC - The Bridge at Valley View, between July 10, 2013 and July 11, 2013. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00006039**

**Allegation #1:** The facility's call light system did not work effectively.

**Findings #1:** On 7/10/13 during an unannounced complaint investigation, four random residents' call lights were tested. All four call lights were promptly responded to by staff, within 2 minutes from activating the call light.

On 7/10/13, twenty-four residents were interviewed. Fourteen residents stated staff always responded quickly when they used their call lights to request assistance. Six residents stated they had never used their call light. Additionally, four residents stated that at times they had to wait up to 20 minutes in the past, but that staff were responding quickly currently.

Seven staff were interviewed on 7/10/13. All seven staff stated that at times two identified residents were noted to rapidly press their call buttons numerous times in a row. The staff state this would "jam the system" and they would have to reset the system and write down all the residents who had pressed their call buttons. All staff stated they were trained to reset the system so residents would receive assistance when they used their call lights.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven due to conflicting information.

Allegation #2: The facility did not have adequate staffing to meet the needs of the residents.

Findings #2: Observations were conducted 7/10 and 7/11/13. Five staff were observed providing care to the residents, along with the facility nurse and administrator. Residents' needs were observed being met by the staff.

On 7/10/13, the facility's staffing schedule was reviewed. It documented at least five staff were scheduled for day and evening shifts. For each day and evening shift, two staff were scheduled as medication aides, two staff were scheduled as caregivers, and one staff member was scheduled as a bath aide. Additionally, the schedule documented the facility nurse, administrator, kitchen staff and maintenance staff were also scheduled during the day time hours throughout the week.

On 7/10/13, twenty-four residents were interviewed. Twenty residents stated there was sufficient staff scheduled to meet their needs. Four stated there were times when staff got behind and they had to wait for assistance.

Seven staff were interviewed on 7/10/13. All of the staff stated resident's needs were met with the current staffing schedule. Two of the staff interviewed also stated that at times "it got pretty busy, depending on the residents' needs," but felt residents' needs were met.

On 7/11/13 at 9:41 AM, the administrator stated that she always scheduled enough caregivers to ensure residents care needs were met. She additionally stated she had hired two PRN caregivers and also used an outside staffing agency, if needed.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #3: The facility did not provide adequate portions of food.

Findings #3: On 7/10/13, the complaint log was reviewed. There was one complaint about not having enough baked potatoes. The complaint resolution was to go to the kitchen and get more potatoes. There were no complaints about not having adequate portions.

On 7/10/13 the lunch meal was observed. Residents received beef noodle soup, a drink, then a tossed salad, turkey tarragon, duchess potatoes (mashed), brussel sprouts and a choice of desserts. All residents were observed to receive adequate portions of each item.

On 7/10/13, twenty-four residents were asked if they were provided adequate portions of food during meals. All residents stated they felt there was "plenty" of food and portions were more than adequate. Residents also stated they could have seconds if they chose to.

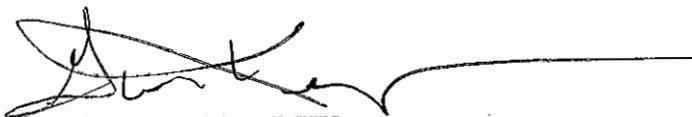
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Seven caregivers were interviewed on 7/10/13. All of the caregivers stated there were adequate portions for the residents and seconds were always available if a resident requested more food.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

A handwritten signature in black ink, appearing to read 'Gloria Keathley', followed by a long horizontal line extending to the right.

Gloria Keathley, LSW  
Health Facility Surveyor  
Residential Assisted Living Facility Program

GK/TFP

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program



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1130 North Allumbaugh Street  
Boise, ID 83704

Dear Ms. Arceneaux:

An unannounced, on-site complaint investigation survey was conducted at Valley View Investors, LLC - The Bridge at Valley View, between July 10, 2013 and July 11, 2013. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00005866**

Allegation #1: Medications were not available as ordered.

Findings #1: On 7/10/13, twenty-four residents were asked if the facility ever ran out of their medications. All the residents stated their medications were available as ordered and the facility did not run out of their medications.

On 7/10/13, six residents' assistance with medication records were reviewed. All six records documented that currently, residents' medications were available as ordered by their physicians.

On 7/10/13 at 9:41 AM, the facility administrator stated prior to June 2013, residents who used the VA (Veteran's Administration) to fill their prescription orders, would occasionally have their medications unavailable for a day or two when they ran out. She stated in June 2013, she and the facility RN, implemented a new system, which was to bubble-pack the VA medications immediately when they arrived at the facility. This gave the facility an exact date when the medications would run out so the facility could order more before any resident ran out of their medications.

Substantiated. However, the facility was not cited as they acted appropriately by correcting the issue prior to the complaint investigation.

Allegation #2: The facility did not schedule adequate staffing to meet the residents' needs.

Findings #2: Observations were conducted 7/10 and 7/11/13. Five staff were observed providing care to the residents, along with the facility nurse and administrator. Residents' needs were observed being met by the staff.

On 7/10/13, the facility's staffing schedule was reviewed. It documented at least five staff were scheduled for day and evening shifts. For each day and evening shift, two staff were scheduled as medication aides, two staff were scheduled as caregivers, and one staff member was scheduled as a bath aide. Additionally, the schedule documented the facility nurse, administrator, kitchen staff and maintenance staff were also scheduled during the day time hours throughout the week.

On 7/10/13, twenty-four residents were interviewed. Twenty residents stated there was sufficient staff scheduled to meet their needs. Four stated there were times when staff got behind and they had to wait for assistance.

Seven staff were interviewed on 7/10/13. All of the staff stated resident's needs were met with the current staffing schedule. Two of the staff interviewed also stated that at times "it got pretty busy, depending on the residents' needs," but felt residents' needs were met.

On 7/11/13 at 9:41 AM, the administrator stated that she always scheduled enough caregivers to ensure residents care needs were met. She additionally stated she had hired two PRN caregivers and also used an outside staffing agency, if needed.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #3: An identified resident's room was not maintained in a clean and sanitary manner.

Findings #3: On 7/9 and 7/10/13, the identified resident's room was observed to be clean and odor free.

On 7/10/13, seven employees were interviewed. They stated the identified resident was incontinent of urine and her room used to have a strong smell. They stated the carpet was shampooed frequently, and recently a large section had been replaced. They stated that housekeeping shampooed the carpet when needed and clean the room weekly. Additionally, they stated when they entered the resident's room they would empty the trash and straightened it up.

On 7/10/13 at 9:41 AM, the administrator confirmed the resident's room used to have a strong smell of urine. She stated they were aware of the resident's incontinence and had taken steps to address the problem. She stated the carpet was

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shampooed frequently, the bed had been replaced, and a section of the carpet and sub-flooring were also replaced. She stated the room was cleaned at least weekly and was monitored for odor.

Substantiated. However, the facility was not cited as they acted appropriately by implementing interventions to ensure the resident's room was clean and odor free.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

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Gloria Keathley, LSW  
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