IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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January 29, 2016

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

Provider #: 135123

Dear Mr. Herink:

On **January 22, 2016**, a 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 one that comprises a pattern 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. If applicable, a similar State Form will be provided 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." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) 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 the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 11, 2016**. Failure to submit an acceptable PoC by **February 11, 2016**, may result in the imposition of civil monetary penalties by **March 1, 2016**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- 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.
- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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 **February 26, 2016 (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 **February 26, 2016**. A change in the seriousness of the deficiencies on **February 26, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **February 26, 2016** includes the following:

Denial of payment for new admissions effective **April 22, 2016**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, 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 **July 22, 2016**, 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, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; 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 **January 22, 2016** 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 non-compliance 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 **February 11, 2016**. If your request for informal dispute resolution is received after **February 11, 2016**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

D. L Scott

David Scott, RN, Supervisor
Long Term Care

DS/lj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	01/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF TREASURE VALLEY	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 federal recertification and complaint survey conducted at the facility from January 19 to January 22, 2015. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Presie Billington ,RN Deborah Abasciano, RN Sherrie McElwain, RN Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CDM = Certified Dietary Manager CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse LPM = Liters per Minute MAR = Medication Administration Record mg = milligram MDS = Minimum Data Set assessment MD = Medical Doctor NC = nasal cannula O2 = Oxygen PRN = As Needed q = every Sat = saturation TAR = Treatment Administration Record	F 000	RECEIVED FEB 16 2016 FACILITY STANDARD *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.* **F 166** **SPECIFIC RESIDENT** **A group meeting was held with those residents who attend resident council to provide prompt feedback on efforts that will be implemented with respect to concerns regarding resident grievances.** Other Residents: All residents have the potential to be affected by this practice. **Root Cause:** **Concerns voiced in resident council meetings were not responded to or resolved in a timely manner.** Systematic Change: Grievance policy to be educated to facility staff regarding timeliness of grievance reporting and timely resolve.	
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	F 166		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	2/15/16

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 166	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to resolve resident grievances regarding delays in answering call lights, staff not giving residents assistance at meal times, and ensuring staff responded to resident requests for making their beds in a timely manner. Findings include: A group meeting was held on 1/20/16 between 3:30 pm and 4:05 pm with 11 residents and two surveyors in attendance. The residents stated that sometimes the CNAs did not make their beds until after lunch time on weekends, which was upsetting to them when family visited. The residents further stated there were ongoing issues with staff not answering call lights in a timely manner after meals and when in the bathroom, especially on weekends. The residents stated they had voiced their concerns at Resident Council Meetings and although they were instructed to tell the DON when they had issues with call lights or unmade beds, the issues were usually on the weekend, when the DON was not typically at the facility. On 1/21/15 at 8:00 am, the DON stated although there was no policy, the expectation was for staff to answer call lights "within seven minutes" of activation. Review of Resident Council Meeting Minutes revealed the following: 6/3/15 - Beds on the resident units were left unmade until 11:30 am. A "Resident Council Response Form", dated 7/21/15, documented	F 166	MONITOR **ED and DON will review concern and comment cards and monthly resident council to ensure grievances are reported and resolved timely.** Grievance procedure audits will be conducted weekly x 4, monthly x 3 and quarterly x 3. Results of audits will be reported to PI. Audits will begin: 02/22/2016 **DATE OF COMPLIANCE: 02/26/2016**	

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F 166	Continued From page 2 education regarding making beds timely was provided to CNAs. 7/8/15 - CNAs told residents they could not assist them at meal time until 1:00 pm. A Resident Council Department Response Form, dated 8/6/15, documented the DON was to monitor call lights and CNAs were educated regarding assisting residents at meal time. 9/2/15 - Staff was getting better with call lights, which the DON was to monitor at shift change. A Call Light Audit on the D Unit, dated 9/14/15, documented a resident call light sounded at 2:00 pm, which was answered by a CNA at 2:15 pm. The Audit indicated the response time was not consistent with the facility's call light answering expectation. Review of a "Call Light Audit" on the D Unit, dated 9/15/15 revealed: -A resident call light activated at 2:07 pm was answered at 2:15 p.m. -A resident call light activated at 2:12 pm was answered at 2:25 pm -A resident call light activated at 2:16 pm was answered at 2:24 p.m., These intervals were not consistent with the facility's call light answering expectation. The Call Light Audit did not identify any CNAs involved in the audit results nor whether education and/or follow-up monitoring was completed for the CNAs involved in the audit. On 1/22/15, at 8:00 am, the DON stated the Call Light Audit of 9/15/15 did not contain the name(s)	F 166		

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F 166	Continued From page 3 of CNAs who failed to answer a resident call light within seven minutes and could not provide documentation that the involved CNAs were educated. *11/4/15 - Resident Council minutes documented residents "waited too long" on evening shift on weekends for staff to answer call lights activated both in the room and bathroom. *12/9/15 - Resident Council minutes documented beds were not being made and residents waited too long in the bathroom for assistance. Review of the Call Light Audit for the D Unit, dated 12/28/15, revealed that a resident call light that was activated at 3:40 pm was answered at 3:55 pm. CNA education/monitoring regarding timely response to resident call lights was requested for the involved CNA, but not provided. Review of the Staff Development record, dated 11/24/15 and 12/15/15, revealed one nurse and nine CNAs received education regarding the facility's call light answering expectation. There was no indication audits related to call lights or unmade beds were conducted on the weekend. On 1/20/16 at 12:20 pm, the Activity Director stated residents had expressed concerns with call lights at many of the Resident Council Meetings during the previous six months. The Activity Director stated the DON attended those meetings, addressed call light concerns, and told residents to notify her of call light issues with specific CNAs.	F 166		

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F 166	Continued From page 4 Audits related to call lights and/or unmade beds were conducted on weekends and while some staff received education regarding timely call light response, providing timely bathroom assistance, and ensuring resident beds were made, these issues continued to be problematic for residents.	F 166		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to maintain an environment that enhanced residents' dignity and respect at meals. This was true for 2 of 16 (#s 6 & 9) sampled residents, 13 random residents and any resident eating meals in the 300 hallway dining area when they were offered clothing protectors and not a cloth napkin. This practice created the potential for psychosocial harm if residents experienced embarrassment or a lack of self-esteem due to their appearance. Findings included: On 1/20/16 at 11:55 am and 5:40 pm, during the lunch and dinner observations with 15 residents in the 300 hallway dining area, staff members were observed passing out clothing protectors without offering the choice of a cloth napkin. On 1/21/16 at 8:20 am, during the breakfast observation, 15 residents were observed with clothing protectors; cloth napkins were not	F 241	**F 241** **SPECIFIC RESIDENT** **All residents who dine in 300 hall dining area were provided with cloth napkins** **OTHER RESIDENTS** **All residents will be offered cloth napkins regardless of the dining room they dine in.** **Root Cause:** **Cloth napkins were not provided to 300 hall dining room.** **Systematic Changes:** **All residents will be offered cloth napkins regardless of the dining room they dine in.** **Monitor:** **Dining rooms will be audited weekly x 4, monthly x 3, and quarterly x 3. Results of audits will be reported to PI for further review.** Audits will begin: 02/15/2016 **Date of Compliance: 2/26/2016**	

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F 241	Continued From page 5 observed at the time. On 1/20/16 at 12:28 pm and 5:20 pm, during the lunch and dinner observations in the Ponderosa and Syringa Dining rooms, all the residents had cloth napkins at their place settings or had them on their persons. On 1/21/16 at 10:37 am, the CDM said cloth napkins were offered in the Ponderosa and Syringa Dining rooms, but had not been provided to the 300 hallway dining area for staff to offer residents there.	F 241		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure medications were not initialed as given on the Medication Administration Record prior to the administration of the medication. This was true for 1 of 7 (#3) sampled residents during the medication pass observation when an LN initialed the medication prior to administration. This failed practice had the potential for harm if residents were documented as having received medications they either refused or were not given. Findings included: On 1/18/16 at 2:30 pm, LN #9 was observed pre-initialing Resident #3's Hydrocodone 10 mg/Acetaminophen 325 mg for pain on the MAR	F 281	**F 281** **SPECIFIC RESIDENT** **LN #9 was educated on pre-initialing of medications prior to administration in order to meet professional standards.** **OTHER RESIDENTS:** **All residents have the potential to be impacted by this practice.** **Root Cause:** **LN failed to follow professional standards with documentation of medication after administration.** **Systemic Changes:** **All LN's were educated on professional standards of documentation of medications after administration.** **Monitor:** **Medication pass audits will be conducted on three different LN's weekly x 4, monthly x 3, and quarterly x 3. Results will be reported to PI for review.** Audits will begin: 02/15/2016 **Date of Compliance: 2/26/2016**	

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F 281	Continued From page 6 prior to its actual administration. On 1/18/16 at 2:36 pm, LN #9 said she initialed the MAR because she knew Resident #3 would take the medication because he was in pain.	F 281		

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January 29, 2016

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

Provider #: 135123

Dear Mr. Herink:

On **January 22, 2016**, an unannounced on-site complaint survey was conducted at Life Care Center of Treasure Valley. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from January 19, 2016 to January 22, 2016. The following observations were completed:

Four residents were observed during physical and occupational therapy.

The following documents were reviewed:
The medical record of the identified resident;
Eight other residents' records were reviewed for therapy concerns;
The facility's Grievance file for 2015 and 2016;
Resident Council minutes from July to December 2015;
The facility's Incident and Accident reports from July 2015 to January 2016; and,
The facility's Allegation of Abuse reports from August 2015 to January 2016.

The following interviews were completed:
Four residents were interviewed regarding therapy, abuse and resident rights concerns;
Two family members were interviewed regarding quality of care and resident rights concerns;
Eleven residents in the group interview were asked about therapy, abuse and resident rights

concerns;
Two therapist were interviewed regarding abuse and resident rights;
One nurse and two CNAs were interviewed for abuse and resident rights concerns;
The Director of Nursing was interviewed regarding abuse and resident rights concerns; and,
The Director of Rehabilitation was interviewed regarding therapy, abuse and resident rights concerns.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007130

ALLEGATION #1:

The Reporting Party stated an identified therapy staff member hurt an identified resident while providing therapy services and made the resident participate in therapy despite the resident's wishes.

FINDINGS #1:
The identified resident was no longer residing in the facility at the time the complaint was investigated. Four other residents were observed during therapy sessions and no concerns were identified. A grievance and an abuse investigation regarding the identified resident were reviewed and abuse could not be substantiated. Eight other residents' records were reviewed and no abuse or therapy concerns were identified. Resident council meeting minutes from July to December 2015 were reviewed and no abuse or therapy concerns were identified. Four residents were interviewed and they said therapy staff have been appropriate with them and staff have honored their therapy requests. Two family members said staff have been appropriate and have not witnessed abuse. Eleven residents in the group interview had no concerns regarding therapy or abuse. Two therapists said they encourage residents in reaching their therapy goals, will stop doing therapy when a resident asks and will encourage and educate residents to continue in order to reach their goals. The Director of Nursing said once a complaint for the identified resident and an identified staff member came to the facility, a thorough investigation was completed and the facility could not substantiate abuse.

Based on observation, record review, and resident, family and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The identified resident was not allowed to sleep in.

FINDINGS #2:

The medical record of the identified resident was reviewed for sleep concerns. Eight other residents' records were reviewed and resident rights concerns were identified. A grievance and an abuse investigation regarding the identified resident were reviewed. Resident council meeting minutes from July to December 2015 were reviewed and no sleeping in concerns were identified. Four residents were interviewed and they said they are allowed to sleep in when they want. Two family members had no concerns with staff allowing residents to sleep in. Eleven residents in the group interview had no concerns with staff honoring their requests to sleep in. One nurse and two CNAs said they always honor resident choices, including allowing them to sleep in. The Director of Nursing said resident choices are honored.

Based on observation, record review, and resident, family and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

D. L Scott

David Scott, RN, Supervisor
Long Term Care

DS/lj