

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 06/26/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center of Treasure Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 502 North Kimball Place Boise, ID 83704	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on incident and accident log review, record review and interviews, it was determined the facility failed to ensure resident representatives were notified following resident fall with injury. This was true to 1 of 4 residents (Resident #211) whose records were reviewed. This deficient practice created the potential for harm or adverse outcomes if the residents' representatives were not notified of resident injuries. Findings include:</p> <p>Resident #211 was admitted to the facility on [DATE], with multiple diagnoses including dementia and history of falls.</p> <p>On 6/23/25, reviewed documentation in the facility incident and accident log of a resident who fell with resulting injury to her elbow on 4/1/23, and resident representative had not been notified of the fall or injury.</p> <p>On 6/26/25 at 11:45 AM, the DON stated the facility failed to notify the family/POA of the resident's fall with injury.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on incident and accident log review, record review and interviews, it was determined the facility failed to ensure resident specific discharge paperwork was provided to the hospital during transfer to the hospital. This was true for 1 of 2 residents (Resident #211) whose records were reviewed. This deficient practice had the potential for harm if resident required health information was not provided to the hospital. Findings include:</p> <p>Resident #211 was admitted to the facility on [DATE], with multiple diagnoses including dementia and history of falls.</p> <p>On 6/23/25, reviewed documentation in the facility incident and accident log of resident who fell on 4/1/23, with resulting nasal fracture, two black eyes, and a facial laceration and no documentation the facility sent resident required information (hospice) to the hospital during transfer.</p> <p>On 6/26/25 at 11:45 AM, the DON stated the facility failed to send resident information to the hospital when she was transported to the hospital.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure the MDS assessment accurately reflected resident's status. This was true for 5 of 19 residents (#4, #30, #34, #45, and #52) whose MDS assessments were reviewed. This deficient practice had the potential for negative outcomes if residents were not assessed and/or monitored due to inaccurate assessments. Findings include:</p> <p>1. Resident #4 was admitted to the facility on [DATE], with a readmission on [DATE], with multiple diagnoses including congestive heart failure (heart does not pump blood as well as it should) and major depressive disorder.</p> <p>On 11/11/24, Resident #4's PASRR level I documented she had diagnoses of depressive disorders, bipolar disorder, and anxiety disorders. The PASRR level I was to be forwarded to BLTC for further screening.</p> <p>On 11/21/24, Resident #4's PASRR Level II, documented diagnoses of bipolar, anxiety, and depression. Resident #4's PASRR level II was to be sent for further evaluation by a mental health authority.</p> <p>On 11/22/24, the mental health authority documented Resident #4 had diagnoses of Bipolar I, depression, and anxiety.</p> <p>Resident #4's MDS dated [DATE], did not document in section A1500, the resident had been evaluated by a PASRR level II and determined to have a serious mental illness.</p> <p>2. Resident #30 was admitted to the facility on [DATE], and readmission on [DATE], with multiple diagnoses including muscle weakness and bipolar disorder.</p> <p>On 7/30/24, Resident #30's PASRR level I documented she had diagnoses of depressive disorders, bipolar disorder, and PTSD. The PASRR level I was to be forwarded to BLTC for further screening.</p> <p>On 8/1/24, Resident #30's PASRR Level II, documented diagnoses of depressive disorder, bipolar, and PTSD. Resident #30's PASRR level II was to be sent for further evaluation by a mental health authority.</p> <p>On 8/2/24, the mental health authority documented Resident #30 had diagnoses of major depression, bipolar, and PTSD. Mental health stable on medications.</p> <p>Resident #30's MDS dated [DATE], did not document in section A1500, the resident had been evaluated by a PASRR level II and determined to have a serious mental illness.</p> <p>3. Resident #34 was admitted to the facility on [DATE], with multiple diagnoses including Guillain-Barre Syndrome (a condition which the body's immune system attacks the nerves causing weakness, numbness, or paralysis), bipolar disorder, and a history of PTSD.</p> <p>On 1/9/19, Resident #34's Preadmission Screening and Resident Review (PASRR) level I documented she had a diagnosis of personality disorder, bipolar disorder, and suspected anxiety. The PASRR level I was to be forwarded to BLTC for further screening.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 1/11/19, Resident #34's PASRR level II, documented she meets nursing facility level of care, has multiple diagnoses with medications and a recent psychiatric evaluation. Resident #34 requires further evaluation by a mental health authority.</p> <p>On 1/11/19, the mental health authority documented Resident #34 had a diagnosis of bipolar disorder, personality disorder, and suspected situational depression being treated with medication. She appears stable and no further evaluation is needed.</p> <p>Resident #34's MDS's dated 5/3/22, 10/24/22, 7/18/23, 4/23/24, and 2/27/25, documented in section A1500, the resident had not been evaluated by a PASRR level II and determined to have a serious mental illness.</p> <p>4. Resident #45 was admitted to the facility on [DATE], with multiple diagnoses including stroke, hypertension, and anxiety disorder.</p> <p>On 2/21/22, Resident #45's PASRR level I documented she had a diagnosis of bipolar disorder and suspected anxiety. The PASRR level I was to be forwarded to BLTC for further screening.</p> <p>On 2/22/22, Resident #45's PASRR level II, documented further evaluation by a mental health authority was required due to her diagnosis of bipolar, depression, and anxiety.</p> <p>On 2/24/22, the mental health authority documented Resident #45 had a diagnosis of bipolar disorder and anxiety. She was being treated with medication. She appeared stable and no further evaluation was needed.</p> <p>Resident #45's MDS's dated 1/5/23, 12/14/23, and 11/19/24, documented in section A1500, the resident had not been evaluated by PASRR level II and determined to have a serious mental illness.</p> <p>5. Resident #52 was admitted to the facility on [DATE], with multiple diagnoses including esophageal obstruction (a blockage in the muscular tube that carries food from the throat to the stomach), malnutrition, and bipolar disorder.</p> <p>On 5/23/25, Resident #52's PASRR level I documented she had a diagnosis of bipolar disorder, and suspected anxiety. The PASRR level I was to be forwarded to BLTC for further screening.</p> <p>On 5/23/25, Resident #52's PASRR Level II, documented a diagnosis of bipolar, unspecified anxiety, and depression. Resident #52's PASRR level II was to be sent for further evaluation by a mental health authority.</p> <p>On 5/23/25, the mental health authority documented Resident #52 had a diagnosis of depression, anxiety, and bipolar disorder.</p> <p>Resident #52's MDS dated [DATE], documented in section A1500, the resident had not been evaluated by a PASRR level II and determined to have a serious mental illness.</p> <p>On 6/25/25, at 2:45 PM, the MDS Coordinator with the SSD and DON present, stated Residents #4, #30, #34, #45, and #52's MDS's, section A1500, should have been marked yes, the resident had been evaluated by a PASRR level II and determined to have a serious mental illness.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, it was determined the facility failed to incorporate PASRR recommendations in MDS assessment and care planning. This was true for 1 of 19 residents (Resident #32) reviewed for Level I and II PASRR evaluations. This deficient practice had the potential to cause harm if resident's specialized services for mental health needs were not incorporated in their care. Findings include:</p> <p>The facility's Pre-admission Screening and Resident Review (PASRR) policy dated 10/6/22, documented recommendations from PASRR Level II determination and PASRR evaluation report are to be incorporated into the person-centered care plan as well as in transitions of care. As part of the PASRR process, the facility is required to notify the appropriate state mental health authority or state intellectual disability authority when a resident with a mental disorder (MD) or intellectual disability (ID) has a significant change in their physical or mental condition. This will ensure that residents with a mental disorder or intellectual disability continue to receive the care and services they need in the most appropriate setting.</p> <p>Resident #32 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including difficulty walking and depression.</p> <p>On 6/25/25, reviewed Resident #32's PASRR Level I and PASRR Level II dated 1/12/24 and 11/13/24, documented she had schizophrenia as a MMI however, schizophrenia is not listed in the resident's medical record, MDS's, or care plan.</p> <p>On 6/25/25, reviewed Resident #32's PASRR Level I dated 1/24/25 and 6/23/25, documented she had schizophrenia as a MMI however, schizophrenia is not listed in the resident's medical record, MDS's, or care plan.</p> <p>On 6/25/25 at 1:39 PM, the DON stated Resident #32's PASRR Level I and Level II should have been caught and corrected and an updated PASRRs Level I and II should have been requested.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, it was determined the facility failed to follow current physician oxygen orders. This was true for 1 of 19 residents (Resident #26) whose care plans were reviewed. This placed residents at risk of adverse outcomes if care and services had been provided that were not ordered by the physician. Findings include:</p> <p>Resident #26 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic respiratory failure with hypoxia (refers to the lungs' inability to adequately oxygenate the blood (hypoxia) over an extended period, typically due to underlying chronic lung conditions) and diabetes.</p> <p>Resident #26's physician's order dated 9/11/24, documented oxygen at 2 liters/minutes continuously via nasal cannula and obtain oxygen sats every shift.</p> <p>Resident #26's care plan documented oxygen settings via nasal prongs, liters per current MD/NP orders.</p> <p>Resident #26's TAR for the month of June 2025, documented oxygen saturations from a low of 90% to a high of 97% on oxygen at the prescribed liter flow.</p> <p>On 6/24/25 at 4:23 PM, observed Resident #26's oxygen liter flow set at 4 lpm.</p> <p>On 6/25/25 at 1:43 PM, the DON stated Resident #26's oxygen liter flow had been increased by the physician, but it had not been documented in the resident's chart and should have been.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, it was determined the facility failed to ensure licensed nurses performed tasks which they had the knowledge, skills, and competencies. This was true for 7 of 28 licensed nurses. This had the potential for adverse effects to all residents when skin related issues were missed during assessments. Findings include:</p> <p>The facility's Skin Integrity and Pressure Ulcer/Injury Prevention policy dated 7/9/24, documented a skin assessment/inspection should be performed weekly by a nurse. Skin observations also occur throughout points of care provided by CNAs during ADL care (bathing, dressing, incontinent care, etc). Any changes or open areas are reported to the Nurse. CNAs will also report to the nurse if topical dressing is identified as soiled, saturated, or dislodged. Nurse will complete further inspection/assessment and provide treatment if needed.</p> <p>Resident #16 was admitted to the facility on [DATE], with multiple diagnoses including chronic heart failure and chronic kidney disease.</p> <p>A medical visit progress note dated 8/30/24, documented APRN visited Resident #16 to assess possible growth on right cheek. APRN documented no growth or pain present on right cheek. Staff continue to monitor for growth and notify provider if worsens.</p> <p>Resident #16's licensed nurse weekly skin assessments dated 9/8/24, 9/22/24, and 9/29/24 documented no skin alterations noted.</p> <p>Resident #16's verbal physician order dated 10/4/24, documented dermatology to evaluate and treat growth to right side of face.</p> <p>Resident #16's licensed nurse weekly skin assessments dated 10/6/24, documented no skin alterations noted.</p> <p>Resident #16's nurse's progress note dated 10/7/24, documented resident with large growth on right side of face that did not get documented on skin check.</p> <p>Resident #16's licensed nurse weekly skin assessment dated [DATE], documented has a growth to right cheek.</p> <p>On 6/25/25 at 2:45 PM, the DON stated the growth on the right side of Resident #16's cheek should have been caught, documented, and physician notified by licensed nursing staff and was not.</p>

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<p>F 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.</p> <p>Based on review of the staffing schedules, personnel files, and staff interviews, it was determined the facility failed to ensure full-time employees working as an NA were either in a State approved training and competency evaluation program or had recently and successfully completed such a program. This was true for 3 of 12 NAs (NA #1, #2, and #3) whose personnel files were reviewed. This failure had the potential to result in negative outcomes for all residents living in the facility. Findings include:</p> <p>NA #1 was hired on 1/2/25 and had not obtained their CNA certification and was not enrolled in a CNA program as of 6/23/25.</p> <p>NA #2 was hired on 8/28/24 and had not obtained their CNA certification as of 6/23/25.</p> <p>NA #3 was hired on 4/3/24 and had not obtained their CNA certification as of 6/23/25.</p> <p>On 6/25/25 at 2:35 PM, the DON stated NA #1, #2, and #3 had not yet obtained their CNA certification and should have.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure controlled medications were tracked and kept secure from potential theft and/or diversion. This was true for 2 of 2 medication carts audited. This failure created the potential for undetected misuse and/or diversion of controlled medications and had the potential to affect all residents who received controlled medication in the facility. Findings include:</p> <p>On 6/24/25 at 9:08 AM, during 300-Wing medication cart audit, observed the narcotic accountability record dated 6/1/25 to 6/24/25, with 6 licensed nurse signatures not documented.</p> <p>On 6/24/25 at 11:12 AM, the DON stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart.</p> <p>On 6/25/25 at 2:04 PM, during A-Wing medication cart audit, observed the narcotic accountability record dated 6/1/25 to 6/25/25, with 5 licensed nurse signatures not documented.</p> <p>On 6/25/25 at 2:05 PM, RN #1 stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart.</p> <p>On 6/25/25 at 4:35 PM, the DON stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the State Operations Manual, and staff interviews it was determined the facility failed to ensure medications were stored and kept secure, and biologicals were labeled when opened. This was true for the facility. These deficient practices created the potential for theft and/or diversion and use of expired biologicals. Findings include:</p> <p>The State Operations Manual, Appendix PP, updated [DATE], Schedule II-V medications must be maintained in separately locked, permanently affixed compartments.</p> <p>1. The following was observed for unlocked medication cart.</p> <p>On [DATE] at 9:17 AM, observed 300-Wing medication cart had been left unlocked and unattended by the medication nurse.</p> <p>On [DATE] at 9:20 AM, LPN #1 stated the medication cart should have been locked and had not been.</p> <p>On [DATE] at 3:10 PM, the DON stated the medication cart should have been locked when the medication nurse walks away from the cart.</p> <p>2. The following was observed for controlled medications.</p> <p>On [DATE] at 2:10 PM, observed lorazepam (Schedule IV controlled medication) stored in a removable metal box on the medication refrigerator shelf.</p> <p>On [DATE] at 2:14 PM, RN #1 stated the removable metal box in the medication refrigerator contained narcotics and had not been affixed to the shelf.</p> <p>3. The following was observed for biologicals.</p> <p>On [DATE] at 2:15 PM, observed one set of glucose test solutions without an opened date.</p> <p>On [DATE] at 4:31 PM, the DON stated glucose test solution bottles should be dated when opened and discarded after three months per manufacturer recommendation and were not.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, policy review, and staff interview, it was determined the facility failed to appropriately store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This deficient practice had the potential to put residents who consume thickened liquids at risk for potential contamination and adverse health outcomes including contracting food-borne illnesses. Findings include:</p> <p>Facility policy, Resident Dining Services revised 4/29/25, documented the facility must store, prepare, distribute, and serve food in accordance with professional standards for food service safety.</p> <p>On 6/23/25 at 11:40 AM, during the initial tour of the kitchen, the following was observed with the Food Service Manager present:</p> <p>- In the dry storage room, were 8 cartons of Lemon-flavored thickened water with expiration dates of April 2025.</p> <p>On 6/23/25 at 11:42 AM, the Food Service Manager stated the Lemon-flavored thicken water was expired and should have been discarded.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>Based on observation, interview, and users manual review, the facility failed to ensure patient care equipment was monitored to ensure it was in a safe operating condition. This was true for 1 of 3 warming cabinets. This failed practice: 1) placed residents residing in the facility, at risk for adverse outcomes including skin burns 2) placed facility at risk for adverse outcomes in the event of malfunctioning equipment. Findings include:</p> <p>The Accucold PureTherm Warming Cabinet user manual listed a warning, to reduce the risk of fire, electric shock, or injury when using this appliance, follow these basic precautions . appliance is not meant to exceed a temperature of 140 degrees.</p> <p>On 6/24/25 at 2:52 PM, observed the 100-Hall towel warming cabinet with temperature reading of 148 degrees.</p> <p>On 6/24/25 at 4:05 PM, the DON stated warming cabinet should not exceed temperature of 140 degrees as per manufacturer's recommendation and the cabinet should not have been used.</p>		