



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- Governor
RICHARD M. ARMSTRONG -- Director

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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CERTIFIED MAIL: 7012 3050 0001 2128 3641

July 31, 2014

Sheila Kellogg, Administrator
Life Care Center of Valley View
1130 North Allumbaugh Street
Boise, ID 83704

Provider #: 135098

FILE COPY

Dear Ms. Kellogg:

On **July 25, 2014**, a Recertification and State Licensure survey was conducted at Life Care Center of Valley View 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 3). **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 return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 13, 2014**. Failure to submit an acceptable PoC by **August 13, 2014**, may result in the imposition of civil monetary penalties by **September 2, 2014**.

The components of a Plan of Correction, as required by CMS include:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring.
 - * It is important that the individual doing the monitoring have the appropriate experience and qualifications for the task.
 - * The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3.
 - * A plan for "random" audits will not be accepted.
 - * Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- 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.

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- 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 **August 28, 2014 (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 **August 28, 2014**. A change in the seriousness of the deficiencies on **August 28, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 28, 2014** includes the following:

Denial of payment for new admissions effective **October 25, 2014**. [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 **January 25, 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, they will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626; 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 **July 25, 2014** and continue until substantial

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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)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **August 13, 2014**. If your request for informal dispute resolution is received after **August 13, 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 the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



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

DS/lj
Enclosures

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

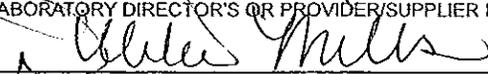
PRINTED: 07/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/25/2014
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704
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(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
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<p>F 000 INITIAL COMMENTS</p> <p>The following deficiencies were cited during your annual Federal recertification survey.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Sherri Case, QMRP, LSW Lauren Hoard, RN, BSN Susan Gollobit, RN</p> <p>The survey team entered the facility on 7/21/14, and exited the facility on 7/24/14.</p> <p>Survey definitions: ADL = Activities of Daily Living BID = Twice a day BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide CP = Care plan DON/DNS = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed TAR = Treatment Administration Record TID = Three times per day</p> <p>F 280 SS=D 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an</p>	<p>F 000</p> <p style="text-align: right;">RECEIVED AUG 13 2014 FACILITY STANDARDS</p> <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 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 conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.</i></p> <p>F 280 F280</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #4 care plan was update to include the guidance to use with slick jello.</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 8/13/14
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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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F 280	<p>Continued From page 1</p> <p>interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to revise care plans for 1 of 11 sampled residents (# 4). The resident's care plan failed to include guidance for the use of slick jello received with every meal. This failure had the potential to result in harm (choking) if the resident did not clear her mouth of food prior to lying down. Findings included:</p> <p>Resident #4 was admitted to the facility on 9/23/11 with diagnoses which included mental disorder, glaucoma and esophageal reflux.</p> <p>The resident's 7/14 Physician Orders (recapitulation) diet section included "extra gravy....slick jello with meals." The orders included no further information regarding the use of the slick jello.</p> <p>The resident's 9/23/11 Care Plan for Alteration in nutrition related to history of chewing and swallowing problems and included interventions of "Extra gravy and sauces on the side, slick</p>	F 280	<p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken:</p> <p>Residents with orders for slick jello have the potential to be affected. Residents who have orders for slick jello were reviewed to ensure that the care plan includes the guidance for use of slick jello.</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;</p> <p>Guidelines for the use of slick jello with patients who have orders will be place on the Care plan and for nursing staff. Care Plans will available for reference on each shift. Staff assisting the residents with meals will reference the guidelines on the care plans to ensure they are followed.</p> <p>Inservice Nursing staff on guidelines for use of slick jello and the importance of referencing the Care Plans for resident who have slick jello ordered. Speech therapy inserviced on ensuring communication and careplan is complete when placing residents on slick jello.</p>

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F 280 Continued From page 2

jello." The care plan identified Dietary as responsible for the intervention. The care plan did not provide guidance when the slick jello was to be offered such as at the beginning or end of the meal, in between bites etc.

On 7/22/14 at 8:13 a.m. the resident was observed eating breakfast, a bowl of jello was placed near the resident. The resident was eating her meal independently and did not take a bite of the jello. At 8:33 a.m. the resident coughed, a CNA assisting another resident came over to the resident and wiped the resident's mouth. The CNA did not offer a bite of jello to the resident.

On 7/22/14 at 12:40 p.m. the resident was observed finishing her mid-day meal. The resident had eaten her meal of chicken and cherry pie but had not eaten any of the slick jello. At 12:45 CNA #3 was observed in the resident's room providing oral care by using a mouth swab to clean the resident's mouth. The CNA stated the resident "pockets" food and was observed to remove partially chewed chicken and cherries from the resident's mouth.

On 7/23/14 at 8:35 a.m. the Staff Development Coordinator (SDC) stated the slick jello helps Resident #4 to swallow. The SDC stated she would provide the assessment completed by speech therapy with the recommendation.

On 7/24/14 at 9:00 a.m. the DON stated speech therapy had determined the need for the slick jello. The DON was asked for the assessment by speech therapy. Later the DON provided the Users Guide for Slick Jello and stated speech therapy had recommended it be followed for Resident #4. The Guide For Slick Jello included:

F 280

How the corrective actions will be monitored to ensure the deficient practice does not recur, what quality assurance program will be put into place

Nurse Managers or Restorative Nurse to audit during meal times that slick jello is being used in accordance to the guidelines. Audits will begin on 8/20/2014. Audits will be completed weekly for four weeks, then every 2 weeks for 1 month and then Monthly for three months. Audits will be brought to the monthly QAPI meeting by the Director of Nurses for review and monitoring.

8/28/14

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

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F 280	Continued From page 3 *Provide jello at every meal unless otherwise specified. *Start the meal with a couple of bites of jello *Offer bites of food *alternate food with bites of jello *make sure to end the meal with a couple of bites of jello On 7/24/14 at 5:00 p.m. the Administrator and DON were informed of the above concern. The facility provided no further information.	F 280		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F329 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Resident #11 careplan and behavior monitor has been updated. Resident #11 will have specific indications for use and behavior monitors will include specific signs and symptoms of depression and interventions for all disciplines to assist with resident psychosocial wellbeing. Justification for use of antidepressant will be routinely assessed in the behavior management meeting weekly by social services and nursing. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken:	

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F 329 Continued From page 4

This REQUIREMENT is not met as evidenced by:

Based on staff interview and record review it, was determined the facility failed to identify specific indications for use, and target behaviors prior to administering an anti-depressant medication. This was true for 1 of 11 (#11) residents reviewed for medication use. This failed practice had the potential to cause harm if the resident suffered side effects of headache, insomnia and/or suicidal behavior etc. from the use of an unnecessary antidepressant. Findings included:

Resident #11 was admitted to the facility on 8/12/13 with diagnoses which included depressive disorder, hypothyroidism and abnormal movement disorder.

The resident's 7/14 recapitulation Physician Orders included an order for Paxil (antidepressant) 30 mg daily with a start date of 6/22/14.

The resident's medical record included a Psychosocial Well-Being Care Plan (PWBCP) dated 8/22/13. The care plan identified in the problem section decreased sense of initiative, unsettled relationships, loss of past roles, anticipatory/actual grief, concern with death, and depression.

The PWBCP did not define decreased sense of initiative, such as staying in bed or not participating in activities. Additionally it did not include what the signs/symptoms of depression were or if the decreased initiative was a symptom

F 329

Residents within the facility on antidepressant medications have the potential to be affected. Residents will have specific indications for use and behavior monitors to include specific signs and symptoms of depression and care plans to include all disciplines. Justification for use of antidepressant will be routinely assessed in behavior management meeting weekly by social services and nursing involved in resident psychosocial wellbeing.

What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;

Staff inserviced on ensuring there is specific indications for antidepressant use for all residents using an antidepressant and assessing for dose reduction as indicated. Social Services inserviced that the careplan and behavior monitor must include specific interventions that the staff can implement.

How the corrective actions will be monitored to ensure the deficient practice does not recur, what quality assurance program will be put into place;

Nurse manager's to audit behavior monitors and select residents on anti depressants to ensure accuracy and

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F 329	<p>Continued From page 5</p> <p>of depression. It was not clear if the concern with death was fear of death or a need to escape from loss of past roles or current life.</p> <p>The Approaches section identified Social services would; Assist in learning stress management/relaxation technique as needed. Determine resident's expectations and discuss each in realistic terms as needed. Discuss coping strategies with resident as needed. Discuss, as needed concerns/fear of being unwanted or feeling useless as needed. Allow resident to discuss past overdose without judgment as needed. Provide supportive resources at the facility and post discharge for continuum of psychiatric concerns. Assess for suicide and depression.</p> <p>All staff were to encourage support from the resident's family and friends.</p> <p>The 11/7/13 Mood Care Plan (MCP) for the resident identified the problem as "potential alteration mood state" and identified verbal expressions of distress and sad, apathetic, anxious appearance.</p> <p>The MCP did not include if verbal expressions were threats of suicide, tearfulness, feelings of worthlessness etc. or what the symptoms of an anxious appearance were (wringing hands, rocking in wheelchair).</p> <p>The Approach section identified all staff would: Discuss with resident ways to utilize coping skills and listed the resident makes daily decisions,</p>	F 329	<p>for one month, every 2 weeks for one month then monthly for 3 months. Results and audits will be brought to the QAPI committee monthly by the Director of Nursing for monitoring.</p> <p>8/28/14</p>

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F 329	<p>Continued From page 6</p> <p>socializes with others and leisure activities such as seasonal parties, musicals and games. Encourage open expression of feelings. Encourage frequent contact with family and included names of family. Promote homelike environment.</p> <p>Both Care Plans identified coping skills were to be discussed with the resident. The 11/7/13 MCP Approach section documented the resident made daily decisions, socialized with others etc. but did not include if staff were to remind the resident she was in control of daily decisions, encourage the resident to attend activities listed in the approach section or what to do if the identified activities were not available when the resident expressed distress. The 8/22/13 PWBCP identified social services would discuss coping strategies but did not include what coping strategies were or the frequency of the strategies.</p> <p>The Behavior/Intervention Monthly Flow Records (BIMFR) documented 0 behaviors of tearfulness and 0 incidents of "Decline Activities" for 12/13 through 7/2/14. The BIMFR had a line through the 7/3/14 dates and were blank.</p> <p>On 7/23/14 the Social Service Director (SSD) was asked if the Coping Strategies were identified in the resident's Care Plan. The SSD stated the coping strategies were sometimes discussed with the MDS assessment questions. The SSD was informed the PWBCP identified social services to implement the interventions and asked if she (SSD) was available 24 hours a day to address the resident's depression. The SSD stated she was not. The Administrator was present during the interview and acknowledged the Care Plan did not include specific interventions for staff to</p>	F 329		

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F 329 Continued From page 7
implement. The SSD was informed the BIMFR did not document the behaviors identified (anxious appearance, sad appearance or concern with death). Additionally the BIMFR documented 0 signs of tearfulness or decline in activities for the past 7 months to provide justification for the need for the antidepressant.

F 332 SS=D 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE

The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and record review, it was determined the facility failed to maintain a medication error rate of less than 5%. This was true for 2 of 15 (#s 2 & 12) sampled residents observed during the medication pass. This failed practice created the potential for harm if a resident experienced increased GI disturbance when the medications omeprazole, prilosec and cranberry were not administered prior to meals as ordered. Findings included:

1. Resident #2 was admitted to the facility on 7/9/11 and readmitted on 6/3/12 with multiple diagnoses which included GERD (Gastroesophageal Reflux Disease) and dementia.

The July 2014 recapitulated Physician's Orders for Resident #2 documented, "7:00am, OMEPRAZOLE 20MG 1 TAB PO [By mouth] Daily DX [Diagnoses] GERD."

F 329

F 332 F 332

What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:

Resident #2 and #12 will be given their medications omeprazole, prilosec, and cranberry in the designated time frame as ordered. LN #1 and LN#2 was inserviced and trained on providing omeprazole, prilosec and cranberry to residents within the time frames appropriate with the medications ordered.

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken:

Residents within the facility receiving omeprazole, prilosec and cranberry have the potential to be affected. Residents will be given omeprazole, prilosec and cranberry medications within the timeframe ordered and as recommended.

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704
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(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
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F 332

Continued From page 8

The July 2014 MAR (Medication Administration Record) for Resident #2 documented the medication omeprazole had been administered as ordered.

On 7/22/14 at 7:52 a.m., Resident #2 was observed by the surveyor sitting in the dining room on the second floor. He had eaten 100% of the breakfast meal.

On 7/22/14 at 8:50 a.m., LN #1 was observed as she poured medications for Resident #2 which included omeprazole 20 mg (milligrams) due at 7:00 a.m. The LN administered the medications to Resident #2 next to the medication cart. The LN was asked about administering the 7:00 a.m. dose of omeprazole and she said, "I know it's late."

The Nursing 2014 Drug Handbook by Lippincott Williams & Wilkins documents, "Omeprazole...Administration P.O....Give drug at least 1 hour before meals."

2. Resident #12 was admitted to the facility on 12/23/10 with multiple diagnoses which included dementia and esophageal reflux.

The July 2014 recapitulated Physician's Orders for Resident #12 documented, "7:00am, PRILOSEC DR 20 MG CAPSULE PO daily," and, "12:00pm...CRANBERRY 1 TAB PO Twice Daily Dx Supplement/UTI [urinary tract infection] Prophylaxis."

The July 2014 MAR for Resident #12 documented the medications prilosec and cranberry had been administered as ordered.

F 332

What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;

Licensed Staff inserviced on Administration of medications at the prescribed time, specifically the time frames for prilosec, omeprazole and cranberry.

How the corrective actions will be monitored to ensure the deficient practice does not recur, what quality assurance program will be put into place;

Nurse Managers to perform audits on medication administration to determine medications, specifically omeprazole, prilosec and cranberry given at the correct time. Audits to begin 8/20/14. Audits will occur weekly for one month, every two weeks for one month then monthly for 3 months. Results of the Audits will be brought to QAPI by DON for review and monitoring.

8/28/14

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F 332	Continued From page 9 On 7/23/14 at 8:20 a.m., LN #2 was observed as she poured multiple medications for Resident #12 which included prilosec 20 mg due at 7:00 a.m. and cranberry 1 tablet due at 12:00 p.m. The LN administered the medications to the resident next to the medication cart. LN #2 was asked about administering the prilosec and she stated, "I did not give it before breakfast." The LN was asked about administering the cranberry and she stated, "Oh, it was due at noon." On 7/23/14 at 4:20 p.m., the Administrator and DON were informed of the medication errors. No further information or documentation was provided. F 514 SS=D 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to maintain	F 332	F 514 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Resident #2 will have Pre/Post Dialysis communication forms filled out completely each dialysis day. Resident #1 will have an accurate and current consent for any positioning and mobility devices. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: Residents within the facility who go to dialysis have the potential to be

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	<p>Continued From page 10</p> <p>clinical records for each resident in accordance with accepted professional standards and practices to ensure the records were complete and accurate regarding dialysis communications and side rail safety assessments. This was true for 2 of 15 (#s 1 & 2) sampled residents. This deficient practice created the potential for medical decisions to be based on incomplete or inaccurate information which increased the risk for complications due to inappropriate care or interventions. Findings included:</p> <ol style="list-style-type: none"> Resident #2 was admitted to the facility on 7/9/11 and readmitted on 6/3/12 with multiple diagnoses which included chronic kidney failure and dementia. <p>The Dialysis Care Plan for Resident #2, dated 7/9/11 and 9/11/13 documented:</p> <ul style="list-style-type: none"> Problems - "Alterations in health maintenance secondary to dialysis treatments d/t [due to] CKD [Chronic Kidney Disease];" Approaches - "Follow pre/post dialysis checklist per facility protocol...Monitor VS [vital signs] as indicated and assess for any significant changes." <p>The Policy and Procedure for Dialysis, no date provided, documented, "Procedure...Day of Dialysis:...3. If dialysis facility requires form(s) to be filled out and sent with resident, complete and send with resident...Post-Dialysis: 1. Obtain vital signs of resident upon return from dialysis. 2. Follow routine dialysis instructions on dialysis transfer form..."</p> <p>The following information was not completed on the Pre/Post Dialysis Communication forms for Resident #2:</p> <ul style="list-style-type: none"> 6/25/14 - Pre-dialysis: weight or resident refused 		<p>affected. Residents within the facility who have physical restraint informed consent have the potential to be affected.</p> <p>Residents on Dialysis were reviewed to assure that they have the pre/post dialysis sheet filled out completely and accurately each time they go to dialysis.</p> <p>Physical Restraint informed consent forms were reviewed for residents and ensured that they are accurate and current for all residents who require them.</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;</p> <p>Licensed staff inserviced on the pre/post dialysis forms and ensuring they are filled out entirely each time.</p> <p>Licensed nurses inserviced on physical restraint informed consents and ensuring accuracy and reason for use.</p> <p>How the corrective actions will be monitored to ensure the deficient practice does not recur, what quality assurance program will be put into place;</p> <p>Nurse managers to audit pre/post dialysis sheets and physical restraint informed consent for accuracy and completeness. Audits to begin 8/20/14. Audits will occur weekly for one month,</p>

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

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FORM APPROVED
OMB NO. 0938-0391

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F 514	Continued From page 11 to be weighed; - Post dialysis: temperature, pulse, respirations, blood pressure, weight or resident refused to be weighed, condition of access/site, bruit present, thrill present, change of site, signature, date and time; * 6/27/14 - Pre-dialysis: weight or resident refused to be weighed, lung sounds, condition of access/site, is resident on antibiotic, bruit present, thrill present, any meds given to the resident to take at the dialysis center, meal given to the resident to take to the dialysis center, signature, date and time; - Post dialysis: time; * 6/30/14 - Pre-dialysis: lung sounds, condition of access/site, is resident on antibiotics, bruit present, thrill present, any meds given to the resident to take at the dialysis center, meal given to the resident to take to the dialysis center, signature, date and time; - Post dialysis: temperature, pulse, respirations, blood pressure, weight or refused to be weighed, condition of access/site, bruit present, thrill present, change of site, signature, date and time; * 7/2/14 - Pre-dialysis: weight or refused to be weighed; - Post dialysis: time; * 7/11/14 - Post dialysis: temperature, pulse, respirations, blood pressure, weight or refused to be weighed, condition of access/site, bruit present, thrill present and time; * 7/14/14 - Pre-dialysis: blood pressure, weight or refused to be weighed, lung sounds, condition of access/site, is resident on antibiotic, bruit present, thrill present, any meds given to the resident to take at the dialysis center, meal given to the resident to take to the dialysis center, signature, date and time; - Post dialysis: temperature, pulse, respirations	F 514	every two weeks for one month then monthly for 3 months. Results of the Audits will be brought to QAPI by DON for review and monitoring. 8/28/14

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F 514 Continued From page 12
and blood pressure;
* 7/21/14 - Post dialysis: temperature, pulse, respirations, blood pressure, weight or refused to be weighed, condition of access/site, bruit present, thrill present, change of site and time.

On 7/23/14 at 2:43 p.m., the DON was asked about the pre/post dialysis communication forms. She stated, "Everything should be filled out in its entirety."

On 7/23/14 at 4:20 p.m., the Administrator and DON were informed of the documentation issues. No further information or documentation was provided.

2. Resident #1 was admitted to the facility on 8/13/13 and readmitted on 4/12/14 with diagnoses which included anxiety, dementia without behaviors and osteoarthritis.

The resident's medical record included a "Physical Restraint Informed Consent " signed by the legal representative on 8/19/13. The form had an area which had a line to document types of restraining devices. A line had been marked through the handwritten statement "1/2 lap tray" and written above the statement was D/C (discontinued) 1/30/14. Written by the crossed out words was 1/2 SR (siderail) x 2. The medical reason for the restraining device had hand written "to improve positioning, support and comfort of casted L (left) UE (upper extremity); patient noted to pin L UE between body and arm rest."

On 7/23/14 at 9:55 a.m. the DON stated a new

F 514

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F 514	Continued From page 13 Consent should have been completed as the current Consent contained inaccurate information.	F 514		

Bureau of Facility Standards

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C 000 16.03.02 INITIAL COMMENTS

The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.

The following deficiencies were cited during your annual State Licensure survey.

The surveyors conducting the survey were:
Amy Barkley, RN, BSN, Team Coordinator
Sherri Case, QMRP, LSW
Lauren Hoard, RN, BSN
Susan Gollobit, RN

The survey team entered the facility on 7/21/14, and exited the facility on 7/24/14.

C 000

RECEIVED
AUG 13 2014
FACILITY STANDARDS

C 099 02.009 CRIMINAL HISTORY AND BACKGROUND CHECK REQUIRE

01. Criminal History and Background Check. A skilled nursing and intermediate care facility must complete a criminal history and background check on employees and contractors hired or contracted with after October 1, 2007, who have direct patient access to residents in the skilled nursing and intermediate care facility. A Department check conducted under IDAPA 16.05.06, "Criminal History and Background Checks," satisfies this requirement. Other criminal history and background checks may be accepted provided they meet the criteria in Subsection 009.02 of this rule and the entity conducting the check issues written findings. The entity must provide a copy of these written findings to both the facility and the employee. (3-26-08)

02. Scope of a Criminal History and Background Check. The criminal history and background

C 099

C 099

What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:

Staff A is no longer an employee at Valley View

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken:

All new hires have the potential to be affected: New staff will have criminal history check completed within 21 days of hire or taken off the schedule

Bureau of Facility Standards

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

TITLE

(X6) DATE

[Signature]

Administrator

8/13/14

Bureau of Facility Standards

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C 099	<p>Continued From page 1</p> <p>check must, at a minimum, be a fingerprint-based criminal history and background check that includes a search of the following record sources: (3-26-08)</p> <p>a. Federal Bureau of Investigation (FBI); (3-26-08)</p> <p>b. Idaho State Police Bureau of Criminal Identification; (3-26-08)</p> <p>c. Sexual Offender Registry; (3-26-08)</p> <p>d. Office of Inspector General List of Excluded Individuals and Entities; and (3-26-08)</p> <p>e. Nurse Aide Registry. (3-26-08)</p> <p>03. Availability to Work. Any direct patient access individual hired or contracted with on or after October 1, 2007, must self-disclose all arrests and convictions before having access to residents. The individual is allowed to only work under supervision until the criminal history and background check is completed. If a disqualifying crime as described in IDAPA 16.05.06, "Criminal History and Background Checks," is disclosed, the individual cannot have access to any resident. (3-26-08)</p> <p>04. Submission of Fingerprints. The individual's fingerprints must be submitted to the entity conducting the criminal history and background check within twenty-one (21) days of his date of hire. (3-26-08)</p> <p>05. New Criminal History and Background Check. An individual must have a criminal history and background check when: (3-26-08)</p> <p>a. Accepting employment with a new employer; and (3-26-08)</p> <p>b. His last criminal history and background check was completed more than three (3) years prior to his date of hire.</p>	C 099	<p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;</p> <p>Inservice human resources and scheduler on criminal history process</p> <p>How the corrective actions will be monitored to ensure the deficient practice does not recur, what quality assurance program will be put into place;</p> <p>Nurse Managers/business Office manager will audit new employee hires and finger printing compliance. Audits to begin on August 20th. Audits will be performed on all new hires for the next 3 months. Results of audits will be brought to QAPI by DON based on trends identified</p>	8/28/14
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Bureau of Facility Standards

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C 099	<p>Continued From page 2</p> <p>(3-26-08)</p> <p>06. Use of Criminal History Check Within Three Years of Completion. Any employer may use a previous criminal history and background check obtained under these rules if: (3-26-08)</p> <p>a. The individual has received a criminal history and background check within three (3) years of his date of hire; (3-26-08)</p> <p>b. The employer has documentation of the criminal history and background check findings; (3-26-08)</p> <p>c. The employer completes a state-only background check of the individual through the Idaho State Police Bureau of Criminal Identification, and (3-26-08)</p> <p>d. No disqualifying crimes are found. (3-26-08)</p> <p>07. Employer Discretion. The new employer, at its discretion, may require an individual to complete a criminal history and background check at any time, even if the individual has received a criminal history and background check within the three (3) years of his date of hire. (3-26-08)</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the criminal history check for Staff A was completed within 21 days of hire. This affected 1 of 5 staff reviewed. Findings included:</p> <p>On 7/24/14 after reviewing the facility's new hire employment files, it was determined Staff A was hired on 5/7/14. Staff A's criminal history check was not completed until 6/25/14 which was 49 days after Staff A was hired.</p>	C 099		
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C 099	Continued From page 3 On 7/24/14 at 3:30 PM, the business office employee was interviewed. The employee stated she was aware Staff A's criminal history check was not completed within the 21 days. The business office employee stated Staff A had missed the first finger print appointment. The surveyor asked what the protocol was when a finger print appointment was missed and the rescheduled appointment was after the 21 days. The business office employee stated she notifies the scheduler and the scheduler takes the employee off of the schedule. The business office employee stated she notified the scheduler but was unsure when. On 7/24/14 at 3:45 PM, The scheduler and DNS were interviewed. The DNS stated Staff A should have been taken off of the schedule. The DNS stated Staff A was not taken off the schedule and continued to work. No additional information was provided to resolve this concern.	C 099		
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F280 as it relates to care plans being periodically reviewed and revised.	C 782	C782 See POC F280	8/28/14
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established	C 798	C798 See POC F332	8/28/14

Bureau of Facility Standards

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C 798	Continued From page 4 written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Refer to F332 as it relates to medication errors.	C 798		
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 as it relates to complete and accurate documentation in the resident's medical record.	C 881	C881 See POC F514	8/28/14



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

August 21, 2014

Debra J. Mills, Interim Administrator
Life Care Center of Valley View
1130 North Allumbaugh Street
Boise, ID 83704

FILE COPY

Provider #: 135098

Dear Ms. Mills

On July 24, 2014, a Complaint Investigation survey was conducted at Life Care Center of Valley View. Amy Barkley, R.N., Sherri Case, L.S.W., Q.M.R.P., Lauren Hoard, R.N. and Susan Gollobit, R.N. conducted the complaint investigation. This complaint was investigated during the annual Recertification and State Licensure survey conducted July 21, 2014 to July 24, 2014.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006238

ALLEGATION #1:

The complainant reported water was not always available to the resident in the identified resident's room, and when it was available, it was not always within reach of the resident.

FINDINGS #1:

The following documents were reviewed:

- The identified resident's closed record;
- Grievances for August 2013 and September 2013; and

- Resident council meeting minutes were reviewed and did not contain documented concerns related to hydration.

Four residents and two family members were interviewed and did not verbalize any concerns related to hydration and/or unavailability of water in the residents' rooms;

The following observations were made:

- Fifteen of fifteen sample residents were observed to have water pitchers in their rooms within reach;
- Certified Nurse Aides (CNAs) were observed during the survey to pass fresh water to the residents twice a day, once in the morning and again in the afternoon; and,
- Staff was observed to offer residents water while in the residents' rooms, providing care.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant had a concern related to bloody cotton balls and dressings on the floor, in an unidentified room in the facility.

FINDINGS #2:

Grievances were reviewed from February 2014 to July 2014 and did not contain any documented concerns related to the cleanliness of the facility.

Resident council meeting minutes were reviewed and did not contain any documented concerns related to soiled or contaminated materials left on floors.

Eleven residents who attended the group meeting did not verbalize any concerns related to the cleanliness of the facility.

Garbage cans in residents' rooms were observed to be clean and free from debris throughout the survey.

Four individual residents and two family members were interviewed, and there were no complaints verbalized related to the cleanliness of the facility.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant had a concern that the resident's call light was not in reach.

FINDINGS #3:

Grievances were reviewed from February 2014 to July 2014 and did not contain any documented concerns related to call lights being inaccessible.

Resident council meeting minutes were reviewed and did not contain any documented concerns related to call lights being inaccessible to residents.

Eleven residents who attended the group meeting did not verbalize any concerns related to call lights being inaccessible.

Call lights were observed to be within residents reach throughout the survey, and fifteen of fifteen sampled residents were observed to have their call lights within reach throughout the survey.

Four individual residents and two family members were interviewed and there were no complaints verbalized related to call lights not being accessible to residents.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant had a concern that the facility did not follow-up on suggestions expressed by her/him at the resident's care plan meetings.

FINDINGS #4:

The identified resident's care plan summaries were reviewed and contained documentation that the complainant was in attendance for the meetings; however, there was nothing documented to indicate any suggestions had been made.

The Director of Nursing was interviewed and verbalized that resident and family input is always

welcomed and considered when care plans are initiated, reviewed and revised.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant had a concern that CNAs were rude to some of the residents.

FINDINGS #5:

The identified resident's closed record was reviewed.

Grievances from August 2013 to September 2013 and February 2014 to July 2014 did not contain any documented concerns related to CNAs being "rude" to residents.

Resident council meeting minutes were reviewed and did not contain any documented concerns related to "rude" CNAs.

The group interview was attended by eleven residents who verbalized that staff "Treats everyone with respect."

Interactions between residents and CNAs were observed by the survey team and the interactions were observed to be considerate and respectful.

Four residents and two family members were interviewed and did not verbalize any concerns related to staff being rude and or inconsiderate to residents.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant had concerns that a resident was not receiving the help from staff that he/she required during meals.

FINDINGS #6:

Grievances were reviewed for August 2013 and September 2013, in addition to, February 2014 through July 2014. The grievances did not contain any documented concerns related to residents

Debra J. Mills, Interim Administrator
August 21, 2014
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not receiving enough assistance during meals.

Four individual residents and two family members interviewed did not verbalize any concerns related to residents not receiving help from staff during meals.

Fifteen of Fifteen sampled residents were observed during meal times, and staff was observed to assist the residents in need.

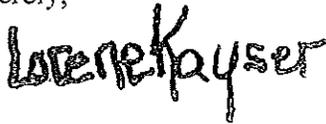
The survey team observed three meals and two dining rooms during the survey process. The residents that required assistance from staff were provided assistance.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- Governor
RICHARD M. ARMSTRONG -- Director

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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August 22, 2014

Debra J. Mills, Interim Administrator
Life Care Center of Valley View
1130 North Allumbaugh Street
Boise, ID 83704

FILE COPY

Provider #: 135098

Dear Ms. Mills:

On **July 24, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Valley View. Amy Barkley, R.N., Sherri Case, L.S.W., Q.M.R.P., Lauren Hoard, R.N. and Susan Gollobit, R.N. conducted the complaint investigation. This complaint was investigated in conjunction with the facility's Recertification and State Licensure survey and a second complaint.

The records of eighteen residents, which included the identified resident, were reviewed.

Observations of resident care were conducted at various times of the day throughout the survey process.

Interviews were conducted with residents, families of residents and facility staff.

The complaint allegations, findings and conclusions are as follows:

Complaint #6378

ALLEGATION #1:

The complainant stated the identified resident had been sick for approximately one month prior to going to the hospital where the resident passed away the next day from pneumonia.

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The complainant felt the facility should have done something sooner. An x-ray was completed with no results. On February 5, 2014, the Nurse Practitioner (NP) saw the resident but did not hospitalize the resident.

FINDINGS #1:

During the investigation, the resident's facility record and hospital record were reviewed. The resident had an x-ray completed on January 15, 2014, with an immediate report.

The NP saw the resident due to a change in condition on February 5, 2014, and treatment was initiated, which included labs and IV fluid. The NP saw the resident on February 6, 2014, and added new orders for medication, labs and IV fluids. The NP saw the resident on February 7, 2014, and requested transportation to the hospital for the resident. The resident passed away on February 8, 2014, at the hospital.

It could not be determined that there was a delay in treatment related to this resident's care.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated a nurse from the facility where the resident was transferred to told the complainant that the resident had dried feces in the peri area when the resident was admitted.

FINDINGS #2:

During the investigation, the records were reviewed and observations were performed of residents' cares at the facility.

The records did not contain documentation of dried feces in the peri area upon admittance to the receiving facility. During observations of cares at the facility, it was noted the staff performed good peri care with no concerns.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the resident was left in the resident's wheelchair for two to three hours at

a time, especially when going to meals.

FINDINGS #3:

During the investigation, residents' in wheelchairs were observed at meal times being assisted to the dining rooms.

During all three meal times, residents were taken into the dining room and not left in the hallways waiting to go in.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated the facility's Social Worker informed the resident that he/she no longer had Medicare/True Blue insurance coverage. This was done in front of the resident's two nieces. This information should not have been shared in front of the nieces, as the resident did not want them to know this information.

FINDINGS #4:

During the investigation, observations were obtained of staff talking with residents and performing cares. No incidents of privacy breeches were identified. Residents interviewed during the investigation did not identify any issues related to this concern.

The Social Worker identified by the complainant was interviewed about the facility's process to inform residents about insurance coverage or any information that would be deemed confidential to the resident and the resident's Power of Attorney. No concerns were identified with the facility's process.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated the resident had a Do Not Resuscitate (DNR) order but did not have a Physician Order for Scope of Treatment (POST).

Debra J. Mills, Interim Administrator
August 22, 2014
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FINDINGS #5:

There is no requirement that a resident has to sign a POST; however, the resident's record did include a POST form that was signed on the day the resident was admitted to the facility, December 30, 2013. A copy of the signed POST was sent with the resident when the resident was transferred.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are written in a cursive, slightly slanted style.

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj