



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  
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PHONE 208-334-6626  
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August 14, 2013

Nancy E. Trout, Administrator  
Life Care Center of Treasure Valley  
502 North Kimball Place  
Boise, ID 83704-0608

Provider #: 135123

Dear Ms. Trout:

On August 8, 2013, an on-site follow-up revisit of your facility was conducted to verify correction of deficiencies noted during the Recertification and State Licensure survey of June 7, 2013. Life Care Center of Treasure Valley was found to be in substantial compliance with health care requirements as of **July 8, 2013**.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing the deficiencies that have been corrected is enclosed.

Thank you for the courtesies extended to us during our follow-up revisit. If you have any questions, concerns or if we can further assist you, please call this office at (208) 334-6626.

Sincerely,

LORETTA TODD, R.N., Supervisor  
Long Term Care

LT/dmj  
Enclosures



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September 23, 2013

Nancy E. Trout, Administrator  
Life Care Center of Treasure Valley  
502 North Kimball Place  
Boise, ID 83704-0608

Provider #: 135123

**RE: COMPLAINT FINDINGS FOR LIFE CARE CENTER OF TREASURE VALLEY**

Dear Ms. Trout:

On **August 9, 2013**, a Complaint Investigation survey was conducted at Life Care Center of Treasure Valley. Karen Marshall, R.D. and Karla Gerleve, R.N. conducted the complaint investigation.

The identified resident was admitted to the facility on May 10, 2013, and was discharged to a local hospital on May 11, 2013.

The following documentation was reviewed.

- May 10, 2013 through May 12, 2013, Incident and Accident Reports;
- The closed record of the identified resident.

Interviews were conducted with the Director of Nursing, the Administrator and one Licensed Nurse.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006073**

**ALLEGATION #1:**

The complainant stated an identified resident sustained a fall in the facility. The facility did not have any bed (fall) alarms in place. A person from the facility called an interested family member and told the family member the resident did not have physician's ordered alarms on at the time of the fall.

**FINDINGS:**

The resident's May 10, 2013, Admission Orders contained a physician's order for alarms at all times when in wheelchair and in bed for safety.

Review of the Incident and Accident Reports revealed the resident sustained a fall on May 11, 2013, at 3:00 p.m. The Incident Report documented the resident attempted to self-transfer out of a wheelchair, the wheelchair brakes were not locked and the wheelchair rolled out from under the resident.

The resident's Resident Progress Notes dated May 10, 2013 through May 12, 2013, at 4:55 a.m. were reviewed. The Resident Progress Notes dated May 11, 2013, at 7:00 p.m. documented in part; at 3:00 p.m., the resident was attempting to get up from wheelchair without locking brakes and slid to the floor. No injuries were noted and no complaints of pain. The entry was electronically signed by a Licensed Nurse.

The Licensed Nurse (LN) who electronically signed the May 11, 2013, 7:00 p.m. entry was interviewed. The LN was asked how it was determined the resident fell as the report did not document the reason the LN went into the resident's room. The LN said a therapist approached the LN and told the LN that the resident fell. The LN also said the resident was in therapy prior to the fall. The LN then went into the resident's room and found the resident sitting on the floor with her back against the bed. The surveyors asked the LN about alarms for the resident. The LN said an alarm was on a table and an alarm was lying on the dresser beside the resident's bed, and the resident's wheelchair brakes were not locked.

The survey team asked the same Licensed Nurse if she called a family member and told the family member that the physician's ordered alarms were not on the resident at the time of the fall. The LN said she did not tell a family member that the alarms were not on the resident at the time of the fall.

There were no Resident Progress Note entries about the resident removing alarms or taking

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alarms off from her person, the bed or from the wheelchair.

The resident's interim care plan identified a May 11, 2013, resident need of "at risk for physical injury from fall related to non-compliance with safety instructions." The care plan also contained a handwritten entry that appeared to be "tabs alarms off."

The Director of Nursing was interviewed about the handwritten entry on the care plan and said the handwritten entry was "takes alarms off" not "tabs alarms off."

The resident's May 2013 Treatment Record contained the entry, alarms at all times when in wheelchair and in bed. The Record contained initials by licensed staff on May 10, 2013, evening shift; May 11, 2013, night and evening shifts and on May 12, 2013, night shift. The initials indicated the alarms were in place as ordered.

However, the facility's investigation did not address when the resident was last observed by staff and did not address whether the alarms were in place or not in place as ordered by the physician or whether the alarms were sounding or not sounding.

There was no documentation in the resident's chart of the resident taking off alarms. The resident's care plan was updated as non-compliant regarding alarms on the same day the resident sustained the fall.

There was no statement from the therapist who notified the Licensed Nurse that the resident fell. In addition, there was no statement from the therapist about the resident's condition upon completion of therapy.

The facility was determined to be out of compliance with the requirements for fall investigation. However, the facility was not cited as the fall occurred prior to the facility's annual Recertification and State Licensure survey of June 7, 2013. That survey team reviewed accident investigations for all sampled residents and found the investigations to be in compliance at that time, indicating that the facility had taken corrective actions.

#### CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

#### ALLEGATION #2:

The complainant stated an identified resident did not have floor padding or side rails on her bed. The facility staff told an interested family member that federal laws did not allow for the use of side rails.

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FINDINGS:

The identified resident's May 10, 2013, Admission Orders did not contain a physician's order for floor padding or side rails on the resident's bed. It is accurate that federal requirements place strict limitations on the use of side rails, due to the danger of resident injury from accidental entrapment or falls resulting from climbing over the side rail.

The facility was in compliance with Federal guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant said an identified resident fell out of bed and had been given one dose of Dilaudid prior to the fall and was given two more doses after the fall.

FINDINGS:

The identified resident was admitted to the facility on May 10, 2013, after undergoing back surgery at a local hospital for Lumbar 1-2 (L 1-2) revision with fusion extension to Thoracic 9 (T9).

The identified resident's May 10, 2013, Admission Orders contained a physician's order for Dilaudid two milligrams; one to three tablets by mouth, every four hours, as needed for pain.

The resident's Medication Record documented the resident was administered two milligrams of Dilaudid on May 11, 2013, at 8:00 a.m., for back pain, and the medication was helpful.

On May 11, 2013, at 1:00 p.m., the resident was administered four milligrams of Dilaudid for pain, and the medication was helpful.

On May 11, 2013, at 3:00 p.m., the Resident Progress Notes contained an entry; the resident was found on the floor, in her room, with her back against the bed. The resident did not complain of pain at that time.

On May 11, 2013, at 8:30 p.m., the resident was administered four milligrams of Dilaudid for back pain, and the medication was helpful.

On May 11, 2013, at 10:30 p.m., the resident was discharged from the facility.

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It was determined the facility was in compliance with the physician's order and federal guidelines.

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 cursive script that reads "Loretta Todd". The signature is written in black ink and is positioned above the typed name.

LORETTA TODD, R.N., Supervisor  
Long Term Care

LT/dmj