



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
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CERTIFIED MAIL: 7012 3050 0001 2125 6102

September 26, 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 **September 16, 2014**, a Complaint Investigation 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 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.**

Philip Herink, Interim Administrator
September 26, 2014
Page 2 of 4

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 **October 9, 2014**. Failure to submit an acceptable PoC by **October 9, 2014**, may result in the imposition of civil monetary penalties by **October 29, 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.

Philip Herink, Interim Administrator
September 26, 2014
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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*.

As noted in the Bureau of Facility Standards' letter of **August 20, 2014**, following the **Recertification, Complaint Investigation and State Licensure** survey of **August 7, 2014**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **February 7, 2015**, if substantial compliance is not achieved by that time.

The findings of noncompliance from the Complaint Investigation of **September 16, 2014**, has resulted in a continuance of the remedy(ies) previously recommended to the Centers for Medicare and Medicaid Services on August 20, 2014.

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, it 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.

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

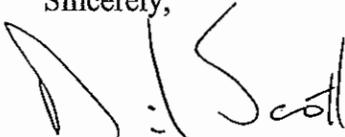
Philip Herink, Interim Administrator
September 26, 2014
Page 4 of 4

2001-10 IDR Request Form

This request must be received by **October 9, 2014**. If your request for informal dispute resolution is received after **October 9, 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, appearing to read "D. Scott". The signature is written in a cursive style with a large initial "D" and a long horizontal stroke.

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

DS/dmj
Enclosures

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

PRINTED: 09/26/2014
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 C 09/16/2014
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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) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint investigation at Life Care Center of Treasure Valley. The survey team was:</p> <p>Susan Gollobit, RN - Team Coordinator Nina Sanderson, BSW LSW</p> <p>The survey team entered the facility on 09/16/14 and exited the facility on 09/16/14.</p> <p>Survey definitions were:</p> <p>DNS = Director of Nursing</p>	F 000	<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 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></p>	
F 333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review it was determined the facility failed to ensure residents were free from significant medication errors. This was true for 1 resident (#1) sampled for medication errors. The deficient practice had the potential to cause harm if the resident suffered permanent visual impairment from having a skin medication administered into her eyes. Findings included:</p> <p>Resident #1 was most recently admitted to the facility on 5/7/14 with multiple diagnoses which included macular degeneration.</p> <p>Resident #1's Physician Admission Orders, dated</p>	F 333	<p>F333</p> <p>SPECIFIC RESIDENT</p> <p>Resident #1 Clobetasol Propionate 0.05% was removed from the medication cart. Nurse who administered the medication was educated, re-trained and monitored to assure proper medication administration is completed.</p> <p>OTHER RESIDENTS</p> <p>All resident's medications were reviewed to assure that discontinued medications were removed from the medication cart.</p>	<p>RECEIVED</p> <p>OCT - 6 2014</p> <p>FACILITY MANAGER</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE DIR.	(X6) DATE 10/3/14
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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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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 333	<p>Continued From page 1 5/7/14, included: *Latanoprost 1 drop to each eye at bedtime for macular degeneration; *Systane eye drops 0.4 - 0.3 1 drop to both eyes as needed for dry eyes; and *Clobetasol propionate 0.05 percent solution topical application to be used three times weekly with shampooing, with no diagnosis listed.</p> <p>A Physician's order dated 5/30/14 documented Resident #2's Clobetasol Propionate solution was discontinued.</p> <p>Resident #1's most recent significant change of condition MDS, dated 8/14/13, documented the resident had moderately impaired vision, was unable to read newspaper print but was able to identify objects.</p> <p>Resident #1's Vision Care Plan, with an onset date of 10/18/13, documented: "Impaired vision [related to] Macular Degeneration with blindness."</p> <p>Records reviewed included Resident #1's Nurse's Notes (NN), Fax Order Request/Notification forms (FOR), Incident and Accident reports (I/A) and Physician's Orders (PO): *NN, 9/9/14 at 10:12 PM, "At approx. 7:45 PM, Clobetasol Propionate 0.05 % [percent] solution was instilled into [left] eye instead of Latanoprost 0.005 % drops. Res[ident] [complained of] burning and [physician's name] was notified and received order to flush eyes [for] 15 minutes...At the end of the flush, res[ident] states, "It's not burning any more and I can see out of it." Res[ident] has history of macular degeneration..." *A facility I/A was completed for the incident on 9/9/14. The incident was characterized as a</p>	F 333	<p>SYSTEMIC CHANGES</p> <p>Root Cause was identified as the nurse not administering medications per the 5 rights of medication pass. All Nursing have been in-serviced on the five rights of medication administration and removal of medications upon discontinuation from the medication cart. Nurses will be educated on the 5 rights of medication administration on a quarterly basis, upon orientation, and as needed.</p> <p>MONITOR</p> <p>DNS and/or designee will perform medication pass audits to ensure nurses are utilizing five rights of medication administration completed weekly x 4 monthly x 3 and quarterly x 3. Discontinued medications will be audited for removal from medication cart weekly x 4 monthly x 3 and quarterly x 3. Results will be reported to the Performance Improvement committee.</p> <p>Audits will begin 9/30/14.</p> <p>DATE OF COMPLIANCE: 10/9/14</p>	10/3/14

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F 333	<p>Continued From page 2</p> <p>"Medication discrepancy."</p> <p>*PO, 9/9/14 at 7:45 PM, "Flush eyes [for] 15 [minutes]" for a diagnosis of, "Wrong drops in [left] eye."</p> <p>*NN, 9/10/14 at 1:46 AM, "Res[ident] resting having no complaints of discomfort or burning to left eye..."</p> <p>*FOR, 9/10/14, from the resident's eye doctor, "Got scalp [drops] in left eye. [No] obvious [corneal] abrasion or toxic epitheliopathy noted. [No] inflammation." The accompanying PO documented, "Balance artificial tears [4 times a day for 1 week] then stop."</p> <p>*NN 9/10/14 at 9:41 PM, "No [complaints of] burning or discomfort to eyes. [New order] lubricating eye drops administered to [positive] effect..."</p> <p>*Similar entries in the resident's NN made for the remainder of 9/10/14 and 9/11/14.</p> <p>*NN 9/12/14 at 11:36 PM, "...Res[ident] stated [left] eye still had slight burning, no redness...cleaned with cloth..."</p> <p>*No further burning or irritation had been noted in the NN at the time of the survey on 9/16/16.</p> <p>On 9/16/14 at 11:15 AM, Resident #1 was observed sitting in her wheelchair in her room, with an overbed table in front of her. The overbed table contained a television remote with extra large buttons. The resident was calm and pleasant. Her eyes were clear blue, with no redness or irritation visible. The resident stated there had been an incident with her eye a few days ago, and, "The nurse put the wrong drop in. It burned. I kept telling them I thought the Indians had me and were poking me in the eyes." The resident stated the facility washed her eyes out "right away," and her eye began to feel better. The resident stated, "I went to the eye doctor the</p>	F 333			

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F 333	<p>Continued From page 3</p> <p>next day and he told me, 'no permanent damage.'" The resident did state she had more trouble with depth perception since the incident, and was to go back to the eye doctor if that did not resolve "after a month or so."</p> <p>On 9/16/14 at 11:50 AM, the Administrator and DNS stated:</p> <p>*At the time of the incident, a nurse who was orienting to the facility administered the scalp medication into the resident's eye without first reconciling the label on the medication with the order on the MAR.</p> <p>*The nurse realized her mistake immediately, and summoned the supervising nurse for assistance. The resident's physician was contacted, and orders received to flush the eye.</p> <p>*The burning and redness was noted to resolve within 20 minutes, so the facility assessed no further action was needed at the time.</p> <p>*The day after the incident, the resident's daughter took the resident to the eye doctor, who also assessed no ongoing damage from the incident. The eye doctor did start the resident on over-the-counter eye drops due to complaints of "foggy" vision. The eye doctor did not feel any follow-up was needed unless the resident experienced further changes. The DNS stated the resident's daughter reported to the facility the resident's "fogginess" should resolve without difficulty.</p> <p>*The nurses involved were educated as to ensuring residents received their medications correctly.</p> <p>*The DNS was unable to explain why the medication applied to the resident's eye was still on the medication cart, since the medication had been discontinued over three months prior to the incident. The DNS stated, "We don't know how it</p>	F 333		
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F 333	Continued From page 4 got there," and the facility should have removed the medication from the medication cart at the time it was discontinued. NOTE: The facility was found to be out of compliance at F 431 for medication disposal during their most recent recertification survey, and had not yet alleged compliance as of the date of this incident. On 9/16/14 at 1:15 PM, the Administrator and DNS were informed of these findings. The facility offered no further information.	F 333		

Bureau of Facility Standards

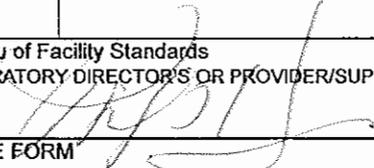
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001430	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/16/2014
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704
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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 complaint survey in your facility. The survey team was: Susan Gollobit RN, Team Coordinator Nina Sanderson BSW LSW	C 000		
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 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: Please see F 333 as it pertains to significant medication errors.	C 798	C798 See F333 for POC	10/3/14

RECEIVED
OCT - 6 2014
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Exec. Dir.	(X6) DATE 10/3/14
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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
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September 26, 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 **September 16, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Treasure Valley. Susan Gollobit, R.N. and Nina Sanderson, L.S.W. conducted the complaint investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006676

ALLEGATION:

The complainant stated an identified resident was administered a topical scalp treatment into her eye.

FINDINGS:

The survey team reviewed the identified resident's record, facility grievances, accident and incident reports and conducted residents and staffs interviews.

The allegation was substantiated and cited at F333 for significant medication errors.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

Philip Herink, Interim Administrator
September 26, 2014
Page 2 of 2

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large, stylized "D" and "S".

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

DS/dmj