



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE- Governor  
DAVE JEPPESEN- 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  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

April 12, 2019

Joe Rudd Jr, Administrator  
Life Care Center Of Boise  
808 North Curtis Road  
Boise, ID 83706-1306

Provider #: 135038

Dear Mr. Rudd Jr:

On **April 10, 2019**, we conducted an on-site revisit and a complaint investigation to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **March 20, 2019**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

**F0000 -- S/S: -- -- Initial Comments**

**F0850 -- S/S: F -- 483.70(p)(1)(2) -- Qualifications Of Social Worker >120 Beds**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. The alleged compliance date must be no later than **April 21, 2019**. 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.) **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 **April 15, 2019**.

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.
- 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*.

As noted in the Bureau of Facility Standards' letters of **November 23, 2019** and **March 7, 2019**, following the surveys of **October 26, 2019** and **February 19, 2019**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for imposition of Civil Money Penalty, Denial of Payment for New Admissions and termination of the provider agreement on **April 26, 2019**, if substantial compliance is not achieved by that time. The findings of non-compliance on **April 10, 2019**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **January 15, 2019**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **January 31, 2019**

**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.**

Joe Rudd Jr, Administrator  
April 12, 2019  
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If you believe the deficiencies have been corrected, you may contact please contact Laura Thompson, RN, or Belinda Day RN, Supervisors LTC, 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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 **April 22, 2019**. If your request for informal dispute resolution is received after **April 22, 2019**, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors at (208)334-6626, option #2.

Sincerely,



Laura Thompson, RN, Supervisor  
Long Term Care Program

lt/dr  
Enclosures

Joe Rudd Jr, Administrator  
April 12, 2019  
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/18/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>04/10/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF BOISE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>808 NORTH CURTIS ROAD</b> <b>BOISE, ID 83706</b>		
(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 deficiency was cited during an unannounced federal recertification revisit and complaint investigation survey conducted at the facility on April 9, 2019 and April 10, 2019.  The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator Cecilia Stockdill, RN Monica Meister, QIDP, MEd Qualifications of Social Worker >120 Beds CFR(s): 483.70(p)(1)(2)  §483.70(p) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is:  §483.70(p)(1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and  §483.70(p)(2) One year of supervised social work experience in a health care setting working directly with individuals. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of facility documents, personnel records, and policies and procedures (P&P), it was determined the facility, with 153 licensed and Medicare certified bed at the time of the survey, failed to employ a qualified social worker to provide on-site coverage on a full-time basis. The failure created the potential for negative outcomes for 12 of 12 residents (#9,	{F 000}			
F 850 SS=F		F 850	This Plan of Correction required under Federal and State Regulations and statutes applicable to long-term care providers. This Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction	4/16/19	

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

TITLE

(X6) DATE

Electronically Signed

04/15/2019

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 850	<p>Continued From page 1</p> <p>#14, #16, #17, #26, #56, #228, #230, #231, #232, #233, and #234) whose clinical records were reviewed, and the other 45 residents living in the facility, if their individual mental and psychosocial needs were not met. Findings include:</p> <p>On 4/9/19, the Director of Nursing Services provided a binder with documentation of the facility's correction of deficiencies cited during the first revisit survey conducted 2/19/19. The binder contained a list of the facility's key personnel. The list documented the name of a Social Services Assistant (SSA), it did not document the name of a Licensed Social Worker (LSW), Social Services Director (SSD), or other social services staff.</p> <p>On 4/9/19 at 3:50 PM, the Administrator said an LSW from a sister facility "does oversight." He said the LSW from the sister facility had not been to the facility during the "3 1/2" weeks since the previous LSW quit. Documentation of the previous LSW's last day of employment was requested.</p> <p>On 4/9/19 at 4:10 PM, the Administrator said the previous LSW's last day was 3/6/19 and that he began advertising the open position the day she left. He restated that the LSW from a sister facility had not yet been to the facility.</p> <p>On 4/10/19 at 9:00 AM, the Administrator, Vice President of Western Operations (VPWO), and Regional Vice President of Operations (RVPO) said the LSW from the sister facility started full-time in the evening on 4/9/19. The Administrator said he knew in January 2019 the</p>	F 850	<p>does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.</p> <p>Additional Abbreviations: Daily = Monday through Friday (with regard to audits) QA = Quality Assurance DNS = Director of Nursing Services IDT = Interdisciplinary Team LSW = Licensed Social Work ED = Executive Director RVPO = Regional Vice President of Operations</p> <p>F 850</p> <p>Corrective Action: 1. On April 9, 2019, the facility secured a full-time Licensed Social Worker to oversee the Social Services Department. 2. As of January 28, 2019, prior to the previous licensed social worker ending her employment on February 19, 2019, the ED placed an ad on our nationwide search engines (Indeed &amp; Glass Door) as well as our company's internal portal. 3. The ED received approximately 15 resumes of which he reviewed to determine who met the qualifications. An interview was scheduled for April 10,</p>		

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F 850	<p>Continued From page 2</p> <p>previous LSW was going to leave and he began advertising the open position right after that. The Administrator said he had received and gone through the resumes of several LSW. He said he had not conducted any interviews for the LSW position thus far. He said an interview was scheduled for 1:00 PM that day (4/10/19).</p> <p>On 4/10/19 at 9:45 AM, the RVPO provided a Personnel Action Form which documented the previous LSW's last day worked was 2/19/19. The RVPO also provided a Social Services Director Consulting Agreement signed by the Administrator and an LSW from a sister facility on 4/9/19. Additionally, the RVPO provided a Social Services Director Job Description signed by the LSW from a sister facility on 4/9/19, with "(consulting for [facility's initials])" in handwriting under her signature.</p> <p>On 4/10/19 at 9:52 AM, the LSW from the sister facility stated her employment with the facility started on 4/9/19 at 4:45 PM. She stated she understood the agreement was for her to "consult" with the facility until another LSW was hired. The LSW said she worked 4 hours on 4/9/19 and reviewed some care plans and made a recommendation. The LSW stated she was "not doing daily work." She said the number of hours she would work each week had not yet been defined. She said full-time was 32 to 40 hours a week and the census would determine the number of hours worked per week.</p> <p>On 4/10/19 at 10:20 AM, the Administrator and VPWO said 30 hours a week was considered full-time. The VPWO stated the LSW from the sister facility was now the facility's full-time LSW</p>	F 850	<p>2019.</p> <p>4.RVPO verbally educated the ED on April 9, 2019 to stress the importance of complying with the State of Idaho and Federal regulations which requires a full-time Licensed Social Worker to be in a facility that has 120 licensed beds or greater. A copy of the regulations was provided for the education.</p> <p>Identification: All residents are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: 1.RVPO verbally educated the ED on April 9, 2019 to stress the importance of complying with the State of Idaho and Federal regulations which requires a full-time Licensed Social Worker to be in a facility that has 120 licensed beds or greater. A copy of the regulations was provided for the education. 2.The facility will continue to follow both the Federal and State of Idaho regulations regarding the requirement to have a full-time Licensed Social Worker for the facility.</p> <p>Monitor: If there should be a termination of the full-time Licensed Social Worker, the ED will immediately inform the RVPO and interim coverage by a qualified social worker will be secured.</p>		

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F 850	<p>Continued From page 3 on an interim basis.</p> <p>On 4/10/19 at 10:47 AM, the Administrator was asked to provide all P&amp;P related to social services. At 11:30 AM, the RVPO provided a stack of P&amp;P, many of which documented they were from a Social Services Manual.</p> <p>The facility's Social Services Personnel P&amp;P, dated 6/17/08 documented, "Each facility has a Director responsible for the provision of social services." It documented the SSD was responsible for the operation of the Social Services department, reported directly to the Administrator, recruited, trained, supervised, and evaluated social services personnel.</p> <p>Social Services P&amp;P documented the SSD "is responsible for" or "ensures" or "facilitates" multiple services to residents, including:</p> <ul style="list-style-type: none"> <li>* Preservation of Resident Rights</li> <li>* Grievance Procedures;</li> <li>* Community Resources;</li> <li>* Staff Education and Orientation</li> </ul> <p>Other P&amp;P documented the social services staff were responsible for or directly involved in services to residents, including:</p> <ul style="list-style-type: none"> <li>* Pre-admission Screening;</li> <li>* Social History Information;</li> <li>* Assessment;</li> <li>* Protection from Abuse, Exploitation and Neglect;</li> <li>* Dignity;</li> <li>* Advance Directives;</li> <li>* Behavioral Health Management;</li> <li>* Family Involvement;</li> <li>* Spiritual Needs/Pastoral Services;</li> </ul>	F 850			

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F 850	Continued From page 4 * Terminal Illness, Death, and Dying; * Discharge planning, the Discharge Summary, and Post-discharge (after discharge) Care Plans;  On 4/10/19 at 11:55 AM, the Senior Division Director of Clinical Services for the West, with the VPWO present, stated the facility had not met the requirement for a full-time qualified Social Worker until after the survey began on 4/9/19.	F 850			



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August 29, 2019

Rachel Storm, Administrator  
Life Care Center of Boise  
808 North Curtis Road  
Boise, ID 83706-1306

Provider #: 135038

Dear Ms. Storm:

On **April 9, 2019** through **April 10, 2019**, an unannounced on-site complaint survey was conducted at Life Care Center of Boise. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008050**

**ALLEGATION:**

The facility failed to ensure professional standards were maintained regarding diabetic management.

**FINDINGS:**

During the investigation, six diabetic residents were observed and their records were reviewed for diabetic management. The facility's Incident and Accident reports, Grievances, and transfers to the hospital were reviewed. Several residents and staff members including the Dietician, a CNA, nurses, and the Director of Nursing (DON) were interviewed regarding management of diabetes.

The records of three diabetic residents documented no signs or symptoms of hyper or hypoglycemia (high or low blood sugar). The records of two diabetic residents documented no medications or blood glucose monitoring was ordered by the physician and their diabetes was managed by diet. The observed residents did not exhibit signs or symptoms of hypo or hyperglycemia. One resident's record documented appropriate administration of insulin (medication to control blood glucose), blood glucose monitoring, and education provided to the resident regarding diabetes.

One resident's record documented she was diagnosed with Type 2 diabetes (non-insulin dependent). Her physician orders documented staff were to monitor for signs and symptoms of hyper or hypoglycemia every shift, and no medications or blood glucose monitoring was ordered. The resident's physician-ordered diet was a consistent carbohydrate diet (a diet that helps control the amount of sugar in the bloodstream) and included diet soda only. The resident's record documented she gained weight since admission, the dietician assessed and followed her, and her family was aware of her choices that were not consistent with the dietician's recommendations. The resident's record documented her family frequently brought in snacks for her, gave her money to buy soda, and was aware of her recommended diet.

Four staff members stated they were aware of the resident choosing to purchase regular soda at times, the staff did not routinely monitor or assist the resident when she purchased soda, and she purchased soda from the vending machine when she wished. The interviewed staff members said they were aware of the physician's orders regarding the resident's diet and she consumed things that were not consistent with her ordered diet, but it was the resident's right to choose what she wanted to drink and eat. One staff member said the resident frequently ate a cheeseburger and chips in the facility, and she was offered and encouraged to make other choices but declined.

The resident said she was aware of her diabetes, the staff did not check her blood sugar, and she did not know what staff did to manage her diabetes. The resident said she was able to propel herself down the hall to the soda machine, and she liked diet soda but sometimes she chose to buy a regular soda.

Based on the investigative findings, the allegation was substantiated with no deficient practice found.

#### CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

The allegation was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Rachel Storm, Administrator  
August 29, 2019  
Page 3 of 3

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson". The signature is written in a cursive style and is positioned above the typed name.

Laura Thompson, RN, Supervisor  
Long Term Care Program

LT/lj