



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS  
3232 Eder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
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FILE COPY

CERTIFIED MAIL: 7012 1010 0002 0836 1512

August 20, 2014

Philip Herink, Interim Administrator  
Life Care Center of Treasure Valley  
502 North Kimball Place  
Boise, ID 83704-0608

Provider #: 135123

Dear Mr. Herink:

On August 7, 2014, a Recertification, Complaint Investigation and State Licensure survey was conducted at Life Care Center of Treasure Valley 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 a widespread 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 **September 2, 2014**. Failure to submit an acceptable PoC by **September 2, 2014**, may result in the imposition of civil monetary penalties by **September 22, 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 **September 11, 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 **September 11, 2014**. A change in the seriousness of the deficiencies on **September 11, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 11, 2014** includes the following:

Denial of payment for new admissions effective **November 7, 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 **February 7, 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

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Office or the State Medicaid Agency beginning on **August 7, 2014** and continue until substantial 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 **September 2, 2014**. If your request for informal dispute resolution is received after **September 2, 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,

A handwritten signature in black ink that reads "L. Kayser, RN for L.K." with a stylized flourish at the beginning.

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

LKK/dmj  
Enclosures

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

PRINTED: 08/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/07/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF TREASURE VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704		
(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	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the annual federal recertification and complaint survey of your facility.  The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Amy Barkley, RN, BSN Rebecca Thomas, RN Susan Gollobit, RN Judy Atkinson, RN  The survey team entered the facility on August 4, 2014 and exited on August 7, 2014  Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed OT = Occupational Therapy	F 000	<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 the 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 constitute a deficiency, or that the scope and severity of the deficiencies cited are correct applied.</i>  <b>RECEIVED</b> <b>SEP 02 2014</b> <b>FACILITY STANDARDS</b>		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  This REQUIREMENT is not met as evidenced	F 318			

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

TITLE

(X6) DATE

Executive Director 9/2/14

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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F 318	<p>Continued From page 1</p> <p>by: Based on record review, and resident and staff interview, it was determined the facility failed to ensure two residents received interventions to prevent a decrease in range of motion (ROM). This was true for 2 of 14 (#s 1 &amp; 12) sampled residents who had the potential to sustain harm when they did not receive services necessary to prevent the deterioration of existing ROM limitations. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 12/22/11 with multiple diagnoses including paraplegia, chronic pain, and muscle spasm.</p> <p>The resident's 11/16/13 annual and 5/16/14 quarterly MDS assessments documented the resident required extensive assistance with transfers, required extensive assistance to ambulate and range of motion impairment to one upper and both lower extremities.</p> <p>The resident's OT Daily Treatment Note on 5/27/14 documented, "P[atien]t education re: planning d/c [discharge/discontinue] from OT d/t [due to] plateau in goals, with pt reporting "I don't want therapy to give up on me"...Pt is agreeable to home exercise program...after therapy had d/c'ed."</p> <p>On 8/5/14 at 9:15 AM, Resident #1 was interviewed regarding ROM issues. She said therapy had worked with her in the past and in May or June of 2014, a therapist had provided a print out of exercises for her to do on her own, but no other therapy had been provided since. Note: Therapy was discontinued on 6/3/14.</p> <p>On 8/6/14 at 1:35 PM, RN Unit Manager #4 was</p>	F 318	<p><b>F318</b></p> <p><b>SPECIFIC RESIDENT</b></p> <p>Resident #s 1 &amp; 12 have been evaluated for restorative nursing programs which have been established as deemed appropriate.</p> <p><b>OTHER RESIDENTS</b></p> <p>Residents who are identified on the MDS to require -- extensive assistance with transfers, ambulation and range of motion impairment to one upper or lower extremity over the last 30 days will be evaluated for appropriate intervention.</p> <p><b>SYSTEMIC CHANGES</b></p> <p>Nursing and Therapy staff will be in-serviced on the benefits of range of motion and process for restorative referral, as well as who to notify if indicated.</p> <p><b>MONITOR</b></p> <p>DNS and/or designee will audit Residents upon admission to the facility and discharge from therapy for restorative program needs. Audits will be completed weekly x 4, monthly x 3 and quarterly x 3. Results will be reported to the Performance Improvement committee.</p> <p>Audits will begin 9/5/14.</p> <p><b>DATE OF COMPLIANCE: 9/11/14</b></p>		

9/11/14

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F 318	<p>Continued From page 2</p> <p>asked if the resident was on a restorative nursing aide (RNA) program and she stated, "No she's not." She said therapy had not given her a referral to begin a restorative program.</p> <p>On 8/7/14 at 9:05 AM, the resident was asked if she would like to be involved in a RNA program and she stated, "Well yes."</p> <p>On 8/7/14 at 11:05 AM, OT #5 was interviewed regarding the lack of referral to the RNA program. OT #5 said the resident woke up late and, "It didn't jive with the RNA schedule." She also said at the time the resident was content with the home exercise program.</p> <p>2. Resident #12 was admitted to the facility on 4/9/14 with multiple diagnoses including difficulty in walking, intracranial hemorrhage with left hemiplegia, and weakness.</p> <p>The resident's 4/16/14 admission and 7/12/14 quarterly MDS assessments documented the resident required extensive assistance with transfers, required extensive assistance to ambulate and range of motion (ROM) impairment to one upper and one lower extremity.</p> <p>The resident's care plan, dated 4/9/14 documented, "The resident has impaired functional mobility Relating to Neurological deficit (CVA, osteoporosis) (L[eft]) side paralysis, spasticity, decreased neuromuscular control, Inability to achieve full functional range of motion in (L) UE/LE [upper/lower extremity] joints as evidenced by inability to open hand...Risk for contractures." One of the interventions was, "Provide active assisted ROM if unable to complete without help."</p>	F 318		

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F 318	Continued From page 3  On 8/6/14 at 1:45 PM, RN Unit Manager #4 was asked if the resident was on an RNA program and she stated, "She's not." She said therapy had not given her a referral to begin a restorative program.  On 8/7/14 at 8:50 AM, the resident was asked if she would like to participate in the RNA program and she stated, "If they think it would help."  On 8/7/14 at 3:30 PM, the Administrator and DON were informed of the issues. No further information was provided by the facility.	F 318		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as possible when equipment and chairs not in use were parked in the hallways blocking handrails. This was true for residents who used the D-wing and A-wing hallways for independent mobility. This failure created the potential for harm should residents slip, trip and/or fall and not have access to handrails.	F 323	F323  SPECIFIC  On D and A wing hallways mechanical lift between Linen room and 301 was removed from handrail, 3 sitting chairs between rooms 147 and 149 were Moved away from handrail. Mechanical lift between Day room and 137 was moved away from hand rail.  The 3 wheelchairs parked between rooms 114 and 116 were removed away from the handrail. One sitting Between rooms 147 and 149 have been removed.  Mechanical lift between dayroom and 137 have been Moved. Mechanical lift between 142 and 144 have been removed.	

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F 323	<p>Continued From page 4</p> <p>Findings included:</p> <p>On 8/4/14 the following observations were made of the D-wing and A-wing hallways:</p> <ul style="list-style-type: none"> <li>* From 9:30 AM to 4:00 PM, a mechanical lift was observed parked between a linen room and room 301 on nine different occasions, which blocked the handrail;</li> <li>* From 2:22 PM to 4:05 PM, three sitting chairs were observed between rooms 147 and 149 on three different occasions, which blocked the handrail;</li> <li>* From 3:15 PM to 4:00 PM, a mechanical lift was observed parked between a day room and room 137 on three different occasions, which blocked the handrail; and,</li> <li>* At 2:30 PM and 3:38 PM, three wheelchairs were observed parked outside a door labeled 'Clean Wheelchair Cushion Storage' and between rooms 114 and 116, which blocked the handrail.</li> </ul> <p>On 8/5/14 the following observations were made of the D-wing and A-wing hallways:</p> <ul style="list-style-type: none"> <li>* From 9:07 AM to 1:38 PM, one sitting chair was observed between rooms 147 and 149 on five different occasions, which blocked the handrail;</li> <li>* From 8:08 AM to 2:55 PM, a mechanical lift was observed parked between a day room and room 137 on five different occasions, which blocked the handrail;</li> <li>* From 10:20 AM to 2:35 PM, three wheelchairs were observed parked outside a door labeled 'Clean Wheelchair Cushion Storage' and between rooms 114 and 116 on five different occasions, which blocked the handrail; and,</li> <li>* From 9:08 AM to 1:34 PM, a mechanical lift was observed parked between room 142 and room 144 on five different occasions, which blocked the handrail.</li> </ul>	F 323	<p><b>OTHER</b></p> <p>All equipment, chairs and other items have been removed away from handrails in the halls on all Units.</p> <p><b>SYSTEMIC CHANGES</b></p> <p>We have located appropriate areas to store the wheel chairs and mechanical lifts.</p> <p>Staff will be in-serviced on appropriate storage areas and not storing items in halls in front of hand rails.</p> <p><b>Monitor</b></p> <p>ED and/or designated person will do audits, which will be conducted weekly x 4, monthly x 3, quarterly x 3. Results of the audits will be reported to the facilities Performance Improvement Committee.</p> <p>Audits will begin on 9/5/14.</p> <p><b>DATE OF COMPLIANCE: 09/11/14</b></p>		9/11/14

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F 323	Continued From page 5  On 8/6/14 at 5:12 PM, the DON was interviewed regarding the blocked handrail issues. When asked about the mechanical lifts and wheelchairs she stated, "We try to store them out of the hallways."  On 8/6/14 at 5:12 PM, CNA #3 was interviewed regarding mechanical lift storage. CNA #3 stated, "We try and keep them in the two hallways," and CNA #3 pointed to the hallways in D-wing where mechanical lifts were observed from the above observations.  On 8/6/14 at 6:05 PM, the Administrator and DON were informed of the equipment storage issue. No further information was provided by the facility.	F 323		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS  The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.  The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:  Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.	F 353	F353  <b>SPECIFIC RESIDENTS</b>  Residents residing on A-wing, D-wing and 300 hall  Including resident #'s 1,3,10 have adequate nursing  Staff to ensure timely answering of call lights and  Performance of care needs.	

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F 353	<p>Continued From page 6</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on a resident group interview, record review, resident and family interviews, and staff interviews, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of most residents. This affected 3 of 14 sampled residents (#s 1, 3, &amp; 10) and 8 of 11 residents who attended the group interview. This practice had the potential to affect all other residents who lived in the facility who required staff assistance with their ADLs. This failure created the potential for psychosocial and physical harm to the residents in the facility. Findings included</p> <p>Grievances:</p> <p>1. On 8/4/14 the facility grievance file was requested. Upon review, the following complaints were documented:</p> <p>a. On 3/8/14 a Concern &amp; Comment Form documented under the concern section, "My mom being left in wheelchair later than normal (Bedtime)." The describe in detail section documented, "There have been 3-4 evenings that a family member or myself has helped my mother to bed. Left in her wheelchair, sometimes sleeping..." The Investigation Findings section documented by a staff member, "...family reports that resident normally goes to bed around 7:30 PM. I</p>	F 353	<p><b>OTHER RESIDENTS</b></p> <p>Residents have the potential to be affected by this practice.</p> <p><b>SYSTEMIC CHANGES</b></p> <p>The facility evaluated staffing levels and amount of staff assistance needed on A, D and 300 halls and additional staff have been hired and trained to meet the acuity of each unit. Staff have been inserviced on their responsibility to ensure call lights are answered and resident needs attended to in a timely manner. Unit Managers inserviced to monitor each unit and communicate with staff to ensure the residents are receiving proper care.</p> <p><b>MONITOR</b></p> <p>ED and DON will monitor through review of the daily/weekly staffing patterns and concern and comment cards related to call lights and care concerns. Resident council on a monthly basis will be asked about responsiveness of staff for call lights and care needs. Call light audits will be conducted on all units weekly x4, Monthly x 3 and quarterly x 3. Staff Development and Unit Managers to audit cares being provided on each unit weekly times 4, monthly times 3 and quarterly times 3. Results will be reported to the performance improvement committee.</p> <p>Start date for audits 09/5/14.</p> <p><b>DATE OF COMPLIANCE: 9/11/14</b></p>	9/11/14	

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F 353	<p>Continued From page 7</p> <p>apologized to [Family Member Name] for this issue and she reported she was very pleased with [unreadable] care except this one issue, I assured her that I would do my best to adress [sic] her concern and make sure the staff are educated on getting her mother layed down early."</p> <p>b. On 3/25/14 a Concern &amp; Comment Form documented under the describe in detail section, "Concern regarding amount of time res[ident] has to wait to toilet, esp[ecially] at noc [night], amount of time she is left on bedpan, getting up to go to the commode as opposed to bedpan. Worried about staffing on noc, as res states she has been told they are too busy to toilet her as often as she needs."</p> <p>The Actions taken to Resolve section documented, "...educate staff on noc shift, S.S. [Social Services] to set up care plan meeting [with] family, nursing, therapies to have a unified plan of care."</p> <p>Resident Interviews:</p> <p>1. On 8/5/14 at 8:15 AM, Resident #10 was interviewed. When asked about staffing concerns, she stated, "They are short staffed and they are always telling you that...they are overworked." When asked about call light response times and how long it took to answer her call light, she stated, "I'd say 15 minutes to never...sometimes they don't come." When asked if the call light issue was a past issue or a current issue, she stated, "It's getting worse, not better." She also stated her roommate is sometimes left on the toilet too long.</p> <p>2. On 8/5/14 at 10:00 AM, Resident #3 was interviewed. When asked about call light</p>	F 353		

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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF TREASURE VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704		
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F 353	<p>Continued From page 8</p> <p>response times, he said it can take up to 40 minutes to answer his light and, "several times I have waited longer than 40 minutes...it seems like they don't come at all."</p> <p>3. On 8/6/14 at 10:30 AM during the resident Group Interview, 8 out of 11 residents complained call lights were an issue. When asked to quantify response times, they said 20-30 percent of the time, they would have to wait longer than 20 minutes.</p> <p>They said sometimes when their call light was answered, a staff member would come in, turn off the light, say they would be back, but would not return for over 10 minutes.</p> <p>One resident said they have had to wait up to 90 minutes for their call light to be answered. Another resident said on several occasions they had to wait so long, they wet their pants waiting for a staff member to assist them. Several of the residents said the staff tried to do their best, but they were understaffed on all shifts.</p> <p>4. On 8/6/14 at 3:20 PM, Resident #1 was interviewed about call lights. She stated normally call lights were answered anywhere from 5 to 10 minutes, but said just this day she turned her call light on and at 2:30 PM an aide came in, turned the call light off and told the resident they would be back in five minutes. By 2:45 PM, the aide had not returned, so the resident used the call light again and staff did not respond until 3:00 PM to assist her with a transfer from her bed to her wheelchair. The resident stated, "I know this is a busy place."</p> <p>Family Interview:</p> <p>1. During the survey a family member, who did</p>	F 353		

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F 353	<p>Continued From page 9</p> <p>not want to be identified, was interviewed regarding call light issues. The family member said the resident has had to wait up to 40 minutes for the call light to be answered. The family member also said, C.N.A. staff had verbalized to them, they needed more help to assist residents.</p> <p>Staff Interviews:</p> <ol style="list-style-type: none"> <li>On 8/6/14 at 2:07 PM, C.N.A. #6 was interviewed and asked if there was enough staff to meet the resident's needs and she stated, "We have our good days and bad days...we've definitely had rough patches." When asked what she said to resident's who had to wait a long time for their call light to be answered, she stated she generally tells them, "I'm so sorry you had to wait."</li> <li>On 8/6/14 at 3:25 PM, C.N.A. #7 was interviewed and asked if there was enough staff to meet the resident's needs and she stated, "We've just not had enough staff...they need a lot of extra help." C.N.A. #7 said in the last month there had not been enough C.N.A. coverage, but when the surveyors came to the building, another C.N.A. was added to help with coverage.</li> <li>On 8/6/14 at 3:33 PM, LN #8 was interviewed and asked if there was enough staff to meet the resident's needs and she stated, "It depends on the day. It feels like we could use more staff some days."</li> <li>On 8/7/14 at 1:20 PM, the DON was interviewed regarding staff levels and call lights. When informed of complaints of call lights that had been turned off and staff told residents they would be back, she stated, "We've educated our</li> </ol>	F 353		

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F 353	Continued From page 10 staff numerous times," to not turn off the lights until the resident was assisted. When asked about staff levels, she stated, "We staff according to the reg[ulation]s." When asked about the number of residents who needed two person assistance with transfers on the D-wing and the amount of aides for that wing, she stated, "I feel that more staff would be better." [Note: 15 out of 40 residents on D-wing required two person assistance.]	F 353			
F 371 SS=F	On 8/7/14 at 3:30 PM, the Administrator and DON were informed of the issue. No further information was provided by the facility. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the kitchen provided food in a safe and sanitary manner for sampled resident #1-14 and all residents who used the dining services. This deficient practice had the potential to cause more than minimal harm when: *Outdated food items were not disposed of and	F 371	<b>F371</b> <b>SPECIFIC</b>  Resident #1-14 and all residents who use dining services will be provided food in a safe and sanitary manner.  Coffee mugs that have scratches and/or residue have been replaced.  Small Kitchen aid mixer has been cleaned.  Industrial Mixer has been cleaned.  Shelves in prep-area and counter have been cleaned.  2 Baking ovens have been cleaned.  Eye wash station has been cleaned.  Outdated food items in fridge 2 have been removed and discarded.  Granola cereal in plastic container has been discarded		

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F 371	<p>Continued From page 11</p> <p>were available to be served to residents. *Areas for food preparations and equipment were not clean and sanitary. *Coffee mugs had residue or uncleanable surfaces. Findings included:</p> <p>1. On 8/4/14 at 9:00 AM, during the initial tour of the kitchen with the CDM, the surveyor observed outdated food items which included: *Walk-In cooler: Spiced Apple rings, dated 7/31/14. *Diet Aide Refrigerator #2: Ham slices in a plastic bag dated of 8/2/14, Maraschino cherry container with juice and cherries, dated 7/20/14, and 1/2 of a peanut butter and jelly sandwich in plastic wrap with no date. *Prep area metal shelf: A plastic bag with "cake mix," in it, dated 5/2/14. *Cereal container shelf: Granola cereal in a plastic container, dated 7/30/14.</p> <p>The surveyor asked the CDM if there was a schedule for checking the kitchen for outdated items and she stated, "No, but it looks like I need one."</p> <p>2. On 8/4 14 at 9:00 AM, during the initial tour of the kitchen with the CDM, the surveyor observed: * The Kitchen Aide mixer, which was ready for use, contained a sticky food type substance at the base of the beater attachment. The surveyor asked the CDM if she observed the same sticky substance, she stated "Yes," and asked the Dietary Aide to clean it. *The Industrial mixer which was observed, ready for use, contained red spots of a type of food, on the beater attachment area. When the surveyor asked the CDM if this was possibly juice, she</p>	F 371	<p><b>OTHER</b></p> <p>All residents could be affected by this deficient practice. The entire Kitchen area was checked and cleaned.</p> <p><b>SYSTEMIC CHANGES</b></p> <p>All dietary staff have been in-serviced on keeping the kitchen items clean, removing worn or blemished dishes and outdated food items removed and discarded.</p> <p><b>MONITOR</b></p> <p>Executive Director, Dietary Manager and/or designee will monitor thru audits of the coffee mugs, Mixer, shelves in prep-area, baking oven, eye wash station and used by date food times.</p> <p>Audits will be conducted weekly x4, Monthly x 3, quarterly x 3.</p> <p>Results of all audits will be reported to the facilities performance improvement committee.</p> <p>Start date for audits 9/5/14</p> <p><b>DATE OF COMPLIANCE: 9/11/14</b></p>	9/11/14

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F 371	Continued From page 12 stated, "Yes, that's what it looks like." The CDM asked the Dietary Aide to clean the mixer. *Two baking ovens were observed. The right wall of the right oven contained a white-tan film, with areas which were both solid and dripped which covered the wall. The surveyor asked if the substance was possibly oven cleaner, the CDM stated, "I don't know, might be." The floor of the left oven contained 2 areas of burned food. On 8/7/14 at 2:00 pm, the CDM and surveyor checked both ovens which were observed to be clean. *The 2 shelf Prep area counter was observed to have a tray on the bottom shelf with containers of food. The tray contained a sticky substance and when the flour container was moved, the tray was visibly wet with a clear liquid. The CDM stated, "Something has spilled on there, I will have them clean that up." *The eye station next to the hand washing sink was observed to have caked on, built up dust particles all around it.  3. On 8/4/14 at 9:00 AM, during the initial tour of the kitchen with the CDM, the surveyor observed 11 maroon colored plastic coffee mugs, ready for use. Five of the mugs had residue inside them, easily removed when wiped with a finger and 2 other mugs had scratched areas to the inside of the mugs that made the mugs an uncleanable surface.  On 8/6/14 at 6:00 PM the Administrator and DON were notified of the findings no additional information was provided.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	<p>Continued From page 13</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, it was determined the facility failed to ensure safe</p>	F 431	<p>F431</p> <p><b>SPECIFIC RESIDENTS</b></p> <p>The LN #1 was in-serviced to not leave the wound Cart unlocked. LN #2 was in-serviced on the proper Disposal of medications.</p> <p><b>OTHER RESIDENTS</b></p> <p>All residents have the potential to be affected.</p> <p><b>SYSTEMIC CHANGES</b></p> <p>All Licensed Nurses will be in-serviced on proper storage and destruction of Medications and to ensure the medication label matches the MD orders.</p> <p>Medication cards will be removed with each order change in order to ensure accurate labeling of medication cards.</p> <p><b>MONITOR</b></p> <p>Medication cards will be monitored monthly by DNS and/or designee with Cycle fill and audits will be conducted weekly x 3, monthly x 4 and quarterly x 3. Medication pass audits looking for accurate labeling of medication cards, proper disposal of medications, and locking of treatment and medication carts will be done weekly times 4, monthly times 4 and quarterly times 3 by the SDC, DDN, or designee. Results will be reported to the performance improvement committee.</p> <p>Audits will be begin on 9/5/14</p> <p><b>DATE OF COMPLIANCE: 9/11/14</b></p>	9/11/14	

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F 431	<p>Continued From page 14</p> <p>storage of medications, safe disposal of medications, and accurate labeling of medication for 2 random residents (#s19, 20) and any resident that might access the 100 hall. This deficient practice had the potential to cause more than minimal harm when medications were not secured in a wound cart and medications were disposed of in a garbage can. This provided access to medications which could possibly harm residents and a medication dispensing card was labeled inaccurately which could lead to administration of the wrong dose of the medication. Findings included:</p> <p>1. On 8/4/14 at 2:07 PM, the surveyor observed a wound cart parked outside the closed door of Room #138. The drawers to the cart were unlocked and easily opened. At 2:09 PM LN #1 came out of room #138. When the surveyor verified with LN #1 she had left the wound cart unlocked, the LN stated "Yes, I usually lock it. It is a dressing cart, so it has gauze and stuff on it." The cart included:</p> <ul style="list-style-type: none"> <li>*Top of the cart: A bottle of Microklenz Antimicrobial First Aid antiseptic, blue pads, box of gloves, Sani-hand wipes container, a container of Hypaflex dressing retention sheets.</li> <li>*Drawer #1: Miscellaneous items which included, Skin preps, currettes, Coban tape, flashlight, biohazard bags.</li> <li>*Drawer #2: Various tubes of Barrier creams;             <ul style="list-style-type: none"> <li>-2% Miconazole Nitrate,</li> <li>-Silvadene 1% cream,</li> <li>-Ammonium Lactate 12%,</li> <li>- LMX 4%- Lidocaine,</li> <li>-Zinc Oxide,</li> <li>-Desonimide 0.05%,</li> <li>-Clobetasol Propionate,</li> <li>-Santyl.</li> </ul> </li> </ul>	F 431		

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F 431	<p>Continued From page 15</p> <p>*Drawer #3: Various types of dressings. Drawer #4: A bag with 3 containers containing liquids for specimen collection, Coban, and documentation papers.</p> <p>*The Facility policy for Wound Care/ Treatment Guidelines documented: *Guidelines: -"Leave the cart locked and in the hall when not attended during wound treatment."</p> <p>2. On 8/5/14 at 11:10 AM, LN#2 was observed by the surveyor to dispense medications for Resident #20 which included: -Ferrous Sulfate (iron tablet) 325 mg (milligram), 1 tablet by mouth, -Theragran Tablet (multivitamin), 1 tablet by mouth. LN #2 went to the resident's room to administer the medications, the resident was not in the room, and the LN returned to the medication cart. The LN was observed by the surveyor to dispose of the two medications in the open garbage can located on the right side of the medication cart. The surveyor asked LN #2 what she had done with the medications. LN #2 stated, "I tossed them in the garbage. If it would have been another medication I would have went and flushed them, since they are over the counter, I tossed them."</p> <p>On 8/7/14 at 11:10 AM, the surveyor asked the ADON what was the facility's policy for disposing of over the counter medications, and she stated, "The medications would be flushed." The surveyor asked the ADON what she thought about staff throwing them in an open garbage can on the medication cart, the ADON stated, "They would have to be educated that is not how we do</p>	F 431			

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F 431	<p>Continued From page 16 it."</p> <p>3. On 8/5/14 at 11:20 AM LN #2 was observed to dispense medications for Resident #19, which included per MD order: -7/28/14 Gabapentin 100 mg tid (three times a day). The resident's medication dispensing card documented: -Gabapentin 100 mg capsule. Give 2 caps(ules) (200 mg) by mouth three times a daily. At 11:30 AM the surveyor verified the dosage per the MD order and the inaccurate medication dispensing card with the DON.</p> <p>On 8/7/14 at 11:10 AM, the surveyor asked the ADON what system the facility had to check the accuracy of the medication dispensing cards with the Doctor's orders, when the orders changed during the month. The ADON stated "A lot of times it is the Unit Managers (who check the cards). I also will alert the nurse and return it to the pharmacy." The surveyor verified if the cards are supposed to be returned to the pharmacy when there was a change. The ADON stated, "Yes, sometimes I have to fight them (the pharmacy) about that.</p> <p>On 8/7/14 at 3:00 PM the Administrator and the DON were notified of the findings. No additional information was provided.</p>	F 431		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF TREASURE VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704
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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 the State licensure and complaint survey of your facility.  The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Amy Barkley, RN, BSN Rebecca Thomas, RN Susan Gollobit, RN Judy Atkinson, RN	C 000		
C 111	02.100,02,f Provide for Sufficient/Qualified Staff  f. The administrator shall be responsible for providing sufficient and qualified staff to carry out all of the basic services offered by the facility, i.e., food services, housekeeping, maintenance, nursing, laundry, etc. This REQUIREMENT is not met as evidenced by: Refer to F353 regarding sufficient staffing to answer call lights.	C 111	RECEIVED SEP 02 2014 FACILITY STANDARDS  C111 Refer to POC for F353	9/11/14
C 325	02.107,08 FOOD SANITATION  08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules	C 325	C325 Refer to POC for F371	9/11/14

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE  
Executive Director

(X6) DATE  
9/2/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001430	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/07/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF TREASURE VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE 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) COMPLETE DATE
C 325	Continued From page 1  Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F371 regarding kitchen sanitation issues.	C 325		
C 786	02.200,03,b,ii Body Alignment, Exercise, Range of Motion  ii. Good body alignment and adequate exercises and range of motion; This Rule is not met as evidenced by: Refer to F318 regarding range of motion issues.	C 786	C786  Refer to POC for F318	9/0/14
C 790	02.200,03,b,vi Protection from Injury/Accidents  vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 regarding mechanical lifts, wheelchairs, and chairs blocking handrail access.	C 790	C790  Refer to POC for F323	9/0/14
C 832	02.201,02,f Labeling of Medications/Containers  f. All medications shall be labeled with the original prescription legend including the name and address of the pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.)  This Rule is not met as evidenced by: Refer to F431 regarding medication labeling issues.	C 832	C832  Refer to POC for F431	9/0/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001430	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/07/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF TREASURE VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE 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) COMPLETE DATE
C 838	Continued From page 2	C 838		
C 838	<p>02.201,02,1 Secure Storage of Medications</p> <p>I. All medications in the facility shall be maintained in a locked cabinet located at, or convenient to, the nurses' station. Such cabinet shall be of adequate size, and locked when not in use. The key for the lock of this cabinet shall be carried only by licensed nursing personnel and/or the pharmacist.</p> <p>This Rule is not met as evidenced by: Refer to F431 regarding an unlocked medication cart.</p>	C 838	<p>C838</p> <p>Refer to POC for F431</p>	<p>9/10/14</p>



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  
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August 20, 2014

Philip Herink, Interim Administrator  
Life Care Center of Treasure Valley  
502 North Kimball Place  
Boise, ID 83704-0608

FILE COPY

Provider #: 135123

Dear Mr. Herink:

On **August 7, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Treasure Valley. Bradley Perry, L.S.W., Amy Barkley, R.N., Becky Thomas, R.N., Susan Gollobit, R.N. and Judy Atkinson, R.N. conducted the complaint investigation. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted on August 4 - 7, 2014.

The following documents were reviewed:

- The facility's grievance files;
- Resident Council minutes for April - July 2014;
- The entire medical record of the identified resident;
- Four residents' records were reviewed for Physician Orders for Scope of Treatment (POST) accuracy;
- Ten other residents' records were reviewed for Quality of Care concerns;
- Three of the ten residents' records were reviewed for diabetes management concerns; and,
- Three of the ten residents' records were reviewed for respiratory concerns.

The following interviews were completed:

- Eleven residents were interviewed at a group interview regarding quality of care issues

- and evening snacks;
- Four individual residents were interviewed regarding Quality of Care issues; and,
- The Director of Nursing was interviewed regarding Quality of Care issues and evening snacks.

The complaint allegations, findings and conclusions are as follows:

**Complaint #6157**

**ALLEGATION #1:**

The complainant stated an identified resident's congestive heart failure and diabetes were mismanaged, which included the resident not getting a high protein snack and having her weight monitored daily.

**FINDINGS #1:**

The identified resident was no longer residing in the facility at the time the complaint was investigated.

During the survey, no issues were identified for the three residents who were reviewed for diabetic management, and no issues were identified for the three residents who were reviewed for respiratory concerns.

The identified resident's record included documentation verifying that evening protein snacks were provided to the resident and weights were recorded daily.

Eleven residents at the group interview said there were no quality of care concerns and evening snacks were offered each night. Four residents were interviewed individually, and they did not express any quality of care concerns. The Director of Nursing was interviewed, and she said the facility offered evening protein snacks, which includes yogurt, soft cheese sticks, shakes, pudding and cottage cheese.

Based on records reviewed and residents' and staff interviews, the allegation could not be verified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated that in the last five days of the identified resident's life, the congestive heart failure and lower extremity edema worsened. The facility did not notify the physician in a timely manner, to obtain treatment orders related to the decline.

FINDINGS #2:

Physicians' orders in the identified resident's closed record dated February 28, 2013, documented the facility was to notify a local cardiologist on March 1, 2013, for further orders regarding medication related to edema. Progress notes dated March 1, 2013, documented the facility left a voice mail for the cardiologist's office; however, they did not receive a call back and waited until March 3, 2013, before contacting another physician to obtain an order for the resident's edema issues.

This allegation was substantiated; however, the facility was not cited since this incident occurred prior to the previous year's annual Recertification and State Licensure survey, which was conducted on June 7, 2013.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated an identified resident's POST was misinterpreted.

FINDINGS #3:

Four other residents' POSTs were reviewed for accuracy, and no issues were found.

The identified resident's POST was reviewed and revealed the resident had signed it on December 24, 2012. The POST indicated the resident did not want to receive heroic or life saving measures. The resident's care plan and Medication Administration Record documented the resident did not want heroic or life saving measures.

A progress note on March 3, 2013, documented paramedics on the scene were given the resident's POST and did not perform resuscitation on the resident.

Based on records reviewed, it was determined the allegation could not be verified.

Philip Herink, Interim Administrator  
August 20, 2014  
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CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As only one of the complaint's allegations was substantiated, but not cited, 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 style with a large initial "L" and "K".

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

LKK/dmj



IDAHO DEPARTMENT OF  
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September 11, 2014

Philip Herink, Interim Administrator  
Life Care Center of Treasure Valley  
502 North Kimball Place  
Boise, ID 83704-0608

Provider #: 135123

Dear Mr. Herink:

On **August 7, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Treasure Valley. Bradley Perry, L.S.W., Judy Atkinson, R.N., Susan Gollobit, R.N., Becky Thomas, R.N. and Amy Barkley, R.N. conducted the complaint investigation. This complaint was investigated during the facility's Annual Recertification and State Licensure survey on August 4, 2014 to August 7, 2014.

The following documents were reviewed:

- The identified resident's closed record;
- Grievances from February 2014 to August 2014;
- Incident/Accident reports from February 2014 to August 2014; and,
- Resident council meeting minutes were reviewed and did not document concerns related to residents being improperly restrained.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006606**

**ALLEGATION #1:**

The complainant reported the identified resident was strapped in a wheelchair with the buckle under the seat so the resident could not get out.

FINDINGS #1:

The resident's Admission Orders documented the resident had an "Adj(ustable) Hi/Low Bed, concave mattress and a toilet seat riser."

The resident's Physician Admitting note documented the resident had advanced stages of Alzheimer's and had become "progressively more difficult to care for..."

The resident's Nurses Admission Note documented the resident had poor safety awareness and was unable to recognize the need to wait for assistance.

A physician's order documented a tag (tab) alarm for the resident's bed and wheelchair. Additionally, the resident received one-to-one care for the first two days of his/her admission to ensure the resident was safe.

NOTE: The tab alarm has a pull-string that attaches magnetically to an alarm with a garment clip to the resident. When the resident attempts to rise out of their chair or bed, the pull-string magnet is pulled away from the alarm, which causes the alarm to sound, alerting the caregiver.

Staff was interviewed regarding the use of tab alarms. The staff stated the purpose of the tab alarm was to remind the resident to stay seated and wait for help and to alert staff when a resident was attempting to self-transfer. Staff stated the alarm does not affect the residents movement and does not prevent him/her from standing up.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The identified resident's upper extremities were covered in bruises. The complainant stated she called the facility, and the Administrator did not return her call for five days.

FINDINGS #2:

The identified resident's initial data collection tool reviewed documented the facility had identified bruising to the resident's left forearm upon admission.

The resident's weekly skin integrity data sheet completed the day after admission identified the resident had some scratches to his/her left upper extremity but did not document additional bruises.

Philip Herink, Interim Administrator  
September 11, 2014  
Page 3 of 3

The Incident/Accident reports reviewed did not contain documentation that the resident sustained any additional bruises or skin issues during his/her stay at the facility.

The Executive Director was interviewed and stated that when a concerned party with a complaint calls the facility after a resident has been discharged, the Executive Director involves a team on the identified hall that includes Social Services and the Unit Manager. The Executive Director said the team determines the type of investigation to be conducted and proceeds with the investigation. Once the investigation is completed, the Executive Director notifies the complainant of the findings.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The identified resident told the complainant he or she received too many medications while in the facility.

FINDINGS #3:

The identified resident's medical record was reviewed; in addition to, the admission and discharge medication record. The resident was admitted and discharged with the same medications.

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