



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS  
3232 Ecker Street  
P.O. Box 83720  
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PHONE: (208) 334-6626  
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October 5, 2015

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

Provider #: 135068

Dear Mr. Lewis, Jr.:

On **September 24, 2015**, a 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

Corwin Lewis, Jr., Administrator

October 2, 2015

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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 **October 19, 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; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 29, 2015 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 29, 2015**. A change in the seriousness of the deficiencies on **October 29, 2015**, may result in a change in the remedy.

Corwin Lewis, Jr., Administrator  
October 2, 2015  
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The remedy, which will be recommended if substantial compliance has not been achieved by **October 29, 2015** includes the following:

Denial of payment for new admissions effective **December 24, 2015**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 24, 2016**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **September 24, 2015** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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October 2, 2015  
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Go to the middle of the page to **Information Letters** section and click on **State** and select the following:

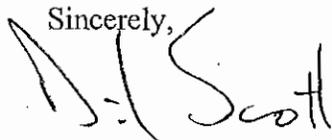
- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **October 19, 2015**. If your request for informal dispute resolution is received after **October 19, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large, sweeping initial "D".

David Scott, RN, Supervisor  
Long Term Care

DJS/lj

Enclosures

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

PRINTED: 10/02/2015  
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  09/24/2015
NAME OF PROVIDER OR SUPPLIER  PARKE VIEW REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318	
(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	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from September 21 to September 25, 2015.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Linda Kelly, RN Amy Barkley, RN, BSN Linda Hukill-Neil, RN Angela Morgan, RN, BSN</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide COPD = Chronic Obstructive Pulmonary Disorder DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment O2 = Oxygen PRN = As Needed TAR = Treatment Administration Record TID = Three Times Daily</p>	F 000	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Parke View Care &amp; Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p>	F 246	<p>1)Resident #7 had call light placed within reach. Resident #1 had water placed within reach. 2)All residents have the potential to be affected related to call light placement. Residents without fluid restriction, thickened liquids, NPO, ect. orders have the potential to be affected by this practice. (Continued)</p>	10/28/15

RECEIVED  
OCT 19 2015  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE 10/16/15

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 246	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure a call light was accessible and water was within reach for 2 of 12 sampled residents (#s 1 & 7). These failures created the potential for harm if the residents' needs were unmet, a negative effect on the residents' psychological well-being when assistance could not be summoned, and increased residents' fall risk with the attempt to transfer independently and reach for fluids. Findings included:  1. Resident #7 was admitted to the facility on 5/4/11 with multiple diagnoses, including congestive heart failure, renal failure, and glaucoma.  The resident's Care Plan documented impaired visual function, ADL deficit with 2 staff assistance for transfers, at risk for falls, and the need to keep items within reach.  During the initial tour on 9/21/15, Resident #7 was observed lying on his bed with the call light coiled and hung on the call light wall mount. LN #1 stated the resident needed to have the call light right by his side or he would not be able to reach it.  2. Resident #1 was admitted to the facility on 11/26/14 with diagnoses of poor oral intake and failure to thrive.  The resident's September Physician's Orders	F 246	(Cont.) 3)Nursing staff on each shift were in-serviced on the importance of availability and accessibility of call lights and fluids. System change will include, call light placement and fluids will be added to new hire orientation and shift change. 4)Beginning on 10/19/15 the Administrator or designee will conduct audits to ensure call lights are within reach of residents and residents without fluid restriction etc. have availability and accessibility to fluids as required. Audits will be performed weekly x 4 weeks, then monthly times 3 months. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective. 5)Date of compliance: 10/28/15		

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F 246	Continued From page 2 documented, "LN to check Q [every] shift water is within reach and filled TID."  Resident #1's Fall Care Plan, initiated 11/26/14 and revised 8/25/15, documented the resident had a bolster air mattress on the bed and that staff were to keep needed items, such as water, within the resident's reach.  Resident #1 had 5 documented falls from 4/5/15 to 8/22/15.  Resident #1 was observed in bed with his water mug placed on a bedside dresser not within a safe reaching distance from his bed on: *9/21/15 at 2:30 PM *9/22/15 at 10:04 AM and 12:30 PM *9/22/15 at 5:00 PM *9/23/15 at 9:40 AM *9/23/15 at 3:30 PM  On 9/23/15 at 4:30 PM, LN #4 was asked if Resident #1's water was within his reach. The LN stated he could grab the mug if he reached over the bolster mattress to get his water from the top of his bedside table that was pushed away from his bed.	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was	F 253	1) Windows have been cleaned and scrubbed for hard water marks. Work order #271-2015-4-01 has been submitted to company project manager. Contractors have been contacted and windows will be repaired. 2) All resident using the Snake River Dining Room have the potential to be affected by this practice. (Continued)	10/28/15

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F 253	Continued From page 3 determined the facility failed to maintain an environment in good repair as evidenced by 6 of 10 windows that were stained with hard water including 3 windows that had cracks. This had the potential to adversely affect a sense of comfort and decrease the vision to the outside for Resident #11 and all other residents who used the Snake River Dining Room. Findings include: On 9/21/15 and 9/23/15, 6 of 10 glass windows observed displayed hard water stains that prevented a clear view to the outside in the Snake River Dining Room. Two of the observed windows had cracks in the glass. On 9/23/15, Resident #11 was observed piecing together a puzzle on a table facing the windows in the Snake River Dining Room. Resident #11 said she could "see better if the windows were not stained with hard water." On 9/24/15, the Maintenance Director was asked if a plan was in place to replace the windows. The Executive Director (ED) later provided a window replacement bid that documented, "Time frame pending bid and contractor availability," and a "Proposal for Pending Projects" outline, dated 5/14/15, that made reference to replacing the affected windows.	F 253	(Cont.) 3) Monitoring of windows has been added to the monthly preventative maintenance checklist. 4) Beginning on 10/26/15 the Administrator or designee will audit the monthly preventative maintenance checklist monthly x 4 months. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective. 5) Date of compliance: 10/28/15	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	1) Resident #3's care plan was updated as needed.	10/28/15
	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an		Resident #4's care plan was updated as needed. Resident #5's care plan was updated as needed. 2) All other residents have the potential to be affected with care plans for oxygen. All residents have been audited and updated as needed. (Continued)	

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F 280	Continued From page 4 interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to revise care plans for 3 of 12 (#s 3, 4 & 5) sampled residents. The care plans were not revised when Resident #3 no longer had a towel placed in her right hand or required having her water placed within her reach; Resident #s 3, 4 and 5 had oxygen (O2) orders that were not included in their care plans. This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in their care plans. Findings included: 1. Resident #3 was admitted to the facility on 10/31/14 with multiple diagnoses, including Chronic Obstructive Pulmonary Disorder (COPD) and contractures. The resident's current care plan did not document the use of oxygen as needed and the resident's Fall Care Plan documented, "Keep needed items, water, etc. in reach." Physician's Orders, dated 7/29/15, documented the resident was to receive oxygen as needed at 2 liters per minute and that nurses were to ensure the resident's water was within reach and filled	F 280	(Cont.) 3) 24 Hour report tool will be modified for resident changes. This tool will have a column to check for care plan updates. Licensed nursing staff will be in-serviced on use of the 24 hour report tool. 4) Beginning on 10/26/15 the DNS or designee will audit the 24 hour report tool for changes requiring care plan updates. Audits will take place weekly x 4 weeks, then monthly x 3 months. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective. 5) Date of compliance: 10/28/15		

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F 280	<p>Continued From page 5 three times daily (TID). The resident's September 2015 TAR documented the resident received oxygen every shift on every day from 9/1/15 to 9/22/15 and that water was within reach and filled TID on all three shifts every day from 9/1/15 to 9/22/15. On 9/21/15, 9/22/15, and 9/23/15, the resident was observed in her room or in the activity room with her oxygen set at 2 liters continuous.</p> <p>On 9/22/15 and 9/23/15, the resident's fluids were observed not within her reach or in her room. On 9/22/15 at 5:00 PM, Resident #3 was observed without a cloth in her right hand. On 9/23/15 at 11:00 AM, LN #4 said placing the cloth in the resident's right hand was discontinued when fingerless gloves were started and the care plan should have been updated. On 9/23/15 at 2:05 PM, LN #3 and LN #2 both said Resident #3's care plan should have have been updated to reflect there was no longer any need to keep fluids within the resident's reach and the oxygen therapy orders, which were not documented on the resident's care plan, should have been included on the care plan.</p> <p>2. Resident #4 was readmitted to the facility on 8/28/15 with multiple diagnoses, including hypertension.</p> <p>The resident's 8/28/15 Physician's Orders documented the resident to have have oxygen as needed and titrate oxygen up to 2 liters per minute to keep saturation levels above 90 percent.</p> <p>The resident's September 2015 TAR documented the resident received oxygen 13 times from</p>	F 280			

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F 280	Continued From page 6 9/1/15 to 9/21/15.  The resident's current care plan did not document the resident used oxygen as needed.  From 9/21/15 to 9/23/15, the resident's room was observed nine times with a room air concentrator. During this time the resident was not receiving oxygen.  On 9/21/15, the resident said she used oxygen "occasionally."  On 9/23/15, the MDS Coordinator said she could not find the resident's oxygen care plan.  3. Resident #5 was admitted to the facility with multiple diagnoses, including Cerebrovascular Accident (CVA), Chronic Airway Obstruction (COPD), and hypoxia.  The resident's September 2015 Physician's Orders and Treatment Administration Record (TAR) documented the following order, "May titrate oxygen to keep saturations over 90% on every shift."	F 280			
	The resident's current care plan did not indicate the resident received oxygen.  On 9/21/15, 9/22/15, and 9/23/15, the resident was observed in her room or the dining room with her oxygen set at 2.5 - 3.0 liters per minute continuous.  On 9/23/15, the Interim Director of Nursing was informed the resident did not have a Care Plan				

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F 280 F 328 SS=D	Continued From page 7 for Oxygen. 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure residents who required and used oxygen had physician's orders, an oxygen Care Plan, and their oxygen therapy monitored. This was true for 1 of 2 (#2) residents sampled for oxygen therapy. This deficient practice created the potential for the delivery of inappropriate oxygen therapy. Findings included:	F 280 F 328	1) Resident #2's care plan and order were updated. 2) Residents using oxygen have the potential to be affected by this practice. Residents using oxygen were reviewed for appropriate order and care plan. 3) 24 hour report tool will be used to identify residents' change of condition requiring use of oxygen. A column will be used for orders obtained and care plan updated. Nursing staff will be in-serviced on the use of the 24 hour report tool. 4) Beginning on 10/26/15 the DNS or designee will audit the 24 hour report tool for orders and care plans related to the use of oxygen weekly x 4 weeks, then monthly x 3 months. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective. 5) Date of compliance 10/28/15	10/28/15	
	Resident #2 was admitted to the facility on 7/29/15 with multiple diagnoses including chronic obstructive pulmonary disease.  The resident's September 2015 Physician's orders, MAR, and TAR did not document the resident used oxygen.  The resident's current Care Plan documented the				

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2015  
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  09/24/2015
NAME OF PROVIDER OR SUPPLIER  PARKE VIEW REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
(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 328	<p>Continued From page 8</p> <p>resident could use an electronic cigarette (e-cig) at the bedside, but staff were to ensure the resident's oxygen was turned off when the e-cig was used.</p> <p>Resident #2's Nurses Progress Notes, dated 9/20/15, documented the resident was on 2 liters of continuous oxygen long term via nasal cannula to maintain oxygen saturation above 90%.</p> <p>On 9/21/15 at 1:50 PM and 2:25 PM and 9/22/15 at 8:50 AM, 10:05 AM, 12:05 PM, and 2:50 PM, the resident was observed in her room, in the dining room, and ambulating in the hallway without oxygen. The resident had an oxygen buddy on her wheelchair and an oxygen concentrator in her room. On 9/21/15, the resident stated she always used 2 liters of oxygen at nighttime and occasionally during the day, when she became short of breath. Resident #2 said she used oxygen at home, during the night, for a "long time."</p> <p>On 9/23/15, LN #2 stated the resident was admitted with oxygen and the facility should have had a physician's order, monitored the oxygen, and a had care plan for the oxygen therapy.</p>	F 328			

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  09/24/2015
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NAME OF PROVIDER OR SUPPLIER  
PARKE VIEW REHABILITATION & CARE CENTI

STREET ADDRESS, CITY, STATE, ZIP CODE  
2303 PARKE AVENUE  
BURLEY, ID 83318

(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) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS  The following deficiencies were cited during the State licensure survey of your facility.  The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Linda Kelly, RN Amy Barkley, RN, BSN Linda Hukill-Neil, RN Angela Morgan, RN	C 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Parke View Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
C 409	02.120.05,i Required Room Closet Space  i. Closet space in each sleeping room shall be twenty inches by twenty-two inches (20" x 22") per patient/resident. Common closets utilized by two (2) or more patients/residents shall be provided with substantial dividers for separation of each patient's/resident's clothing for prevention of cross contamination. All closets shall be equipped with doors. Freestanding closets shall be deducted from the square footage in the sleeping room. This Rule is not met as evidenced by: Based on observation, and resident and staff interview, it was determined 17 of 18 resident room closets on the North Parke Wing (room #'s 110, 112, 117, 118, 119, 120, 121, 122, 124, 125, 126, 127, 128, 129, 130, 131, and 132), did not meet closet space requirements. Findings included: On 9/24/15, The Administrator indicated the facility would again request a waiver for the closet space requirement.	C 409	Parke View Rehabilitation & Care Center is requesting to continue the waiver for the closet space requirements on the North Wing (rooms 110 through 132)	
			RECEIVED OCT 19 2015 FACILITY STANDARDS	

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

TITLE

(X6) DATE

*Administrative*

10/12/15

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  09/24/2015
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NAME OF PROVIDER OR SUPPLIER  PARKE VIEW REHABILITATION & CARE CENTI	STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318
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C 664 C 664	<p>Continued From page 1</p> <p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of the Infection Control Meeting Minutes, it was determined the facility did not ensure the Dietary Manager and Maintenance Supervisor attended the Infection Control Committee. This had the potential to affect all residents, staff, and visitors in the facility. Findings included:</p> <p>On 9/23/15, the Infection Prevention and Control Committee attendance sheets from 1/22 to 8/26/15 were reviewed. The Dietary Manager's signature was not on any of the attendance records and the Maintenance Supervisor's signature was on the meetings only for 3/25 and 4/22/15.</p> <p>On 9/23/15, the Infection Control Chairperson said Dietary had not been represented and a maintenance/housekeeping representative had attended only the March and April meetings.</p>	C 664 C 664	<p>1) Members of committee were talked to regarding responsibility to attend the infection control committee. A committee meeting was held with all required members present.</p> <p>2) All resident have the potential to be affected by this practice.</p> <p>3) An attendance monitoring tool has been created to monitor attendance compliance</p> <p>4) Beginning on 10/15/15 the Administrator or designee will audit the Infection Control Committee Meeting Audit Tool monthly x 4 months. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</p> <p>5)Date of compliance: 10/28/15</p>	10/28/15



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
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October 5, 2015

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

Provider #: 135068

Dear Mr. Lewis, Jr.:

On **September 24, 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 or Entity-Report Incident #ID00007019**

**ALLEGATION #1:**

The complainant stated the food was terrible. The potatoes were black, chicken cordon bleu had too much paprika on it, breakfast was only a slice of toast and a slice of bacon, and boiled zucchini was served four days in a row.

**FINDINGS #1:**

The facility's Grievance file was reviewed and food was not documented as a concern; Resident Council minutes did not document food palatability concerns; and, Menus were reviewed and breakfasts were documented to have several food items and zucchini was not documented to be served four days in a row.

Several individual residents and residents in the Group meeting were interviewed and food palatability was not identified as a concern. The Dietary Manager stated the facility served items from the dietician-approved menus. Food was also observed for quality control and residents

Corwin Lewis, Jr., Administrator  
October 5, 2015  
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could request an alternative.

Breakfasts were observed on three different days during which residents were served more than two items on their plates;

A roasted potato dish was observed without black potatoes; and,

A test tray was found to be palatable without excessive paprika on it.

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

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

The complainant stated therapy exercises for an identified resident did not "make sense." Therapy included tossing balloons, counting silverware, opening an oven door, and batting balloons with a stick.

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey from September 21 to September 25, 2015.

#### FINDINGS #2:

The facility grievances were reviewed and no therapy concerns were identified;

The identified resident's medical record was reviewed for physician orders, physical and occupational therapy orders; and, two other residents were reviewed for therapy. No concerns were identified;

Several individual residents and residents in the Group meeting were interviewed and no therapy concerns were voiced.

An Occupational therapist and the Director of Rehabilitation stated tossing balloons stimulated cognitive functioning as well as improved upper body strength and trunk control for residents with deficits. They also said batting balloons with a stick improved trunk control, balance and helped residents with range-of-motion. They said if residents were going back into the community, then cooking and cleaning type exercises were important to make sure residents could safely live in their own homes, which would include simulating kitchen tasks.

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

Corwin Lewis, Jr., Administrator  
October 5, 2015  
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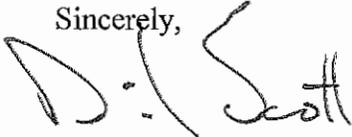
CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary.

If you have questions, comments or concerns regarding our investigation, please contact 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 "D. Scott". The signature is written in a cursive style with a large initial "D" and a stylized "Scott".

David Scott, RN, Supervisor  
Long Term Care

DS/nm