



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  
FAX 208-364-1888

February 19, 2015

Corwin G. Lewis, Jr., Administrator  
Parke View Rehabilitation & Care Center  
2303 Parke Avenue  
Burley, ID 83318-2106

Provider #: 135068

Dear Mr. Lewis:

On **February 11, 2015**, a Complaint Investigation survey was conducted at Parke View Rehabilitation & Care Center 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 actual 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.) **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.

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 **March 4, 2015**. Failure

to submit an acceptable PoC by **March 4, 2015**, may result in the imposition of civil monetary penalties by **March 24, 2015**.

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 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*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

**Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 11, 2015**, 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.**

Corwin G. Lewis, Jr., Administrator  
February 19, 2015  
Page 3 of 3

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Option #2, Fax #: (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](#)  
[2001-10 IDR Request Form](#)

This request must be received by **March 4, 2015**. If your request for informal dispute resolution is received after **March 4, 2015**, 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.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2.

Sincerely,



LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor  
Long Term Care

LKK/dmj  
Enclosures

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

PRINTED: 02/18/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/11/2015
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NAME OF PROVIDER OR SUPPLIER  PARKE VIEW REHABILITATION & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318
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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><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the complaint investigation survey of your facility.</p> <p>The survey team entered the facility on 2/9/15 and exited on 2/11/15.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Karen Marshall, MS, RD, LD</p> <p>Survey Definitions:</p> <p>BFS = Bureau of Facility Standards CAD = Coronary Artery Disease COPD = Chronic Obstructive Pulmonary Disease CVA = Cerebrovascular Attack DON = Director of Nursing ED = Emergency Department EMS = Emergency Medical Services HTN = Hypertension IV = Intravenous MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set assessment MG = Milligram PCP = Primary Care Provider PRN = As Needed RN = Registered Nurse SOB = Shortness of Breath TIA = Transient Isohemic Attack</p>	F 000	<p>The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).</p>	
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) <b>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</b></p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or</p>	F 225	<p>The affected resident was discharged on 10-3-14. All residents have the potential to be affected by this. All Automatic stop orders and discontinued physician</p>	3-13-15

RECEIVED  
MAR - 4 2015  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ADMINISTRATOR	3/3/15

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 225	<p>Continued From page 1</p> <p>mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the BFS Informational Letter #2014-04, closed record review, and staff interview, it was determined the facility failed to</p>	F 225	<p>orders in the past 2 months have been reviewed to assess the potential for risks to all these residents. All department managers (2-25-15) and nursing staff (3-3-15) will be educated to the content of the Informational letter #2014-04 "Resident Abuse Reporting in SNF/NF's to increase their understanding of the reporting requirements. Beginning 3-5-15, the Occurrence Committee will review all Incident and Accident reports as compared to the Informational letter #2014-04 to validate all reportable events are properly reported to the Bureau of Facility Standards. Beginning 3-5-15, The Medication Error committee will review all Medication Errors as compared to the Informational letter #2014-04 to validate all medication related reportable events are properly reported to the Bureau of Facility Standards. Beginning 3-9-15 the DON or Designee will audit all Incident,</p>		

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F 225	<p>Continued From page 2</p> <p>ensure investigations were reported to the state survey agency - BFS. This was true for 1 of 6 sample residents (#5) reviewed for investigations. This practice created the potential for residents to be placed at risk for abuse or neglect. Findings included:</p> <p>BFS Informational Letter #2014-04, dated 5/23/14, requires certain events to be reported to the state survey agency. The Informational Letter documents, "...Specific Possible Neglect Situations that must be Reported: Staff mistakes that result in the resident's need for hospitalization, treatment in a hospital emergency room..."</p> <p>Resident #5 was admitted to the facility with multiple diagnoses including pain, late effects of cerebrovascular disease, other convulsions, muscle weakness, abnormality of gait, lack of coordination, coronary atherosclerosis graft, HTN, chronic airway obstruction, hyperlipidemia, and depressive disorder.</p> <p>Resident #5's 9/17/14 admission MDS coded: - moderately impaired cognition, - CAD, HTN, hyperlipidemia, CVA, TIA, or stroke, seizure disorder or epilepsy, depression, COPD, and - received injections, antidepressant, anticoagulant, and antibiotic medications.</p> <p>Resident #5's Order Listing Report (computer generated copy of physician orders printed 2/10/15) and 9/2014 MAR included the following routine and PRN medications with "until" (stop or discontinue) dates:  - Levofloxacin 750 mg every other day for</p>	F 225	<p>Accident and Medication Error reports to confirm that the Bureau of Facility Standards is notified as required, weekly x 4 weeks, then bimonthly x 4 weeks, then monthly x3 months. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems in place are effective.</p>	

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F 225	<p>Continued From page 3</p> <p>infection until 9/13/14</p> <ul style="list-style-type: none"> <li>- Lovenox 40 mg one time a day for clot prevention until 9/18/14</li> <li>- Simvastatin 20 mg every day for cholesterol until 9/23/14</li> <li>- Citalopram 10 mg daily for depression until 9/24/14</li> <li>- Clopidogrel Bisulfate 75 mg daily for CAD until 9/24/14</li> <li>- Isosorbide Mononitrate 15 mg daily for CAD until 9/24/14</li> <li>- Aspirin 81 mg daily for CAD until 9/24/14</li> <li>- Keppra 250 mg two times a day for seizures until 9/24/14</li> <li>- Senexon 5 ml twice daily for bowels until 9/25/14</li> <li>- Metoprolol Tartrate 25 mg twice daily for HTN until 9/25/14</li> <li>- Amlodipine Besylate 5 mg daily for HTN until 9/26/14</li> <li>- Combivent Respimat 20-100 mcg one puff as needed for COPD until 9/24/14</li> <li>- Ipratropium-Albuterol 3 ml as needed for SOB or wheezing until 9/24/14</li> <li>- Tylenol 325 mg as needed for pain until 9/24/14</li> </ul> <p>Resident #5's 9/20/14 MAR documented nursing staff discontinued the administration of the above identified medications on the above "until" indicated dates.</p> <p>Resident #5's medical record documented he was seen by two different doctors during the month of September 2014..</p> <p>- MD #1's 9/15/14 progress note documented "...MEDICATIONS: Noted in chart. Include blood thinners..."</p>	F 225			

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F 225	<p>Continued From page 4</p> <p>- MD #2's 9/23/14 "Physician's Visit Communication &amp; Progress Note" documented "...will go home but not quite ready yet. No [change] in [indistinguishable word]..."</p> <p>Neither of the doctor progress notes documented or addressed the "until" dates of the above identified medications on Resident #5's 9/2014 MAR.</p> <p>Resident #5's medical record also included a pharmacy Medication Chart Review form, dated 9/18/14. The form was initialed by the consulting pharmacist. The form did not identify any medication irregularities, concerns, recommendations, or comments from the consultant pharmacist.</p> <p>During an interview on 2/10/15 at 3:05 p.m., the DON said the consultant pharmacist did the monthly medication regime review on 9/18/14 and did not identify any irregularities, concerns, or recommendations related to Resident #5's medications.</p> <p>Resident #5's 10/3/14 at 2:37 a.m. Progress Note documented "Called to room at 0200 [2:00 a.m.] resident in room having a seizure...called [MD's name] who is on call for [MD's name] and was given an order to transfer to the emergency room. Resident was unresponsive to stimuli for 20 min [minutes] after seizure and then started to respond when ambulance crew came to facility. Resident transferred at 0225 [2:25 a.m.]."</p> <p>Resident #5's 10/3/14 ED report documented "...history of prior CVAs and seizures...presents...to ED...via EMS after...a prolonged seizure at...nursing facility...history of</p>	F 225			

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F 225	Continued From page 5 being on Keppra, but for some reason was taking [taken] off the medication about 2 weeks ago. The nursing staff reported that they found him having a grand mal seizure...started on Keppra 1000 mg IV x1 [one time]...continue on IV Keppra and IV fluids...admitted...in stable condition."  A grand mal seizure, also known as a generalized tonic-clonic seizure, features a loss of consciousness and violent muscle contractions.  During an interview on 2/10/15 at 3:40 p.m., the Administrator said he did not think the event met the state agency reporting criteria.  The facility failed to report an event after nursing staff, two different MDs, and the consultant pharmacist did not address the "until" (discontinue or stop) dates of Resident #5's medications.  Resident #5 suffered a grand mal seizure, required emergent transport to a local ED and IV medication and fluids, and was admitted to a local medical center.	F 225			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced	F 309	The affected resident was discharged on 10-3-14. All residents have the potential to be affected by this. All Automatic stop orders and discontinued physician orders in the past 2 months have been reviewed to assess the potential for risks to all other residents. An in service will be held on 3-3-15 for the nursing	3-13-15	

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F 309	<p>Continued From page 6</p> <p>by: Based on closed record review and staff interviews, it was determined the facility failed to ensure the necessary care and services were provided for a resident admitted with medication administration stop or discontinue dates. This was true for 1 of 6 sample residents (#5) whose medications were reviewed. Resident #5 was harmed when he suffered a grand mal seizure, required emergent transport to a local ED, IV medication and fluids, and was admitted to a local medical center. Findings included:</p> <p>Resident #5 was admitted to the facility with multiple diagnoses including pain, late effects of cerebrovascular disease, other convulsions, muscle weakness, abnormality of gait, lack of coordination, coronary atherosclerosis graft, HTN, chronic airway obstruction, hyperlipidemia, and depressive disorder.</p> <p>Resident #5's 9/17/14 admission MDS coded: - moderately impaired cognition, - CAD, HTN, hyperlipidemia, CVA, TIA, or stroke, seizure disorder or epilepsy, depression, COPD, and - received injections, antidepressant, anticoagulant, and antibiotic medications.</p> <p>Resident #5's Order Listing Report (computer generated copy of physician orders printed 2/10/15) and 9/2014 MAR included the following routine and PRN medications with "until" (stop or discontinue) dates:</p> <p>- Levofloxacin 750 mg every other day for infection until 9/13/14 - Lovenox 40 mg one time a day for clot prevention until 9/18/14</p>	F 309	<p>staff to review the Stop Date Order Policy, Admissions Medication Policy, and Physician's Order Policy. We will also review how to correctly double note orders, Medications should not be abruptly discontinued and medication errors. The Order Summary report will be sent out to the physicians for review of all current residents on 3-2-15 to confirm that the medication regime and total program of care for each resident matches MD intent. The consultant pharmacist performed a medication regime review of all current residents on 2-12-15 with findings compiled and reported to the facility on 2-13-15. The Physician's Order policy was updated on 2-26-15 to include: quantity or specific duration of therapy. The Stop Date Order policy was updated on 2-26-15 to include: If medications other than Lovenox, Zofran, and antibiotics have a stop date ordered; the Admitting Nurse or Charge Nurse will call the physician and clarify the order.</p>		

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F 309	<p>Continued From page 7</p> <ul style="list-style-type: none"> <li>- Simvastatin 20 mg every day for cholesterol until 9/23/14</li> <li>- Citalopram 10 mg daily for depression until 9/24/14</li> <li>- Clopidogrel Bisulfate 75 mg daily for CAD until 9/24/14</li> <li>- Isosorbide Mononitrate 15 mg daily for CAD until 9/24/14</li> <li>- Aspirin 81 mg daily for CAD until 9/24/14</li> <li>- Keppra 250 mg two times a day for seizures until 9/24/14</li> <li>- Senexon 5 ml twice daily for bowels until 9/25/14</li> <li>- Metoprolol Tartrate 25 mg twice daily for HTN until 9/25/14</li> <li>- Amlodipine Besylate 5 mg daily for HTN until 9/26/14</li> <li>- Combivent Respimat 20-100 mcg one puff, as needed for COPD until 9/24/14</li> <li>- Ipratropium-Albuterol 3 ml as needed for SOB or wheezing until 9/24/14</li> <li>- Tylenol 325 mg as needed for pain until 9/24/14</li> </ul> <p>Resident #5's 9/2014 MAR documented nursing staff discontinued the administration of the above identified medications on the above "until" indicated dates.</p> <p>a. When he was admitted to the facility, RN #1 entered the medication orders into the facility's electronic MAR program and faxed a copy of Resident #5's medications to the PCP.</p> <p>During an interview on 2/11/15 at 9:41 a.m., RN #1 said, when she faxed Resident #5's medication information to the PCP, she did notice the medication stop or discontinue dates specifically for Keppra. She also said she did not include any documentation to the PCP to draw</p>	F 309	<p>The Medication Orders Upon Admission Policy was updated to include: Any dose or order that appears contraindicated considering the resident's age, condition, or diagnosis is directly verified with the attending physician. A new physician communication form will be implemented on 3-2-15 to include a statement verifying the physician has reviewed the current medication list with start and stop dates and the total program of care for the resident at each physician's visit. Beginning 3-2-15 all newly admitted or readmitted resident's medication orders will be reviewed by the pharmacist, within 72 hours of admission with a signed confirmation of review and recommendations as necessary with special attention to orders with stop dates.</p> <p>Beginning 3-13-14 a second pharmacist will randomly review 10% of the resident's medication regimes to to confirm that irregularities, concerns, recommendations or comments regarding the physician orders are</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/11/2015
NAME OF PROVIDER OR SUPPLIER  PARKE VIEW REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
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F 309	<p>Continued From page 8</p> <p>the doctor's attention to the different stop or discontinue dates nor did she ask the PCP for any clarification. She stated, "I thought the doctor would look at the medication stop or discontinue dates on the MAR and determine if the dates were appropriate."</p> <p>b. Resident #5's medical record documented he was seen by two different doctors during the month of September 2014. The resident was seen by MD #1 on 9/15/14 and MD #2 on 9/23/14. Neither of the doctor's progress notes documented or addressed the stop or discontinue dates of the above identified medications on the resident's 9/14 MAR. Please refer to F386.</p> <p>c. Resident #5's medical record included a pharmacy Medication Chart Review form, dated 9/18/14. The form did not identify any medication irregularities, concerns, recommendations, or comments from the consultant pharmacist. Please refer to F428.</p> <p>Resident #5's 10/3/14 at 2:37 a.m. Progress Note documented, "Called to room at 0200 [2:00 a.m.] resident in room having a seizure...called [MD's name] who is on call for [MD's name] and was given an order to transfer to the emergency room. Resident was unresponsive to stimuli for 20 min [minutes] after seizure and then started to respond when ambulance crew came to facility. Resident transferred at 0225 [2:25 a.m.]."</p> <p>Resident #5's 10/3/14 ED report documented "...history of prior CVAs and seizures...presents...to ED...via EMS after...a prolonged seizure at...nursing facility...history of being on Keppra, but for some reason was taking [taken] off the medication about 2 weeks ago.</p>	F 309	<p>addressed. Beginning 3-9-15, the DON or designee will perform audits on medication orders to confirm they are in compliance with existing policy at the facility weekly x 4 weeks, then bimonthly x 4 weeks, then monthly x3 months. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems in place are effective. Beginning 3- 9-15 the Administrator or Designee will audit all physician communication forms returned to confirm the physician has reviewed the medications and total program of care at each resident's appointment weekly x4 weeks, then bimonthly x 4 weeks, then monthly x 3. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems in place are effective. Beginning 3-9-15 the DON or Designee will audit all admission/readmission orders for confirmation of the pharmacist's review and any recommendations made weekly x 4, then bimonthly x 4 weeks, then monthly x 3.</p>		

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F 309	Continued From page 9 The nursing staff reported that they found him having a grand mal seizure...started on Keppra 1000 mg IV x1 [one time]...continue on IV Keppra and IV fluids...admitted...In stable condition."  A grand mal seizure, also known as a generalized tonic-clonic seizure, features a loss of consciousness and violent muscle contractions.  The nursing staff, two different doctors, and the consultant pharmacist failed to determine the appropriateness of discontinuing or stopping the resident's medications.  Resident #5 suffered a grand mal seizure, required emergent transport to a local ED and IV medication and fluids, and was admitted to a local medical center.  On 2/11/15 at 11:15 a.m., the Administrator was informed of the finding. No further information was provided.	F 309	The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems in place are effective.		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on closed record review, staff interview, and review of medication error reports, it was determined the facility failed to ensure there were no significant medication errors for 1 of 6 residents (#5) whose medications were reviewed. Resident #5 experienced a grand mal seizure, required emergent transport to a local ED, IV	F 333	The affected resident was discharged on 10-3-14.  All residents have the potential to be affected by this. All Automatic stop orders and discontinued physician orders in the past 2 months have been reviewed to assess the potential for risks to all other residents. An in service will be held on 3-3-15 for the nursing staff to review the Stop Date Order Policy, Admissions Medication Policy,	3-13-15	

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F 333	<p>Continued From page 10</p> <p>medications for seizure management and anxiety, and was admitted to a local medical center nine days after an anticonvulsant medication was abruptly discontinued. In addition, abrupt discontinuation of medications for CAD, depression, and high cholesterol also placed the resident at increased risk for angina (chest pain), heart attack, untreated depression and untreated high cholesterol. Findings included:</p> <p>Resident #5 was admitted to the facility on 9/10/14 with multiple diagnoses which included CAD, HTN, hyperlipidemia, CVA, TIA (stroke), seizure disorder (epilepsy), depression, and COPD.</p> <p>The resident's 9/17/14 admission MDS coding included moderately impaired cognition and the use of injections and antidepressant medication.</p> <p>The resident's 9/9/14 "Interagency/Physician Orders" from the referring hospital included a 4 page MAR, dated 9/10/14. This MAR listed numerous medications, all of which had an "until" or stop/discontinue date.</p> <p>The listed medications included:</p> <ul style="list-style-type: none"> <li>- Keppra (levetiracetam) 250 mg two times a day for seizures until 9/24/14;</li> <li>- Norvasc (amlodipine besylate) 5 mg daily for HTN until 9/26/14;</li> <li>- Celexa (citalopram) 10 mg daily (antidepressant) until 9/24/14;</li> <li>- Lopressor (metoprolol) 25 mg twice daily for HTN until 9/25/14;</li> <li>- Imdur (isosorbide mononitrate) 15 mg daily for CAD until 9/24/14;</li> <li>- Zocor (simvastatin) 20 mg every day for cholesterol until 10/23/14.</li> </ul>	F 333	<p>and Physician's Order Policy. We will also review how to correctly double note orders, Medications that should not be abruptly discontinued and medication errors.</p> <p>The Physician's Order policy was updated on 2-26-15 to include: quantity or specific duration of therapy. The Stop Date Order policy was updated on 2-26-15 to include: If medications other than Lovenox, Zofran, and antibiotics have a stop date ordered the Admitting Nurse or Charge Nurse will call the physician and clarify the order. The Medication Orders Upon Admission Policy was updated to include: Any dose or order that appears inappropriate considering the resident's age, condition, or diagnosis is verified with the attending physician.</p> <p>Beginning 2-18-15, all new orders are checked by the DON or Designee 5 days per week to ensure they are entered correctly on the Medication Administration Record and that there are no stop dates on orders that have</p>		

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F 333	Continued From page 11  The resident's 9/2014 MAR documented all of the aforementioned medications were discontinued on their respective "until" dates; except Zocor, which was stopped after the 9/23/14 dose.  The October 2014 MAR documented only 1 medication, omeprazole, was administered to the resident.  The resident's Progress Note, dated 10/3/14 at 2:37 a.m., documented, "Called to room at 0200 [2:00 a.m.] resident...having a seizure...called [MD's name]...given an order to transfer to the emergency room. Resident was unresponsive to stimuli for 20 min [minutes] after seizure and then started to respond when ambulance crew came to facility. Resident transferred at 0225 [2:25 a.m]."  Review of the resident's emergency department report, dated 10/3/14, revealed the following documentation, "History of Present Illness: ...prior CVAs and seizures...presents...via EMS after...a prolonged seizure at...nursing facility...history of being on Keppra, but for some reason was taking [taken] off the medication about 2 weeks ago. The nursing staff reported that they found him having a grand mal seizure...Plan: ...IV established...given some IV morphine, which did help quite a bit with...anxiety. Following that...started on Keppra 1000 mg IV x 1 [one time]...continue on IV Keppra and IV fluids...admitted to the hospital for continued treatments for seizure...in stable condition."  A Medication Error Report, dated 10/3/14, documented 11 medications, including the aforementioned medications, were omitted on	F 333	not been clarified.  Beginning 3-9-15, the DON or designee will perform audits on medication orders to confirm they are in compliance with existing policy at the facility weekly x 4 weeks, then bimonthly x 4 weeks, then monthly x3 months. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems in place are effective.	

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F 333	<p>Continued From page 12</p> <p>9/23/14. Further investigation Notes documented, "On admit, 9-10-14, orders from the hospital had various dc [discontinue] dates for each med [medication], however, the nursing staff did not question the stop dates. [Resident's name] saw [physician's name] on 9-23-14...and the progress note we received...stating no [change] in meds. RN noted off these progress notes but did not call the physician to clarify the dc of the medications. All nurses involved were counseled and attended med error prevention meeting."</p> <p>On 2/11/15 at 9:35 a.m., the DON was interviewed. When asked about the medication errors, the DON stated, "When the resident went to the hospital I decided to find out why he had a seizure when he had not had one before. That is when I found out his meds were dc'd."</p> <p>On 2/11/14 at 9:40 a.m., LN #1 was interviewed. The LN said she had admitted the resident to the facility on 9/10/14. The LN was asked if she was familiar with Keppra, Norvasc, Lopressor, Imdur, Celexa and Zocor. She indicated she was. When asked if she noticed the stop dates on the medications, the LN said "Yes we did. We faxed the orders to the physician's office. We thought he would clarify the meds." When asked if she thought it unusual that Keppra had a stop date, the LN stated, "Yes but I'm not the nurse who administered the meds. I figured the doctor would clarify the orders." When asked if the physician was alerted/informed about the stop dates, the LN stated, "I don't believe we wrote anything when we sent over the info [information]." The LN said she had talked to the physician's receptionist, "But I don't recall mentioning the stop dates."</p>	F 333		

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F 333	<p>Continued From page 13</p> <p>The Nursing 2015 Drug Handbook documented the following regarding the medications:</p> <ul style="list-style-type: none"> <li>- Kepra: "Seizures can occur if drug is stopped abruptly. Tapering is recommended."</li> <li>- Norvasc: "Abrupt withdrawal of drug may increase frequency and duration of chest pain. Taper dose gradually under medical supervision."</li> <li>- Lopressor: "Black Box Warning. When stopping therapy, taper dosage over 1 to 2 weeks. Abrupt discontinuation may cause exacerbations of angina or MI [myocardial infarction]. Don't discontinue therapy abruptly even in patients treated only for hypertension."</li> <li>- Imdur: "Caution patient to take drug regularly as prescribed, and to keep it accessible at all times. Alert: Advise patient that stopping drug abruptly may cause spasm of the coronary arteries with increased angina symptoms and potential risk of heart attack."</li> <li>- Celexa: "Advise patient not to stop drug abruptly."</li> </ul> <p>The Nursing 2015 Drug Handbook, page 17, "Elements contributing to safer drug administration" noted, "Ensuring the safe delivery of medication involves a system-wide approach...improvements in communication, education, and prevention of hazardous drug exposure can facilitate the safe delivery of medication." On page 18, it noted, "Lack of education has been implicated in many medication errors... All health care team members involved in the process of medication administration, including the prescriber, pharmacist, and nurse, must have access to accurate information about each drug's indications, appropriate dosing frequency...any cautions, and possible adverse effects..."</p>	F 333		

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F 333	Continued From page 14 Significant medication errors occurred when the facility failed to clarify the "until" or stop/discontinue dates for the aforementioned medications with the resident's physician upon and after admission (refer to F 309), on 9/18/14 when the medication regimen review was conducted (refer to F 428), and on 9/15/14 (5 days after admission to the facility) when a physician saw the resident and 9/23/14 when the attending physician saw the resident (refer to F 386).	F 333			
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS  The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.  This REQUIREMENT is not met as evidenced by: Based on review of the facility's Physician Services Policy and Procedures, record review, and staff interview, it was determined the physicians failed to determine the continued appropriateness of a resident's current medication regime. This was true for 1 of 6	F 386	The affected resident was discharged on 10-3-14. All residents have the potential to be affected by this. The Order Summary Report will be sent out to the physicians for review of all current residents on 3-2-15 to confirm that the medication regime and total program of care for each resident matches MD orders and intent. A new physician communication form will be implemented on 3-2-15 to include a statement to be signed by the physician which confirms that he/she has reviewed the current	3-13-15	

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F 386	Continued From page 15 sample residents (#5) whose medications were reviewed. This practice resulted in Resident #5's emergent transfer to a local hospital when found unresponsive to stimuli. Findings included:  1. The facility's 10/2007 Physician Services Policy and Procedure documented "...Physician Services include, but are not limited to...A medical evaluation of the resident and review of orders for care and treatment..."  Resident #5's 9/17/14 admission MDS coded: - moderately impaired cognition, - CAD, HTN, hyperlipidemia, CVA, TIA, or stroke, seizure disorder or epilepsy, depression, COPD, and - received injections, antidepressant, anticoagulant, and antibiotic medications.  Resident #5's Order Listing Report (computer generated copy of physician orders printed 2/10/15) and 9/2014 MAR included the following routine and PRN medications with "until" (stop or discontinue) dates:  - Levofloxacin 750 mg every other day for infection until 9/13/14 - Lovenox 40 mg one time a day for clot prevention until 9/18/14 - Simvastatin 20 mg every day for cholesterol until 9/23/14 - Citalopram 10 mg daily for depression until 9/24/14 - Clopidogrel Bisulfate 75 mg daily for CAD until 9/24/14 - Isosorbide Mononitrate 15 mg daily for CAD until 9/24/14 - Aspirin 81 mg daily for CAD until 9/24/14 - Keppra 250 mg two times a day for seizures	F 386	medication list with start and stop dates and the total program of care for the resident at each physician's visit. Beginning 3- 9-15 the Medical Records or Designee will audit all physician communication forms returned to confirm that the physician has reviewed the medications and total program of care at each resident's appointment weekly x4 weeks, then bimonthly x 4 weeks, then monthly x 3. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems in place are effective.	

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F 386	<p>Continued From page 16 until 9/24/14</p> <ul style="list-style-type: none"> <li>- Senexon 5 ml twice daily for bowels until 9/25/14</li> <li>- Metoprolol Tartrate 25 mg twice daily for HTN until 9/25/14</li> <li>- Amlodipine Besylate 5 mg daily for HTN until 9/26/14</li> <li>- Combivent Respimat 20-100 mcg one puff as needed for COPD until 9/24/14</li> <li>- Ipratropium-Albuterol 3 ml as needed for SOB or wheezing until 9/24/14</li> <li>- Tylenol 325 mg as needed for pain until 9/24/14</li> </ul> <p>Resident #5's 9/2014 MAR documented nursing staff discontinued the administration of the above identified medications on the above "until" indicated dates.</p> <p>Resident #5's medical record documented he was seen by two different doctors during the month of September 2014.</p> <ul style="list-style-type: none"> <li>- MD #1's 9/15/14 progress note documented "...MEDICATIONS: Noted in chart. Include blood thinners..."</li> <li>- MD #2's 9/23/14 "Physician's Visit Communication &amp; Progress Note" documented "...will go home but not quite ready yet. No [change] in [indistinguishable word]..."</li> </ul> <p>Neither of the doctors' progress notes documented or addressed the stop or discontinue dates of the above identified medications on Resident #5's 9/2014 MAR.</p> <p>During an interview on 2/10/15 at 11:45 a.m., the DON said when Resident #5 went to the doctor appointments, the facility provided the resident's</p>	F 386			

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F 386	<p>Continued From page 17</p> <p>current 9/2014 MAR for the doctors to review. She said neither doctor communicated a concern about the "until" (stop or discontinue) dates of the above identified medications. She also said the facility determined MD #2's 9/23/14 progress note documented "no change in medications."</p> <p>Resident #5's 10/3/14 at 2:37 a.m. Progress Note documented "Called to room at 0200 [2:00 a.m.] resident in room having a seizure...called [MD's name] who is on call for [MD's name] and was given an order to transfer to the emergency room. Resident was unresponsive to stimuli for 20 min [minutes] after seizure and then started to respond when ambulance crew came to facility. Resident transferred at 0225 [2:25 a.m]."</p> <p>Resident #5's 10/3/14 ED report documented "...history of prior CVAs and seizures...presents...to ED...via EMS after...a prolonged seizure at...nursing facility...history of being on Keppra, but for some reason was taking [taken] off the medication about 2 weeks ago. The nursing staff reported that they found him having a grand mal seizure...started on Keppra 1000 mg IV x1 [one time]...continue on IV Keppra and IV fluids...admitted...in stable condition."</p> <p>A grand mal seizure, also known as a generalized tonic-clonic seizure, features a loss of consciousness and violent muscle contractions.</p> <p>The doctors failed to determine the appropriateness of discontinuing or stopping Resident #5's medications.</p> <p>On 2/11/15 at 11:15 a.m., the Administrator was informed of the finding. No further information was provided.</p>	F 386		

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F 428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility's Consultant Pharmacist Services Provider Requirements Policy and Procedures, record review, and staff interviews, it was determined the pharmacist failed to identify to the facility medication discontinue dates for 1 of 6 sample residents (#5) whose medications were reviewed. This practice resulted in Resident #5's emergent transfer to a local hospital when found unresponsive to stimuli. Findings Included:</p> <p>1. The facility's 3/1/13 Consultant Pharmacist Services Provider Requirements Policy and Procedures documented, "...The consultant pharmacist provides consultation on all aspects of the provision of pharmacy services in the facility...the consultant pharmacist helps to identify, communicate, address, and resolve concerns and issues related to the provision of pharmaceutical services. This includes, but is not limited to:...Evaluating the process of receiving and interpreting prescriber's orders...assisting in the identification and evaluation of</p>	F 428	<p>The affected resident was discharged on 10-3-14.</p> <p>All residents have the potential to be affected. The consultant pharmacist performed a medication regime review of all current residents on 2-12-15 with findings compiled and reported to the facility on 2-13-15.</p> <p>Beginning 3-2-15 all newly admitted or readmitted resident's medication orders will be reviewed by the pharmacist, within 72 hours of admission with a signed confirmation of review and recommendations as necessary. with special attention to orders with stop dates.</p> <p>Beginning 3-13-14 a second pharmacist will randomly review 10% of the resident's medication regimes to confirm that any irregularities, concerns, recommendations or comments regarding the physician orders are addressed.</p> <p>Beginning 3-9-15 the DON or Designee will audit all admission/readmission orders for confirmation of the pharmacist's review and any recommendations made weekly x 4,</p>	3-13-15

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/11/2015
NAME OF PROVIDER OR SUPPLIER  PARKE VIEW REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
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F 428	<p>Continued From page 19 medication-related issues, including the prevention...of medication errors..."</p> <p>Resident #5 was admitted to the facility with multiple diagnoses including pain, late effects of cerebrovascular disease, other convulsions, muscle weakness, abnormality of gait, lack of coordination, coronary atherosclerosis graft, HTN, chronic airway obstruction, hyperlipidemia, and depressive disorder.</p> <p>Resident #5's 9/17/14 admission MDS coded: - moderately impaired cognition, - CAD, HTN, hyperlipidemia, CVA, TIA, or stroke, seizure disorder or epilepsy, depression, COPD, and - received injections, antidepressant, anticoagulant, and antibiotic medications.</p> <p>Resident #5's Order Listing Report (computer generated copy of physician orders printed 2/10/15) and 9/2014 MAR included the following routine and PRN medications with "until" (stop or discontinue) dates:</p> <ul style="list-style-type: none"> <li>- Levofloxacin 750 mg every other day for infection until 9/13/14</li> <li>- Lovenox 40 mg one time a day for clot prevention until 9/18/14</li> <li>- Simvastatin 20 mg every day for cholesterol until 9/23/14</li> <li>- Citalopram 10 mg daily for depression until 9/24/14</li> <li>- Clopidogrel Bisulfate 75 mg daily for CAD until 9/24/14</li> <li>- Isosorbide Mononitrate 15 mg daily for CAD until 9/24/14</li> <li>- Aspirin 81 mg daily for CAD until 9/24/14</li> <li>- Keppra 250 mg two times a day for seizures</li> </ul>	F 428	then bimonthly x 4 weeks, then monthly x 3. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems in place are effective.		

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F 428	<p>Continued From page 20 until 9/24/14 - Senexon 5 ml twice daily for bowels until 9/25/14 - Metoprolol Tartrate 25 mg twice daily for HTN until 9/25/14 - Amlodipine Besylate 5 mg daily for HTN until 9/26/14 - Combivent Respimat 20-100 mcg one puff as needed for COPD until 9/24/14 - Ipratropium-Albuterol 3 ml as needed for SOB or wheezing until 9/24/14 - Tylenol 325 mg as needed for pain until 9/24/14</p> <p>Resident #5's 9/14 MAR documented nursing staff discontinued the administration of the above identified medications on the above "until" indicated dates.</p> <p>Resident #5's medical record included a pharmacy Medication Chart Review form, dated 9/18/14. The form was initialed by the consulting pharmacist. The form did not identify any medication irregularities, concerns, recommendations, or comments from the consultant pharmacist.</p> <p>Resident #5's 10/3/14 at 2:37 a.m. Progress Note documented "Called to room at 0200 [2:00 a.m.] resident in room having a seizure...called [MD's name] who is on call for [MD's name] and was given an order to transfer to the emergency room. Resident was unresponsive to stimuli for 20 min [minutes] after seizure and then started to respond when ambulance crew came to facility. Resident transferred at 0225 [2:25 a.m.]."</p> <p>Resident #5's 10/3/14 ED report documented "...history of prior CVAs and seizures...presents...to ED...via EMS after...a</p>	F 428		

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F 428	<p>Continued From page 21</p> <p>prolonged seizure at...nursing facility...history of being on Keppra, but for some reason was taking [taken] off the medication about 2 weeks ago. The nursing staff reported that they found him having a grand mal seizure...started on Keppra 1000 mg IV x1 [one time]...continue on IV Keppra and IV fluids...admitted...in stable condition."</p> <p>A grand mal seizure, also known as a generalized tonic-clonic seizure, features a loss of consciousness and violent muscle contractions.</p> <p>During an interview on 2/10/15 at 2:24 p.m., the consultant pharmacist said Keppra medication should be tapered and not stopped abruptly.</p> <p>During an interview on 2/10/15 at 3:05 p.m., the DON provided the survey team with a resident listing form, dated 9/19/14, from the consultant pharmacist. Resident #5's name was on the form. The DON said the pharmacist performed the monthly medication review on 9/18/14 and no medication irregularities, concerns, recommendations, or comments were conveyed to the facility regarding Resident #5.</p> <p>The 2014 Nursing Drug Handbook documented the following medications should not be stopped abruptly and should be tapered as follows:</p> <ul style="list-style-type: none"> <li>- Keppra - seizures may occur, tapering recommended</li> <li>- Amlodipine Besylate - taper dose gradually under medical supervision</li> <li>- Metoprolol Tartrate - Black Box Warning. When stopping therapy taper dosage over 1 to 2 weeks. Abrupt discontinuation may cause exacerbations of angina or myocardial infarction.</li> </ul>	F 428			

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F 428	Continued From page 22 The pharmacist failed to report Resident #5's medication regime irregularities to the facility.  Resident #5 suffered a grand mal seizure, required emergent transport to a local ED and IV medication and fluids, and was admitted to a local medical center.  On 2/11/15 at 11:15 a.m., the Administrator was informed of the finding. No further information was provided.	F 428			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001580	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 02/11/2015
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STREET ADDRESS, CITY, STATE, ZIP CODE  
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C 000	16.03.02 INITIAL COMMENTS  The following deficiencies were cited during the complaint investigation survey of your facility.  The survey team entered the facility on 2/9/15 and exited on 2/11/15.  The surveyors conducting the survey were:  Linda Kelly, RN, Team Coordinator Karen Marshall, MS, RD, LD  Survey definitions:  DON = Director of Nursing H&P = History and Physical HTN = Hypertension PCP = Primary Care Provider	C 000		
C 175	02.100,12,f Immediate Investigation of Incident/Injury  f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Please refer to F225.	C 175	Please refer to F225  <b>RECEIVED</b> MAR - 4 2015 FACILITY STANDARDS	
C 735	02.154,02,d Current History and Physical and Findings  d. The physician shall provide the facility with medical information necessary to care for the patient/resident which includes at least a current history and physical or medical findings completed made no	C 735	All newly admitted or readmitted residents have the potential to be affected. All residents admitted within the past 2 months have been reviewed to assess the potential for risks to other residents.	

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Bureau of Facility Standards

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C 735	<p>Continued From page 1</p> <p>longer than five (5) days prior to admission or within forty-eight (48) hours after admission. The information shall include diagnosis, medical findings, activity limitations, and rehabilitation potential.</p> <p>This Rule is not met as evidenced by: Based on closed record review and staff interview, it was determined the facility did not ensure a H&amp;P for 1 of 3 sample residents (#5) was completed no more than five days prior to admission and no later than 48 hours after admission. Failure to have a current H&amp;P created the potential for the resident's care to be less than optimal. Findings included:</p> <p>Resident #5 was admitted to the facility with multiple diagnoses including pain, late effects of cerebrovascular disease, other convulsions, muscle weakness, abnormality of gait, lack of coordination, coronary atherosclerosis graft, HTN, chronic airway obstruction, hyperlipidemia, and depressive disorder.</p> <p>During an interview on 2/11/15 at 10:00 a.m., the DON was asked for the admission information provided to the resident's PCP when the resident was admitted. At approximately 10:30 a.m., the DON provided the following:</p> <p>- A copy of the resident's previous facility's Admission H&amp;P, dated 8/25/14, which was 16 days before the resident's admission.</p> <p>The facility failed to ensure a current H&amp;P was provided to Resident #5's PCP for admission to the facility.</p> <p>On 2/11/15 at 11:15 a.m., the Administrator was informed of the finding. No further information</p>	C 735	<p>Beginning 3-2-15, on the day of admission, prior to the patient's arrival, the H&amp;P, progress notes, medical findings (including the current medication list), activity limitations and rehab potential will be reviewed by the Admission Coordinator or Designee to confirm that all such orders and clinical information current within the previous 5 days; if not an appointment will be made with the attending physician within 48 hours of admission to obtain this information. The preadmission intake sheet has been updated to include the above information. The admission nurse will complete a checklist upon admission and Medical Records will complete a 24 hour post admission chart review to verify the information is present. Beginning 3-9-15 the Administrator or Designee will audit all new admissions to confirm they have a current H&amp;P (within 5 days prior to admission). If not appointment will be made within 48 hours post admission to obtain the clinical information weekly x 4, then bimonthly x 4 weeks, then monthly x 3.</p>	

Bureau of Facility Standards

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C 735	Continued From page 2 was provided.	C 735	The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems in place are effective.  Please refer to F386	3/13/15  Per TC & the Administrator 3/19/15 8:45 AM Asst. Dir. RA
C 736	02.154,02,e Physician Plan of Care  e. A physician's plan of care shall be provided to the facility upon admission of the patient/resident which reflects medication orders, treatments, diet orders, activity level approved, and any other directives to the facility for the care of the patient/resident. This Rule is not met as evidenced by: Please refer to F386.	C 736		
C 784	02.200,03,b Resident Needs Identified  b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F309.	C 784	Please refer to F309	
C 810	02.200,04,g,vi Medication Omitted  vi. Medications omitted; This Rule is not met as evidenced by: Refer to F 333 as it related to medications that were abruptly stopped/discontinued.	C 810	Please refer to F333	
C 811	02.200,04,g,vii Medication Errors Reported to Physician  vii. Medication errors (which shall	C 811	Please refer to F333	

Bureau of Facility Standards

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C 811	Continued From page 3  be reported to the charge nurse and attending physician. This Rule is not met as evidenced by: Please refer to F333.	C 811		
C 820	02.201,01, a 30-Day Review of All Meds  a. Reviewing the medication profile for each individual patient at least every thirty (30) days. The attending physician shall be advised of drug therapy duplication, incompatibilities or contraindications.  This Rule is not met as evidenced by: Please refer to F428.	C 820	Please refer to F428	



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  
FAX 208-364-1888

FILE COPY

February 19, 2015

Corwin G. Lewis, Jr., Administrator  
Parke View Rehabilitation & Care Center  
2303 Parke Avenue  
Burley, ID 83318-2106

Provider #: 135068

Dear Mr. Lewis:

On **February 11, 2015**, an unannounced on-site complaint survey was conducted at Parke View Rehabilitation & Care Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #6839**

**ALLEGATION #1:**

Residents' medications are stopped or discontinued resulting in a lack of quality care for the residents.

**FINDINGS #1:**

During the investigation, policy and procedures and records were reviewed and staff interviews were completed with the following results:

The Bureau of Facility Standards (BFS) Informational Letter #2014-04 dated May 23, 2014, requires certain events to be reported to the state survey agency. Specific possible neglect situations that must be reported are staff mistakes that result in the resident's need for hospitalization and treatment in a hospital emergency room.

The facility's Physician Services Policy and Procedure dated October 2007 documented physician services include, but are not limited to, a medical evaluation of the resident and review of orders for care and treatment.

The facility's Consultant Pharmacist Services Provider Requirements Policy and Procedures dated March 1, 2013, documented the consultant pharmacist provides consultation on all aspects of the provision of pharmacy services in the facility. The pharmacist helps to identify, communicate, address and resolve concerns and issues related to the provision of pharmaceutical services. This includes, but is not limited to, evaluating the process of receiving and interpreting prescriber's orders and assisting in the identification and evaluation of medication-related issues, including the prevention of medication errors.

Six residents were selected for review. One of the residents was admitted to the facility with several medication orders that had stop or discontinue dates. One of the medications was an anti-convulsant medication.

Nursing staff entered the medications stop or discontinue dates into the facility's electronic database and did not question the stop or discontinue dates. The nursing staff who administered the medications did not question the medications stop or discontinuation dates.

The resident's medication administration record (MAR) documented the specific stop or discontinuation dates of the medications. Nursing staff did not administer the medications after the stop or discontinue dates on the orders.

The resident was seen by two different doctors who did not question or clarify the medication stop or discontinue dates. One of the doctors saw the resident prior to any of the medications stop or discontinue dates.

The facility's consultant pharmacist reviewed the resident's medications on the day the first medication was to stop or be discontinued. The pharmacist did not identify to the facility any irregularities or concerns with the medications stop or discontinue dates.

Approximately six days after the last medication was stopped, the resident suffered a grand mal seizure requiring emergent transport to a local emergency department and intravenous (IV) medications and fluids. The resident was admitted to a local medical center while still receiving the IV medications and fluids.

Interviews were conducted with the Director of Nursing (DoN), the registered nurse who entered resident medications into the facility's electronic database, the consultant pharmacist and the facility Administrator.

The DoN said a medication error report was conducted due to nursing staff not identifying the stop or discontinue dates for resident medications. The DoN also said the nurses should have questioned the medications stop or discontinue dates.

The RN said she faxed the resident's orders and MAR to the current doctor but did not ask for clarification related to the medications stop or discontinue dates.

The consultant pharmacist said anti-convulsant medication should be tapered and not abruptly stopped.

The event was not reported to the BFS. The Administrator said he did not think the event met the state agency reporting criteria.

It was determined that nursing staff did not identify the medications stop or discontinue dates to the facility or the resident's doctors. The resident was seen by two different doctors who did not address the stop or discontinue dates on the resident's medication orders. The consultant pharmacist did not report the irregularities to the facility. In addition, the facility did not submit the required report of possible neglect to the BFS.

Therefore, the allegation was substantiated and deficient practice was cited at F225, F309, F333, F386, F428 and C735.

#### CONCLUSIONS:

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

#### ALLEGATION #2:

The facility does not post advocacy contact information.

#### FINDINGS #2:

A facility tour was conducted when the survey team arrived at the facility. Advocacy information was posted in two separate locations in the facility.

The contact information was available related to the local ombudsman, office on aging, Medicare and Medicaid and the Bureau of Facility Standards.

It could not be established that the facility did not post advocacy contact information in the facility.

Corwin G. Lewis, Jr., Administrator  
February 19, 2015  
Page 4 of 4

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2. 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 "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor  
Long Term Care

LKK/dmj